

Audiology Market Review

Final report [with redactions]

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Glossary

Abbreviation

ACC

ACE

AUD

BC

BTE

CAD

CIC

dBA

DKK

DSS

ENT

HAFS

HASS

HIMADA

ITC

ITE

MELAA

MSD

NHS

NSW

NZAS

NZD

NZHIA

ONIHL

OTC

RIC

RITE/RIC

TA/LB

USD

WCB

WHO

WSIB

Stands for

Accident Compensation Corporation

Angiotensin-converting enzyme

Australian Dollar

British Columbia

Behind-the-ear

Canadian Dollar

Completely-in-canal

A-weighted decibel

Danish Kroner

Disability Support Services

Ear, nose, and throat

Hearing Aid Funding Scheme

Hearing Aid Subsidy Scheme

Hearing Instrument Manufacturers and Distributors Association

In-the-canal

In-the-ear

Middle East, Latin America and Africa

Ministry of Social Development

National Health Service (United Kingdom)

New South Wales

New Zealand Audiology Society

New Zealand Dollar

New Zealand Hearing Industry Association

Occupational noise-induced hearing loss

Over-the-counter

Receiver-in-canal

Receiver-in-the-ear

Territorial Authority/Local Board

United States Dollar

Workers' Compensation Board (Canada)

World Health Organization

Workplace Safety and Insurance Board (Canada)

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We acknowledge the input from the Accident Compensation Corporation (ACC), the clinical expert we consulted at the University of Auckland, and the stakeholders who provided their time and thoughts during interviews, in responding to questions, or in completing the online survey coordinated by the New Zealand Audiology Society (NZAS).

A list of those we engaged with is provided in Appendix A. These people were generous with their time and the discussions helped inform our thinking which has fed into this report. However, the views expressed in this report are those of the authors only and should not be taken as representing the views of any of the individuals engaged with during this process, nor any of the organisations they are associated with.

Executive summary

ACC engaged us to undertake a targeted review of the audiology market, including:

- a summary of the New Zealand market, looking at access and service provision across New Zealand
- compiling and comparing information on international service models of similar jurisdictions (particularly those with workplace injury/personal injury schemes for hearing loss)
- describing the current global hearing aid manufacturers, including their relationship with audiology service suppliers.

Global trends relate to demographics, technology, funding and regulation and service delivery models

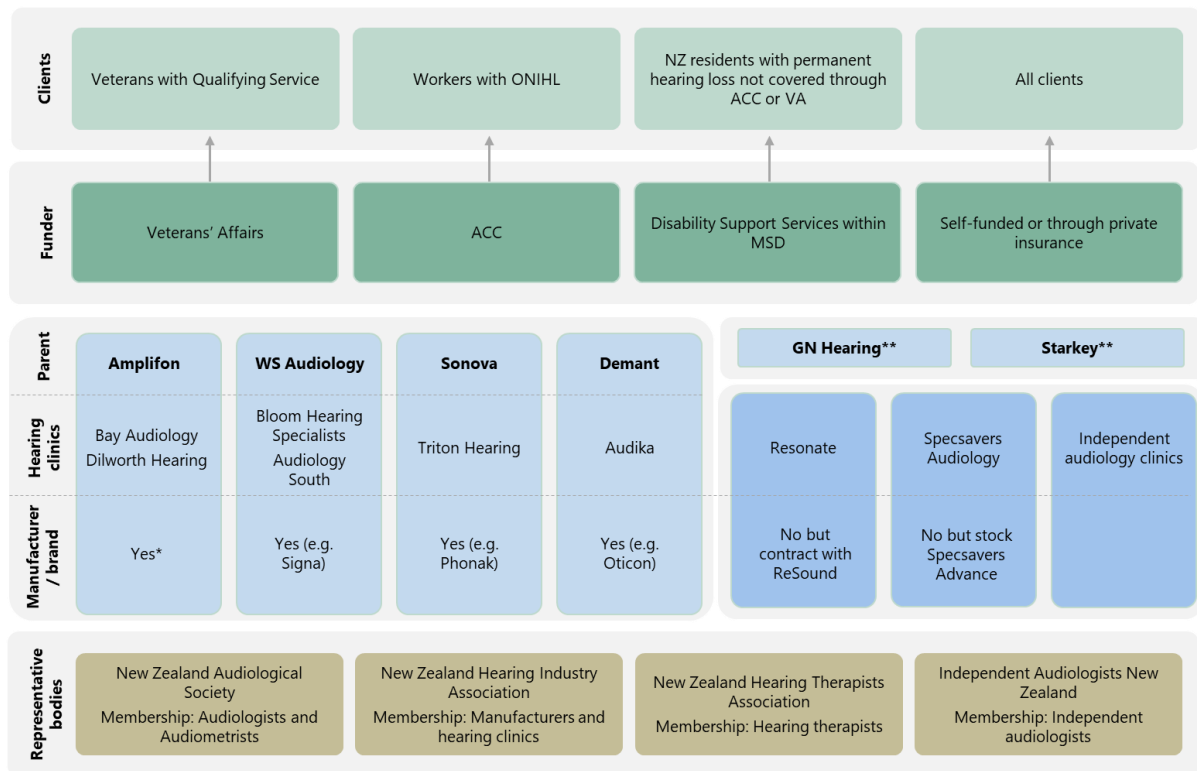
The audiology sector is undergoing change, driven by demographic shifts, technological innovation, changes in funding and regulation, and evolving models of service delivery. Trends impacting the sector include:

- rising demand driven by demographic change
- technological advances in hearing devices
- emergence of over-the-counter hearing aids
- changing service delivery models
- market consolidation, concentration and vertical integration
- increased focus on equity and access
- workforce pressures and skill mix.

Overview of the New Zealand market

The New Zealand market is complex and involves a number of public funders alongside the private market. Vertical integration with manufacturers and hearing clinics is also a key feature. provides a high-level overview of the New Zealand market, which provides context to broader insights discussed below.

Figure 1: Overview of the New Zealand market



*Amplifon is manufactured by GN, WSA, Sonova, Starkey and Demant, and has recently acquired GN Hearing

** These manufacturers do not have a NZ presence in terms of retail, however may supply devices to hearing clinics

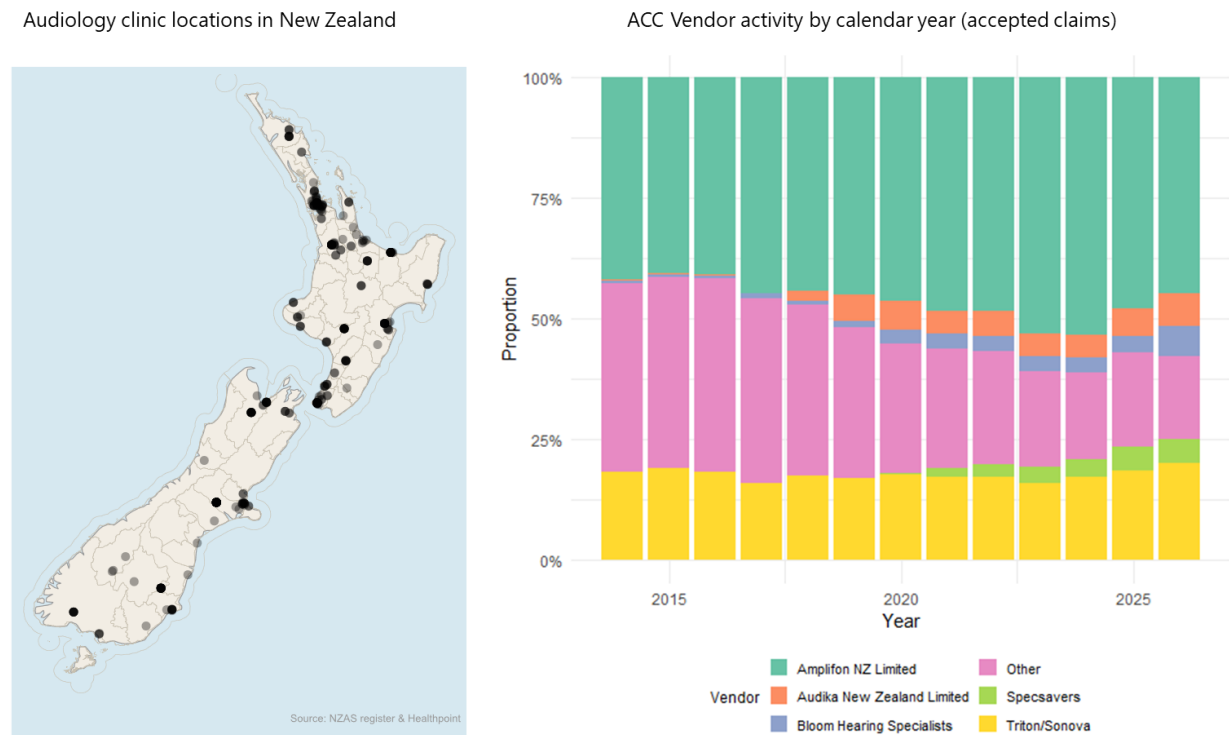
The provision of audiology services has grown in New Zealand, the market is concentrated (as is common internationally), and there are disparities in access

The New Zealand audiology market has experienced sustained growth over the past decade, consistent with global trends driven by population aging, increased recognition of hearing loss, and technological innovation. This growth is reflected in an expanding number of audiology providers, an increased number of clinic locations, and rising demand for hearing aids and audiology services. New Zealand broadly reflects international markets in this respect, where global audiology device markets are growing strongly at an estimated compound annual growth rate of 7 to 8 per cent.

Internationally, the audiology market appears highly concentrated. In New Zealand, a small number of vertically integrated providers dominate service delivery, mirroring a global pattern in which five multinational manufacturers account for around 90 per cent of global hearing aid production and increase their presence in retail clinic networks.

Despite what appears to be growth in provision, access to audiology services is uneven. Geographic disparities persist, with rural and more remote regions experiencing lower service availability and workforce shortages. There are also inequities across population groups, with Māori, Pacific peoples, and some lower-income groups less likely to access funded services or more likely to face higher barriers such as co-payments (though we acknowledge these population inequities are experienced across the whole health sector and are not necessarily exclusive to audiology). These disparities are evident in both international and New Zealand evidence and risk undermining the overall value and equity of hearing loss interventions.

Figure 2: Audiology clinic locations and ACC Vendor activity for accepted claims



Internationally there are examples of different approaches, and possible adjustments might help improve outcomes and sustainability

Figure 3: High-level summary of features of international models

Area	New Zealand - ACC	NSW - SIRA	Victoria - WorkSafe	South Australia - ReturnToWork SA	BC - WorkSafe BC	Alberta - WCB	Ontario - WSIB	Denmark
Feature of scheme (services)*	Maximum service fees (unbundled)	Maximum service fees (unbundled)	Maximum service fees (unbundled)	Maximum service fees (unbundled)	Maximum service fees (unbundled)	Maximum fees by type of assessment. Fitting fee is bundled with hearing device cost.	Bundled fees depending on year of service.	Available through public health system
Feature of scheme (hearing devices)*	Maximum capped fee	Approved hearing device list under a capped price	Price agreed with manufacturer through an approved hearing device list	Maximum capped fee	Approved hearing device list under a capped price	Maximum capped fee	Price agreed with manufacturer through a tender process	Price agreed with manufacturer through a tender process

* Maximum fees refer to the maximum fee that the funder will reimburse / compensate for.

Our review has examined audiology funding and commissioning models in several comparable jurisdictions, including Australia (New South Wales, Victoria, and South Australia), Canada (Alberta, Ontario, and British Columbia), Denmark, and the United Kingdom to the extent possible. We found the following:

- Across these jurisdictions, a range of approaches are used to manage cost, access and quality. These include maximum fee schedules, approved device lists, bundled payments for services and devices, contracted provider models, and large-scale centralised procurement or mass tendering. While no single model is without challenges, international experience demonstrates

that more active management of device selection, pricing, and service expectations can improve cost control, increase transparency, and reduce unwarranted variation in care.

- Common issues identified internationally include managing incentives in vertically integrated markets, ensuring equitable access, balancing clinical discretion with cost control, and maintaining responsiveness to technological change. Adjustments such as clearer separation of service and device funding, tighter governance of device choice, stronger use of contracting and performance requirements, and greater emphasis on prevention and early intervention have been used to help address these challenges.

Three potential contracting and funding options are identified together with targeted considerations to address identified challenges and achieve objectives

Figure 4: Overview of challenges, objectives, and options

Challenges	Objectives	Options
<u>Within our core focus:</u> • potential for commercial incentives to be at odds with client focus or funding sustainability • ease, predictability and process to access funding • inequities in access and outcomes. <u>Wider challenges:</u> • insufficient focus on prevention and education • lack of broader pathways to provide wider support.	• Sustainability of funding • Intervention based on client needs • Costs to clients are manageable and do no deter access/choice • Equitable access • Administrative efficiency	<u>Contracting and funding options:</u> • 1: Active management of the market • 2A: Mass tendering for supply • 2B: Mass tendering for supply, centrally distributed • 3A: Contracting for services , audiologist procures hearing aids • 3B: Contracting for services , ACC procures hearing aids <u>Further targeted considerations:</u> • Broader consideration : access, education, prevention, support pathways, monitoring and outcomes. • Unbundling services : paying for services separately to products and reviewing which services require and audiologist/audiometrists. • Increasing transparency and reducing provider incentives : client rights and reporting, commercial interest, trailing low -cost options. • Information sharing and exploring potential process improvement : potential portal for audiologists; reviewing guidance, forms and processes; targeting supply to at -risk populations.

Challenges

We identify the following potential challenges within the core focus of our review:

- Potential for commercial incentives to be at odds with client focus or funding sustainability.
- Ease, predictability and process to access funding.
- Inequities in access and outcomes.

The following challenges may extend beyond the review or ACC's role:

- Insufficient focus on prevention and education.
- Lack of broader pathways to provide wider support.

Objectives

In the context of these challenges and ACC's role, we identify the following objectives in addressing these challenges:

- Sustainability of funding.
- Intervention based on client needs.
- Costs to clients that are manageable and do not deter access/choice.
- Equitable access.
- Administrative efficiency.

Options

We identify the following as potential options to explore:

Contracting and funding options

- **Option 1:** Active management of the market—approved lists with features and/or costs.
- **Option 2A:** Mass tendering for supply (potentially for all funders).
- **Option 2B:** Mass tendering for supply, centrally distributed.
- **Option 3A:** Contracting for services—audiologist manages and procures hearing aids.
- **Option 3B:** Contracting for services—ACC manages and procures hearing aids.

Further targeted considerations

- **Broader consideration:** access, education, prevention, support pathways, monitoring and outcomes.
- **Unbundling services:** paying for services separately to products and reviewing which services require and audiologists/audiometrists.
- **Increasing transparency and reducing provider incentives:** client rights and reporting, commercial interest, trialling low-cost options.
- **Information sharing and exploring potential process improvement:** potential portal improvements for audiologists; reviewing guidance, forms and processes; targeting supply to at-risk populations.

Options may warrant further consideration in terms of possible design and combinations

Based on a high-level preliminary assessment of these options (summarised below and discussed in the report), we suggest considering whether a combination of options is worth considering further in terms of potential design, merit, and application.

Table 1: High-level summary of preliminary options assessments

Option	Funding sustainability	Intervention based on client needs	Costs to clients are manageable	Equitable access	Administrative efficiency	Risk
1: Active management of market	+	+	+	+	0 / -	-
2A: Mass tendering of supply	++	0 / -	+	+	0 / +	--
2B: Mass tendering of supply, central distribution	++	0 / -	+ / ++	+ / ++	0 / +	--
3A: Contracting for services, Audiologist manages procurement of devices	0 / +	+	+	+	-	-
3B: Contracting for services, ACC manages procurement of devices	+ / ++	++	++	+	0 / -	--

1. Introduction

The Accident Compensation Corporation (ACC) is the Crown entity that delivers New Zealand's accident insurance scheme. The scheme delivers injury prevention initiatives and no-fault personal injury cover for everyone in New Zealand. ACC provides funding assistance for audiology services where eligibility criteria is met (discussed below), and has engaged us to undertake a targeted review of the audiology market in New Zealand and in particular international jurisdictions (Australia, Canada, Denmark and the United Kingdom).

1.1 Basis for ACC's audiology funding assistance

Where funded by ACC, audiology services and hearing aids are largely funded and provided through the Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010 (Hearing Loss Regulations), (Parliamentary Counsel Office, 2024)¹. There are also some audiology-related services provided as non-contracted services, such as ear, nose, and throat (ENT) assessment and therapy for issues like injury-related tinnitus.

The Hearing Loss Regulations specify hearing loss related costs, including the maximum payment for hearing aids and associated service fees. Hearing aids are paid via an apportionment model, which adjusts ACC's contribution based on a proportion of the total hearing loss attributed to the covered injury. The Ministry of Social Development (MSD), via Disability Support Services (DSS) (a business unit within MSD) also funds a contribution towards those clients who have mixed hearing loss (i.e. both injury and non-injury related hearing loss). Other funding sources available in New Zealand are discussed in section 3.5.

1.2 Contextual pressures underpinning the review

ACC seeks to explore opportunities and options available to help ensure it funds the right hearing aid costs and audiology services at the right prices, while incentivising providers to provide better value for money to clients. Prior to this review, concerns with the current commissioning model that had been raised included the following:

- There has been a significant increase in audiology service costs (46 per cent since 2019) which has ACC now spending around \$52 million per annum on audiology services and hearing aids.
- Audiology services have an actuarial impact, as once ACC cover for an injury-related hearing loss is established, entitlements (e.g. 're-aiding' which allows for new hearing aids at intervals of at least six years) are ongoing. This places pressure on the associated Outstanding Claims Liability, and impacts scheme sustainability.
- There is potential for overservicing, overcharging and/or direct-to-consumer marketing on the part of providers, which could impact cost growth.

¹ With Schedule 1, Clause 13 relating specifically to the provision of aids and appliances, such as hearing aids.

- The current entitlements and associated costs set out in the Hearing Loss Regulations leave little opportunity for ACC to effectively manage the provision of hearing aids and other services once cover has been granted.
- New Zealand's aging population means there is likely to be an increasing amount of people with non-injury (age-related) hearing loss, putting increasing pressure on the apportionment model between ACC and MSD.

These pressures come in the context of identified benefits from treating hearing loss and variable access to services, which are noted in sections 2.1 and 2.3.

1.3 Purpose and scope of the review

The **purpose** of this review is to help inform ACC's exploration of commissioning models, seeking to improve efficiency as well as health and social outcomes, and ensure scheme sustainability.²

The **scope** includes both New Zealand and international markets and connections, commissioning models for hearing aids and associated products, and commissioning and integration of audiology services. Specifically, the scope includes the following (detailed further in Appendix B):

1. The audiology market nationally and internationally, suppliers and their market shares, and international service models.
2. Comparative hearing aid service provision and cost in New Zealand.
3. New Zealand use of hearing aids including manufacturers, range and quality, comparative costs and volumes.
4. New Zealand procurement and funding models, and eligibility.
5. Accessories and batteries procured and distributed, their costs, and where these costs are borne.
6. Audiology assessments and fittings costs, quality and volumes.
7. Disparities in client access.

More complex audiology services and the broader benefits of audiology services and hearing aids are not a focus of the review.

² This is done by assisting ACC in understanding if there would be value in exploring commissioning options for audiology services and hearing aids.

1.4 Information sources and methodology

We used a mixed method approach to draw on different sources of information able to be accessed

We combined quantitative methods (targeted analysis of claims data and other data available or collated) with qualitative methods (literature review and interviews), drawing across data sources set out in the table below.

Table 2: Sources and treatment of data

Sources of data	Treatment of data
Data	We drew on ACC's claims and other associated data sources as well as publicly available information on key market participant financials and any pricing/cost schedules.
Academic literature	Academic literature supported our contextual understanding and provided information on service provision disparities.
Legislation and policy	Legislation and policy documentation provided insight into different schemes' coverage, design, support, and eligibility. This was supported by engagement with different funders to understand their context and practices further.
Publicly available material	Previous studies, reports and other publicly available sources of information provided more colour and context to supplement academic literature, legislation and policy, particularly in relation to the market, participants in it, their products and services, and the benefits of and access to these.
Survey of NZAS members	A survey undertaken through the New Zealand Audiology Society (NZAS) provided input into the cost model and an understanding of the challenges with the current model and drivers of cost.
Key stakeholders	Interviews with stakeholders provided additional insights. We agreed a stakeholder list with ACC including informants from other funders/workplace insurance schemes, hearing aid manufacturers, audiology service providers, and others including those that support clients. The interview sample covered different business models, sizes, levels of integration/focus/independence, and geographic and service coverage. By engaging with NZAS and the New Zealand Hearing Industry Association (NZHIA), we garnered views across wider audiologists/audiometrists and manufacturers/retailers (including seeking non-identifiable market-level information). Further detail on those interviewed is provided in Appendix A.

We established workstreams focusing on the demand and supply side as well as considering different commissioning models and outcomes

We established three complementary workstreams (with a focus agreed on with ACC for the third workstream in identifying potential options/opportunities):

- **demand side analysis:** largely claims data analysis but also selected interviews with hearing aid providers

- **supply side analysis:** market review, technology scan, and interviews with suppliers
- **review of commissioning models and outcomes:** international interviews, problem definition for New Zealand, and options development.

We organised the review into four phases to deliver within the timeframes

To ensure clarity and progress, we divided the project into four digestible phases (scoping and planning, discovery/data collection, synthesis, report writing), with the three workstreams being started at the same time. The figure below outlines these phases, from initial scoping and planning through to final reporting alongside key tasks, with work completed between February and April 2026.

Figure 5: Project phases

Scoping and planning	Discovery / data collection	Synthesis	Report writing
Planning and inception • Hold inception meeting • Obtain relevant documentation • Confirm stakeholder list and stakeholder engagement • Confirm responsibilities, scope, and timelines • Define project management and ongoing communication • Discuss potential sensitivities	Review, stakeholder engagement, and analysis • Review and analyse ACC claims data • Conduct literature search • Review and analyse relevant documentation • Conduct stakeholder interviews • Collect additional data (including NZAS survey) • Develop summary of findings	Interpretation • Identify problem definition and framework for considering options • Contextualise analysis considering objectives • Compare NZ market against international jurisdictions • Validate quantitative insights with qualitative evidence • Integrate data streams • Identify themes in procurement and funding mechanisms and equity considerations	Finalisation • Develop report with methodology, limitations, and key insights • Obtain ACC feedback, refine results and presentation • Deliver findings through detailed report with executive summary

1.5 Limitations

We focused on questions within our scope that were able to be answered with time available, and available data. Specific limitations in the data include the following:

- Information not available due to commercial sensitivity—several stakeholders raised concerns about sharing commercially sensitive information.
- Survey information obtained through the NZAS was obtained over a relatively short period and not all members were able to respond. We understand some employers may have asked employees not to respond, and instead potentially responded on behalf of their entities, which could introduce a degree of bias. Respondents might not have access to the information needed to answer certain questions with 100 per cent accuracy, so responses should be interpreted as respondents' views. Further, response rates vary by question and respondent type, meaning the confidence in answers may vary and differences across stakeholders should be interpreted in this context.
- Analysis of interventions or costs relative to degree of hearing loss is not possible.
- There are some gaps in recorded information which may hide a bias in our analysis.
- We sampled ACC data to give us an extended data set. The sample is over a short time period and has missing information, which means it might not be representative of the wider claims over an entire year.

1.6 Report outline

The remainder of the report is set out as follows:

- Context is provided in relation to audiology services globally in section 2, including funding and commissioning models.
- The New Zealand landscape market is discussed in section 3, including inequities in access and ACC-funded services.
- Products, pricing, and the costs of audiology services are discussed in section 4.
- Challenges and potential options to explore further are considered in section 5.

We provide a full set of references and appendices setting out: the stakeholders engaged with during the review; the full scope of the review; a hearing industry map; greater detail on the international commissioning models examined, and international price comparisons of hearing aid models and accessories where data is publicly available; greater detail on audiologist supply relative to population and age structure; insights from ACC claims data; and a summary of responses to the NZAS survey.

2. Audiology context globally

This section outlines the scope and role of audiology, the value generated by effective hearing care, and the key challenges facing the sector. It presents an overview of audiology services and technologies, examines their individual, social, and economic benefits, and highlights persistent disparities in access globally. The section also summarises key trends shaping the future demand, delivery, and equity of audiology services, describes the supplier landscape internationally, and concludes by looking at funding and commissioning models used internationally or in other contexts that could represent opportunities. In this section, we look at audiology generally and not just hearing loss from work-related injury.

2.1 Overview of audiology

Audiology is a clinical health discipline concerned with the assessment, diagnosis, management, and rehabilitation of hearing and balance disorders. Audiologists are trained health professionals who work with people across the life course, from newborns to older adults, and their role spans clinical care, device management, and long-term rehabilitation.

Audiology covers a broad set of conditions, including the following:

- **Hearing loss:** can be age related, noise-induced or sensorineural, conductive, or mixed. Global modelling shows that more than 400 million people worldwide have hearing loss severe enough to benefit from hearing aids (WHO, 2024) , with over 80 per cent having unmet need (Orji et al., 2020). The World Health Organization (WHO) (2024) estimates around 17 per cent of people who could benefit actually use hearing aids.
- **Tinnitus:** the persistent perception of sound without an external source. Tinnitus frequently co-occurs with hearing loss and is commonly managed within audiology services through counselling, sound therapy, and hearing aids (Chisolm, 2014).
- **Balance and vestibular disorders:** dizziness, vertigo, and balance dysfunction. These conditions are routinely assessed and managed by audiologists, particularly within hospital and specialist settings (IBISWorld, 2025).
- **Auditory processing disorders:** difficulty interpreting sound despite normal peripheral hearing, particularly relevant in paediatric and some adult populations.

Audiology services extend beyond simply treating a set of conditions and include wider follow-up care to assist patients with adjusting to devices and the impacts of their conditions.

Hearing technologies used in audiology

Hearing aids constitute the largest share of hearing interventions globally and include (The Business Research Company, 2025):

- behind-the-ear (BTE)
- receiver-in-the-ear (RITE/RIC)
- in-the-ear (ITE)

- in-the-canal and completely-in-canal (ITC/CIC).

Implantable and specialist devices are also utilised in audiology. These devices are typically managed collaboratively between audiologists and specialist medical services and include:

- cochlear implants
- bone-anchored hearing systems.

The audiology sector is innovating and evolving, with additional technological developments such as the use of Bluetooth, AI, rechargeability and remote fitting or tele-assessments.

2.2 The value of audiology services

Audiology services generate value at individual, societal, and system levels. Well-designed and accessible audiology services deliver benefits that extend beyond hearing improvement alone, affecting participation, productivity, and long-term health outcomes.

Individual and clinical value

Hearing loss has a direct impact on communication, social interaction, and daily functioning. Audiology services, particularly hearing assessment, hearing aid fitting, and rehabilitation, are associated with measurable improvements in hearing-related quality of life and communication ability.

Evidence indicates that:

- hearing aids improve speech understanding and listening ability in everyday environments
- ongoing audiological support and follow-up are critical to achieving and sustaining benefit from devices (Chisolm, 2014)
- rehabilitation services amplify the benefit of devices by supporting adaptation and effective use (Jilla et al., 2024).

Prevention of secondary health impacts

Untreated hearing loss is also associated with broader health consequences, including (WHO, 2021):

- social isolation and loneliness
- depression and reduced mental wellbeing
- cognitive decline and increased risk of dementia
- reduced safety and independence.

Audiology services contribute to the prevention or mitigation of these secondary impacts by identifying hearing loss early and supporting effective hearing rehabilitation.

Social and economic value

There appears to be a clear relationship between hearing loss and reduced workforce participation, especially for moderate to severe hearing loss. Studies from Europe and Scandinavia show associations between hearing loss and lower employment rates, reduced workability, and a greater reliance on partial employment arrangements (Svinndal et al., 2018).

Audiology services play a role in maintaining work participation by assessing work-related hearing loss and supporting access to treatments, hearing aids and assistive technologies. Injury-related and occupational audiology services are therefore associated with productivity benefits and reduced long-term economic costs related to income loss and compensation (WHO, 2021). WHO (2024) estimates unaddressed hearing loss costs the global economy somewhere in the region of \$980 billion USD per annum.

2.3 International disparities in access to audiology

Demand is driven primarily by demographic change. WHO estimates that over 1.5 billion people globally live with hearing loss, with around 430 million requiring rehabilitation (Orji et al., 2020). Despite this, global uptake remains low, more than 80 per cent of those who could benefit from hearing aids do not have them, indicating substantial unmet need (Orji et al., 2020). Key barriers identified in the literature include high device costs, limited reimbursement, workforce constraints, and stigma.

Internationally, access to audiology services is uneven across populations and regions despite the high prevalence of hearing loss and the demonstrated value of intervention. These disparities contribute to large volumes of unmet need and reduce the overall effectiveness and value of hearing care systems.

Cost and funding implications

A cause of inequitable access is the cost of hearing aids and the differing levels of funding coverage.

Globally, affordability cited as a primary driver of unmet need (Orji et al., 2020; WHO, 2021). Evidence from New Zealand and comparable jurisdictions indicates co-payments and private market pricing are associated with delayed uptake or non-use of hearing aids, even among individuals with clinically significant hearing loss (Wallace et al., 2019).

Access to services can also vary depending on eligibility for public funding. International comparisons show that countries with universal or near-universal coverage for audiology services, such as the United Kingdom (UK) and Denmark, achieve higher access rates than systems relying heavily on private payment or insurance (WHO, 2021). New Zealand-specific analysis highlights differences in access between individuals covered under ACC, Veterans' Affairs, or disability schemes and those reliant on general hearing aid subsidy arrangements (ACC, 2025; Wallace et al., 2019).

Geographic disparities

Geographic location plays a significant role in access to audiology services. Workforce assessments in New Zealand and Australia identify shortages of audiologists in regional and rural areas, contributing to longer wait times and limited service availability (IBISWorld, 2025; Technical Advisory Services, 2018). Similar patterns are observed internationally, where specialist audiology services are concentrated in urban centres (WHO, 2021).

Tele-audiology and remote service models are increasingly cited as partial mitigations, but the literature indicates they do not fully address the access gap where device fitting, follow-up, or multidisciplinary care is needed (Chisolm, 2014).

2.4 Trends in audiology

The audiology sector is undergoing significant change, driven by demographic shifts, technological innovation, changes in funding and regulation, and evolving models of service delivery. Trends impacting the sector include:

- **Rising demand driven by demographic change:** the prevalence of hearing loss increases sharply with age (62 per cent of people with hearing loss are over 50 years old (Shen et al., 2025), with global estimates suggesting that more than 1.5 billion people have some degree of hearing loss, and around 430 million require rehabilitation (WHO, 2021). More recent analysis (Shen et al., 2025) supports the estimate of 1.5 billion people, and projects that by 2050 around 2.5 billion people will suffer some degree of hearing loss.
- **Technological advances in hearing devices:** hearing devices continue to evolve with advances such as adaptive sound processing, directional microphones, and wireless connectivity becoming standard (DelveInsight, 2024; Grand View Research, 2025). Smartphone compatibility, rechargeable batteries, and app-based controls are increasingly important to users and influence purchasing and uptake decisions (Shepherd, 2024).
- **Over-the-counter (OTC) hearing aids:** there is increasing demand from consumers for OTC hearing aids, leading to the Food and Drug Administration in the United States (US) to establish and develop regulations for a class of OTC hearing aids (American Academy of Audiology, n.d.). A number of studies indicate that OTC hearing aids may have a role alongside traditional hearing aids provided by audiologists, being only slightly poorer or providing similar benefits in comparison (Humes et al., 2017; Swanepoel et al., 2023; Tran & Manchaiah, 2018). However, challenges continue in the OTC hearing aid market, with indications that more expensive OTC devices may have difficulty catering to consumers looking for lower price points (Strom, 2026).
- **Changing service delivery models:** remote consultations, device programming, and follow-up appointments are increasingly feasible for some service components (Chisolm, 2014; DelveInsight, 2024). However, audiology services such as initial assessments, complex fittings, and rehabilitations still require in-person care for many patients.
- **Market consolidation and concentration:** global hearing aid manufacturing is dominated by the “Big Five” (Sonova, Demant, GN Store Nord, Starkey, WS Audiology) (Grand View Research, 2025). These firms also own or control retail audiology clinic networks, leading to vertical integration (Abram Bailey & Karl Strom, 2019).
- **Increased focus on equity and access:** international policy frameworks, including the WHO World Report on Hearing (2021), emphasise integration of hearing care into universal health coverage.
- **Workforce pressures and skill mix:** there are persistent shortages of audiologists, in particular in rural areas (Garuccio et al., 2025). Suggested changes include integrating hearing screening and referral networks within community health centres, or expanding reimbursement rates for tele-audiology services (Garuccio et al., 2025).

2.5 The supplier landscape

The global hearing aid market is highly concentrated, with manufacturing dominated by five multinational firms: Sonova, Demant, GN Store Nord (GN Hearing), Starkey Hearing Technologies, and WS Audiology. Together, these five firms account for over 80 to 90 per cent of global market share (Better Hearing Australia, 2023). Other sources (Global Market Insights Inc., 2025) suggest the top five manufacturers control around 92 per cent of the global hearing aid market. In either case, the market can be described as highly consolidated. These firms operate extensive multi-brand portfolios across premium and value segments, enabling them to tailor products to different funding, regulatory, and consumer environments.

Downstream, Amplifon is identified as the world's largest specialist hearing aid retailer, operating across more than 25 countries and selling private-label devices sourced from the major manufacturers (Better Hearing Australia, 2023). Cochlear is a major global player in implantable hearing devices and forms part of the broader audiology device ecosystem. An overview of suppliers and their services and products is provided in Appendix C.

Technological developments, including digital signal processing, Bluetooth connectivity, rechargeable batteries, smartphone integration, and tele-audiology are reshaping products and consumer expectations, and supporting continued market expansion (DelveInsight, 2024).

2.5.1 Vertical integration

A defining feature of the industry is strong vertical integration, with manufacturers increasingly owning or having interests in retail audiology clinics. Evidence from New Zealand and Australia indicates that multinational firms own more than 80 per cent of hearing clinics, mirroring trends observed in Europe and the US (Better Hearing Australia, 2023; Pratley, 2026). This integration enables bundled pricing of devices and services and may be associated with manufacturer control over product choice. Concerns have been raised in relation to competition, price transparency, and consumer outcomes, particularly where public subsidies or insurance funding apply (Wallace et al., 2019).

2.5.2 Global market size and growth

Market research consistently points to robust growth. The Business Research Company (2025) estimates the global hearing aid devices and equipment market at USD 11.9 billion in 2024, projected to reach USD 17.7 billion by 2029 (compound annual growth rate ~8 per cent). Broader estimates of the audiology devices market place its value at USD 14 to 15 billion in 2024, rising to over USD 20 billion by 2030 (DelveInsight, 2024). Fortune Business Insights (2026) estimates the market was worth USD 15.1 billion in 2025, when wider audiology devices are included.

Europe currently represents the largest revenue share, supported by strong public reimbursement systems, while North America leads in premium and technologically advanced devices. Asia-Pacific is the fastest-growing region, driven by population aging, rising healthcare access, and expanding screening and rehabilitation programs (Grand View Research, 2025; The Business Research Company, 2025).

2.5.3 Market disruption

Recent regulatory changes enabling OTC hearing aids, particularly in the US from 2022, are identified as a potential disruptor to traditional clinic-based models. While OTC devices promise lower prices and improved access for people with mild-to-moderate hearing loss, the literature documents strong resistance from incumbent manufacturers concerned about competitive and margin impacts (Shepherd, 2024). During interviews and in other materials, concerns have also been raised in terms of ensuring quality and fit, with risks of missing client health issues (or treating something where alternative interventions may be more suitable) also raised.

2.5.4 Costs across the supply chain for hearing aids

A 2017 study provided the following as an indication of costs across components of the US hearing aid supply chain at the time (Humes et al., 2017):

"There are two primary components to the average retail price of hearing aids sold in the United States: (a) the cost of the devices themselves from the manufacturer and (b) the fees for services rendered by the professionals delivering the devices. The production costs of most hearing aids are relatively low, although production costs do not include other costs such as research and development, marketing, technical support, and so on. For example, for the devices used in this project—good-quality devices with multiple channel compression, feedback cancellation, noise reduction, and directional microphones—the production costs were about \$100/aid at study onset. Extremely high-volume dispensers of these devices, such as Costco and the Veterans Administration, were charged by the manufacturer about \$250–\$500 per aid at that time. Wholesale prices to lower volume dispensers for these devices ranged from about \$900–\$1,200, and the average retail price charged by these dispensers for these same aids in the United States was about \$2,000–\$3,000 per aid at that time. Of course, the difference between the dispenser's wholesale price paid and retail price charged is not all profit. The dispenser too has a variety of business expenses to cover."

2.6 Funding and commissioning models

A variety of funding and commissioning models are used internationally and in other sectors in New Zealand. This sub-section outlines the following models:

- **Fee schedule model:** this model, largely applied in both Australia and Canada, uses maximum fee schedules that service providers can invoice for from the workplace injury scheme. There are variations on the mechanisms used within this model regarding hearing aid device management, service provider management, and the bundling of services and devices.
- **Mass tender model:** this model is applied in Denmark and involves a tender process for hearing aid devices that covers 98 per cent of hearing aids supplied under the public system.
- **The Pharmac model:** allowing access to subsidy depending on whether the device is the same or similar, or generically the same.

More detailed descriptions of the international models included in this review can be found in Appendix D.

2.6.1 Fee schedule model

Across Australia and Canada, workplace injury compensation schemes commonly apply a maximum fee schedule approach to fund audiology services and hearing aids. Under this model, schemes publish prescribed schedules that set the upper limits payable for hearing assessments, hearing devices, fittings, batteries, repairs, and related clinical services, with services delivered by approved or authorised providers. In Australia, these fee schedules are administered at a state or territorial level and are intended to promote cost certainty while allowing clinical discretion on recommended devices. Similarly in Canada, workers' compensation boards establish maximum reimbursable fees.

Within this model there are several mechanisms that differentiate some states in Australia and provinces in Canada. These mechanisms include:

- contracted versus non-contracted providers
- approved hearing device lists
- procurement through approved providers
- bundling of services and devices.

A comparison of the maximum fee schedules across three states in Australia and three provinces in Canada is presented in the figure below.

Figure 6: Comparison of fee schedules in relevant workplace compensation schemes³

Area	New Zealand - ACC (\$NZD, excl GST)	NSW – SIRA (\$AUD)	Victoria - WorkSafe (\$AUD)	South Australia – ReturnToWork SA (\$AUD)	BC – WorkSafe BC (\$CAD)	Alberta – WCB (\$CAD)	Ontario – WSIB (\$CAD)
Audiology services	Hearing assessment report: \$168.86 Specialised hearing assessment p/h: \$180	Audiologist: \$237.70 (\$290.07 NZD) Audiometrist: \$195.90 (\$239.06 NZD)	Audiologist: \$216.13 (\$263.74 NZD) Audiometrist: \$187.47 (\$228.77 NZD)	Audiologist: \$244.60 (\$298.49 NZD) flat fee Audiometrist: \$219.60 (\$267.98 NZD) flat fee	\$130 (\$161.42 NZD) per audiologist diagnostic assessment	\$105 (\$130.38 NZD) initial assessment, \$50.40 (\$62.59 NZD) subsequent assessment	Initial bundle – first year of services tied to selection and dispensing of first hearing aids including batteries: \$800 per ear (\$993.37 NZD).
Fittings	Monoaural: \$873.45 Binaural: \$1,198.85 (excl. GST)	\$686.90 (\$838.24 NZD)	Monoaural: \$1,001.82 (\$1222.52 NZD) Binaural: \$1,422.12 (\$1735.41 NZD) <i>Once every five years</i>	Monoaural: \$897.40 (\$1095.10 NZD) Binaural: \$1,317.20 (\$1607.38 NZD)	\$620 (\$769.86 NZD) per hearing aid (incl follow-up appointments and care for 1 year)	Monoaural: \$498.40 (\$618.87 NZD) Binaural: \$996.80 (\$1237.74 NZD)	Ongoing bundle: - for services required in subsequent years \$177.50 (\$220.40 NZD) per ear every 180 days, or \$710 annually (\$881.62 NZD). Mini bundle – for replacements due to change in prescription: \$310 per ear (\$384.93 NZD).
Hearing aids	Monoaural: \$1,668.17 Binaural: \$3,336.34	Cost price of hearing aids, including remote control, charger, batteries and consumables to a maximum of \$2,500 (\$3,050.75 NZD) per aid. Batteries and consumables are for the first 12 months.	Price agreed between manufacturer and WorkSafe	\$2,020 (\$2,465.01 NZD) maximum	Each manufacturer has a list (Price Grid) of hearing aids available to workers that are under the Hearing Aid Price Cap	Monoaural hearing aid: \$900 + \$40 shipping (\$1,117.54 + \$49.67 NZD) Binaural hearing aid: \$1,800 + \$80 shipping (\$2,235.09 + \$99/34 NZD)	Price agreed between manufacturer and WSIB
Repairs	\$54.47 (onsite repairs, maximum two per year) \$217.89 (offsite repairs, maximum two per year)	Up to \$461.50 (\$563.17 NZD)	\$504.28 (\$615.37 NZD)	Reasonable cost	Manufacturer invoice cost, including shipping	Out of office clinic fee: \$65/aid (\$80.71 NZD) Manufacturer repair: Manufacturer cost In office after warranty period: \$30/aid (\$37.25 NZD). A maximum 2 times per aid in a 12-month period after one year from initial fitting date	Reasonable costs for the manufacturer to repair
Replacements	Re-aiding is available after six years	If lost or damaged and not covered by warranty or can no longer communicate with the current aid	After five years if the replacement is reasonable or necessary	The expected life of a hearing aid is five years. A replacement prior to five years may be approved in some circumstances	Replacement hearing aids must be applied for and are not automatically replaced after five years.	A hearing aid is replaced only as required, regardless of age. If the hearing aid is less than five years old, prior authorisation is required	Generally, one request to replace a lost, stolen or damaged hearing aid is considered in every five year cycle. A replacement can be applied for before the five-year renewal date for consideration.
Batteries		\$141.60 (\$172.79 NZD) per hearing aid (12 months supply). This cannot be supplied until after 12 months from initial supply of hearing aid	\$80 (\$97.62 NZD) (12 month supply). This can be claimed 12-months after the hearing aid fitting.	\$101 (\$123.25 NZD) per device per year, applicable 12 months after the fitting of the hearing device	Up to \$1.15 (\$1.43 NZD) per cell, maximum of one years worth	\$0.75 (\$0.93 NZD) each, 60 per year per aid or 100 per year per aid for size 10	See above. Batteries are included as part of initial bundle. For subsequent service years, reasonable requests for batteries are covered.

³ Conversions to NZD as at 29 April 2026. Fee schedules and entitlements have been sourced from workplace compensation scheme websites, interviews and responses to information requests (ACC, 2025; ReturnToWorkSA, 2025c; State Insurance Regulatory Authority, 2024a; Workers Compensation Board - Alberta, 2026; Workplace Safety and Insurance Board, 2025b, 2026a; WorkSafe Victoria, 2025c; WorkSafeBC, 2022a).

Contracted versus non-contracted providers

In Victoria, WorkSafe enters into contracts with hearing services practices through a public tender process (WorkSafe Victoria, 2025a). [Redacted

]. Non-contracted hearing service providers can charge up to the maximum fees set out in Appendix D.

The contracted provider model allows for more control from the funder to monitor services and their adherence to policy guidelines. With greater adherence, there is more cost control despite higher fees being available.

Approved hearing device lists

Approved hearing device lists are maintained by states, such as New South Wales and Victoria (WorkSafe Victoria, 2026). Approved hearing device lists include hearing aids that fall under a certain cost cap (as in New South Wales), or at a price that is agreed with the manufacturer (as is the case in Victoria).

Management and development of the approved hearing device list differ across schemes. In New South Wales, the list is managed by asking manufacturers to provide hearing aids that are under the price cap specified by the funder (or icare). In Victoria, the approved hearing aid list is developed alongside a clinical panel using a feature-based approach as opposed to a cost-cap approach (WorkSafe Victoria, 2026). This means hearing aids included must meet WorkSafe's required features that are intended to cater to the expected needs of workers.

Audiologists and approved hearing aid providers are able to recommend any device that is included on the approved list without additional approval from the funder. In Victoria, if the requested device is not on the approved list, a device exception request form must be completed and the WorkSafe Clinical Panel assesses each application on a case-by-case basis (WorkSafe Victoria, n.d.).

Funding flows through authorised service providers

In Alberta, funding from the Workers' Compensation Board (WCB) for hearing aids flows through contracted and authorised service providers. This means that when an audiology service provider requests funding for a hearing aid, they will provide WCB with a manufacturer invoice. The reimbursement of manufacturer costs is subject to a maximum fee (Workers Compensation Board - Alberta, 2026).

Procurement of service providers is through standing service agreements with qualified community-based providers. These providers enter into a multi-year contractual agreement with WCB that defines (Workers Compensation Board - Alberta, 2026):

- clinical service standards and requirements
- authorisation and approval processes
- reporting and documentation obligations
- fee schedules and maximum payable amounts.

This model provides clinician choice and some cost certainty to the funder.

Bundling of services and/or devices

Fee schedules across Australia and Canada often have a degree of bundling. This may include bundling the costs of fittings or the first 12 months of batteries with the hearing aid device itself.

Bundling may involve bundling of services only, such as the model in Ontario. In Ontario, the Workplace Safety and Insurance Board (WSIB) uses a mandatory bundled fee model (Workplace Safety and Insurance Board, 2025b). This model means that regardless of how many follow up appointments a client attends with the service provider, there is a set amount that can be claimed as part of the bundle. Bundles include the following (Workplace Safety and Insurance Board, 2025b):

- **Initial bundle:** includes the first year of service tied to the selection and dispensing of first hearing aids, including batteries.
- **Ongoing bundle:** includes all services required for subsequent years (one year after initial bundle) and can be billed every 180 days for \$710 annually. It is prompted by a client's visit for services.
- **Mini bundle:** includes clinical service required following the WSIB-approved replacement of hearing aids due to a change in prescription.

Other schemes, such as in Alberta, will bundle fittings and hearing devices up to a maximum total fee (Workers Compensation Board - Alberta, 2026). In South Australia and Victoria, the first 12 months of batteries is bundled with fittings (ReturntoWorkSA, 2025c; WorkSafe Victoria, 2025c). In New South Wales, batteries and consumables are bundled with the hearing device (State Insurance Regulatory Authority, 2024a).

A bundling approach can reduce the administrative burden on the service provider through ease of invoicing. Audiology clinics may also find more stability in revenue, particularly in a model such as Ontario. Patients may find more equity in the quality of care provided across clinics as there is certainty in follow-up appointments and aftercare.

2.7 Mass tender model

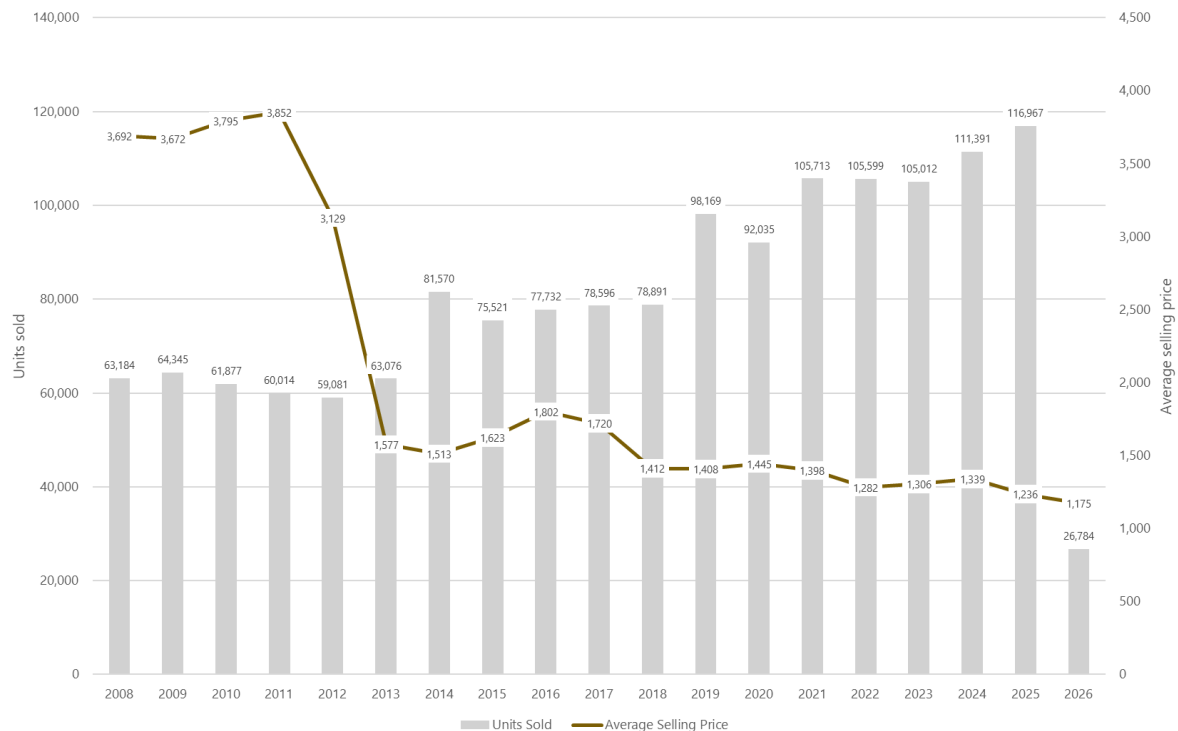
The Danish model

A mass tender model is used in Denmark to procure hearing aids as part of the public health service. This model involves Amgro, a third-party organisation, inviting tenders for hearing aids on behalf of five regions. The tender covers 98 per cent of publicly funded hearing aids fitted to Danish citizens and includes five suppliers (Widex, GN Hearing, Sivantos, Oticon and Sonova). The most recent process came into force on 1 March 2025 and covered 430,000 hearing aids at a total value of ~DKK 800 million including supplementary devices over a period of four years (Amgro, 2025).

Hearing aid suppliers are selected from the tender process through requirements that are defined by clinicians. This covers, for example, varying degrees of hearing loss, form factors, and functionality. Suppliers are able to update and adjust the range that they provide in line with technological development and clinical practice twice a year. The tender process has been built to ensure a level of fair and transparent competition (Amgro, personal communication, 2026).

This model had measurable benefits demonstrated by an average price decline per hearing aid as outlined in the figure below. Since 2007, the average price of a hearing aid has fallen from ~DKK 3,541 to ~DKK 1,400 kroner in 2018, a decrease of more than 60 per cent (Amgros, n.d.).

Figure 7: Average tender price per hearing instrument from 2007-2026



Challenges with the mass tender process concern the range of hearing instruments provided. As suppliers on the tender also own private retail clinics, the newest and more premium range of aids are rarely available on the tender and instead can be purchased from a private clinic.

2.7.1 The Pharmac procurement model

The Pharmaceutical Management Agency (Pharmac) procurement model for pharmaceuticals here in New Zealand is an alternative model which combines commercial negotiation with patient need and clinician preference. The model has developed over a 33-year period, beginning during health reforms in 1993. Pharmac was created to manage the growing costs of pharmaceuticals in New Zealand and, also, to get better value for money from the pharmaceutical spend, as pharmaceuticals appeared to be more costly in New Zealand than, for instance, in Australia. It began as a joint venture company owned by the four regional health funding agencies and transitioned to being a Crown entity in 2001. While originally responsible only for community medicines, its role has expanded over the years to include hospital medicines (2013) and medical devices.

In the main, Pharmac subsidises pharmaceuticals, and ability to access the pharmaceutical market is managed through the Pharmaceutical Schedule and a backdrop of supply contracts. The supply chain is increasingly concentrated and often managed through Healthcare Logistics, several wholesalers,

and then with distribution through pharmacies. Pharmacies are paid a dispensing fee amongst other payments for their services. Pharmacies pay for pharmaceuticals and are reimbursed by Health New Zealand for dispensing services and pharmaceutical claims on a monthly or fortnightly basis.

Pharmac's Pharmaceutical Schedule classifies pharmaceuticals by anatomical class (e.g. cardiovascular system, then by mode of action (e.g. agents affecting the renin-angiotensin system), then class of drug (e.g. ACE⁴ inhibitors), then lists the subsidised chemical entities. This classification is highly relevant to subsidisation and allows a therapeutic view of pharmaceutical costs for different condition, as well as being a tool for therapeutic group managers to manage a portfolio of drugs. Some of those drugs are so-called innovators and new to the market, some are "me-toos" which have the same or similar effect to previously listed chemical entities, and some are generic (direct copies with proven therapeutic equivalence). Generic drugs are proven directly equivalent.

The tools used to manage the Pharmaceutical Schedule have changed over time. At first, there was a need to close off "back doors" to subsidisation, as new pharmaceuticals were funded through "special approvals." Then, progressively, pharmaceuticals were classified as same or similar in a series of therapeutic reviews, and then subsidisation was levelled out in an approach known as reference pricing. There might be two chemical entities on the schedule, but if they had the same or similar effect then the same subsidy would be paid (and patients might face a part-charge). Part charges could be very significant in shifting market share from one pharmaceutical to another if the part-charges were significant, but otherwise patients would likely stay with the same brand, and cost could be transferred on to patients.

Over time, many costly therapeutic groups transitioned from innovator to "me-toos" and then to generic markets. These generic markets opened the opportunity to tender markets for specific chemical entities. The savings from tenders were considerable and, also, allowed full subsidisation thus reducing part-charges to patients. Now, approximately two thirds of the Pharmaceutical Schedule is tendered.

At the same time, supply chains have become more fragile. The obligations on suppliers to ensure adequate stocks and supplies, and the communication to identify and reduce shortages, have developed and been stress tested through Covid.

⁴ Angiotensin-converting enzyme.

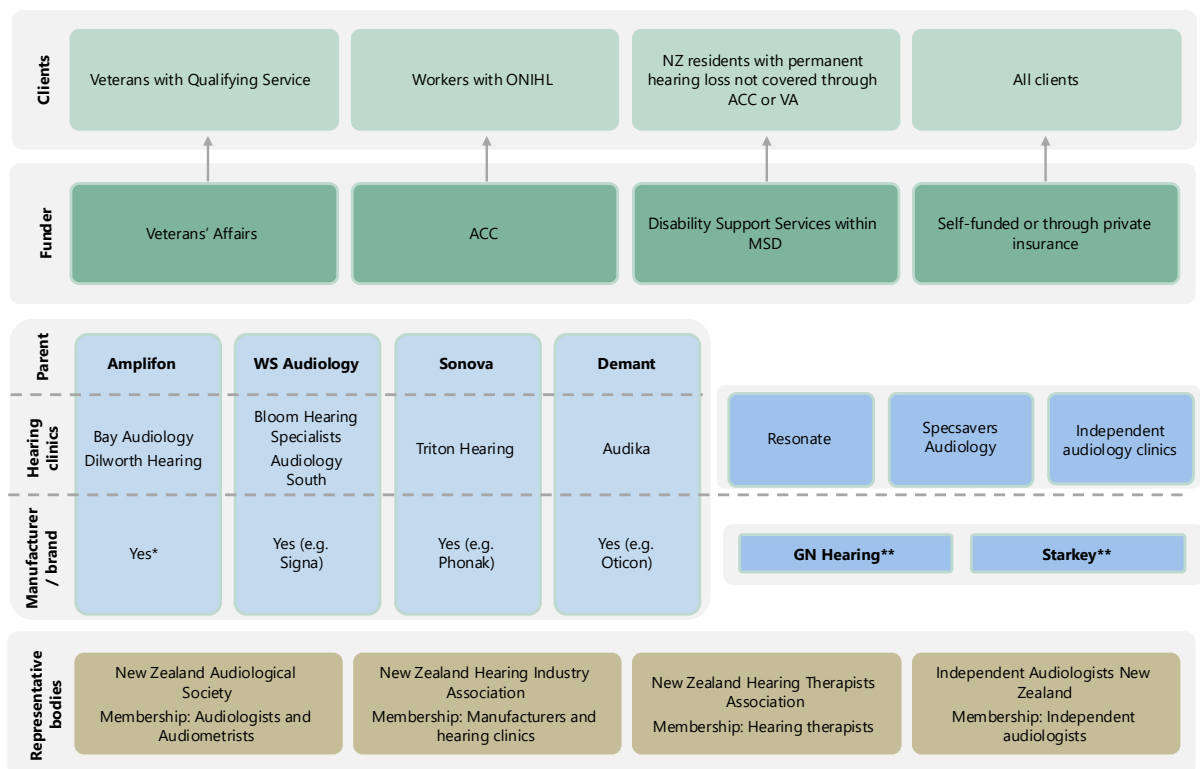
3. The New Zealand landscape

This section provides an overview of the participants and size of the audiology market in New Zealand before providing greater detail on the different suppliers of audiology services, funders of services, and supply and pricing of relevant productions compared to key international markets.

3.1 Overview of the New Zealand market

Figure provides an overview of the structure and participants in the New Zealand market, which we elaborate on in the following subsections. Information provided in confidence (and explicitly not for further distribution) by the NZHIA indicates that over [Redacted] were sold by members⁵ in the 12 months to the end of March 2026, with around 434 clinic locations and public funding of greater than ~\$100 million. We understand from NZHIA that there has been an increase in the portion of RITE/RIC and rechargeable hearing aids, and decrease in BTE (and especially ITE) over recent years.

Figure 8: Overview of the New Zealand audiology market



*Amplifon is manufactured by GN, WSA, Sonova, Starkey and Demant, and has recently acquired GN Hearing

** These manufacturers do not have a NZ presence in terms of retail, however supply supply devices to hearing clinics

⁵ Those who anonymously report data to the Hearing Instrument Manufacturers and Distributors Association (HIMADA).

Table 3: Hearing aid units sold in the 12 months to 2026 by reporting HIMADA members (by style and battery type)

Style	Battery type	Net units
BTE	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
RIC	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
ITE	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
	[Redacted]	[Redacted]
Total		[Redacted]

Source: NZHIA using data provided from HIMADA. Not for wider sharing.

Notes: [Redacted]

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3.2 Supplier landscape

The New Zealand audiology sector is characterised by a mix of large national chains, small regional independents, and hospital-based services. We drew on a combined dataset of 434 clinic locations sourced from the NZAS register ((NZAS, 2026) extracted in January 2026) and Healthpoint. Of these, 36 records were successfully matched across both sources, 318 appeared only in the NZAS register, and 80 appeared only on Healthpoint. Service type information (drawn from Healthpoint) was available for 100 of these locations. The remaining records, which are predominantly NZAS-only entries, did not carry structured service data.

Across the dataset, distinct audiology providers were identified. These range from large national chains with several locations, to sole practitioners operating from a single site.

We note that there appears to be stringent limitations on the data, and only report on information identified from NZAS and Healthpoint. For instance, a scan of one provider's own website reveals substantially more locations, but we are unable to verify whether registered audiologists or audiometrists practice at or provide support across those sites. Nonetheless, the picture is broadly consistent with reporting elsewhere (Pratley, 2025; Resonate, 2025), indicating that Bay Audiology,

Dilworth, Specsavers, and Bloom Hearing may have larger numbers of locations than those indicated below.

3.2.1 Provider landscape

Figure 9 shows the geographic locations for 429 clinics where the address was able to be determined, with darker points indicating a greater concentration of supply.

Figure 9: Audiology clinic locations in New Zealand



Before discussing the different providers, we set out below some of the key relationships between providers and their parent companies/manufacturers in Figure 10.

Figure 10: Overview of major hearing clinic providers and links to parent companies/manufacturers

Parent	Amplifon	WS Audiology	Sonova	Demant			
Hearing clinics	Bay Audiology (70) Dilworth Hearing (13)	Bloom Hearing Specialists (22) Audiology South (8)	Triton Hearing (70)	Audika (35)	Resonate (30)	Specsavers Audiology (35)	Independent audiology clinics
Manufacturer / brand	Yes*	Yes (e.g. Signa)	Yes (e.g. Phonak)	Yes (e.g. Oticon)	GN Hearing** Starkey**		

*Amplifon is manufactured by GN, WSA, Sonova, Starkey and Demant, and has recently acquired GN Hearing

** These manufacturers do not have a NZ presence in terms of retail, however supply devices to hearing clinics

Large providers

Five large providers dominate the commercial market by location count, accounting for 206 of the 434 clinic locations:

- **Bay Audiology (Amplifon):** operates 70 locations across 15 regions with strong presence in Auckland, Waikato and Canterbury.
- **Triton Hearing (Sonova):** largest provider by location count in the country, operating 70 clinic locations across 19 regions. It has a presence in most urban centres and many smaller towns, making it a geographically extensive audiology network in New Zealand. The practice has 74 recorded registered audiologists listed across its locations.
- **Audika (Demant):** operates 36 clinics across eight regions, predominantly those with major urban centres.
- **Specsavers Audiology:** operates 35 locations across 11 regions. There are 36 registered audiologists associated with Specsavers Audiology.
- **Resonate Health:** has 30 locations listed across 13 regions, though the majority of these appear only in Healthpoint data and carry no NZAS-registered staff data. Their reported seven staff come from seven NZAS-only entries which appear to be regional rather than specific clinics.

Mid-tier providers

A second tier of providers operate from several locations and regions, but not to the extent of the large providers identified above (though as noted above, some are owned by the same parent company):

- **Bloom Hearing Specialists (WS Audiology):** 22 locations in eight regions and is one of the few providers serving the West Coast region.
- **Dilworth Hearing (Amplifon):** 13 locations in six regions, primarily those with major urban centres, and with higher concentration in Auckland.
- **Audiology South (WS Audiology):** we understand are part of bloom hearing specialists, but are primarily concentrated in the South Island, namely in Otago and Southland, with around eight locations in those regions.
- **Courtenay Hearing Centre:** has four locations across Wellington and Whanganui.

Independent providers

Many independent providers operate from a single location. They collectively represent a significant proportion of total supply and make up most of the supply in many regional and rural communities, including in Hawke's Bay, Manawatu-Whanganui, the West Coast and Taranaki.

3.3 Services offered

Across regions where service data is available, the service mix is broadly consistent with standard audiology services being offered in most regions. Regions such as Manawatu-Whanganui, Nelson-Tasman and West Coast have limited service type data available, limiting the ability to comment on their specific service profile.

The most common services offered by nearly all locations for which data is available include:

- hearing tests
- hearing aids
- older adult technology
- tinnitus.

Ear wax removal is the most common supplementary service, present across most regions and appears to have expanded as a routine offering across commercial providers. Regional representation of earwax removal is present in Auckland, Waikato, Bay of Plenty, Hawke's Bay, Wellington, and Northland, with small numbers in Canterbury, Otago, Marlborough, Taranaki, Tasman, Whanganui and Southland.

3.3.1 Specialist services

The provision of specialist services is not extensively stated in Healthpoint data, but where specialist services are described, they can include the following:

- **Auditory processing disorder:** offered at eight locations, primarily in Auckland and Canterbury, with one provider in the Bay of Plenty and another in Otago.
- **Child audiology:** listed in ten locations, mostly concentrated in Auckland, with some accessibility in Otago and the Bay of Plenty. This, however, is likely to be an undercount given that hospital paediatric audiology services may exist but are not explicitly coded in this dataset.
- **Newborn hearing screening:** listed in three locations, with two in Auckland and one in Hawke's Bay. As with child audiology, this likely reflects the limitations of the dataset rather than the true supply picture, as newborn screening in New Zealand is delivered through the Universal Newborn Hearing Screening and Early Intervention Programme (Health NZ | Te Whatu Ora, 2025).
- **Cochlear implant services:** the Southern Cochlear Implant Programme is a registered charity providing public and private specialist cochlear implant services independent of commercial audiologists; they operate clinics across Wellington and Canterbury.

3.3.2 Trends in regional distribution of audiologists

We investigated the trends in the number of registered audiologists using previous snapshots of the NZAS registered audiologist data and present these trends in Figure .

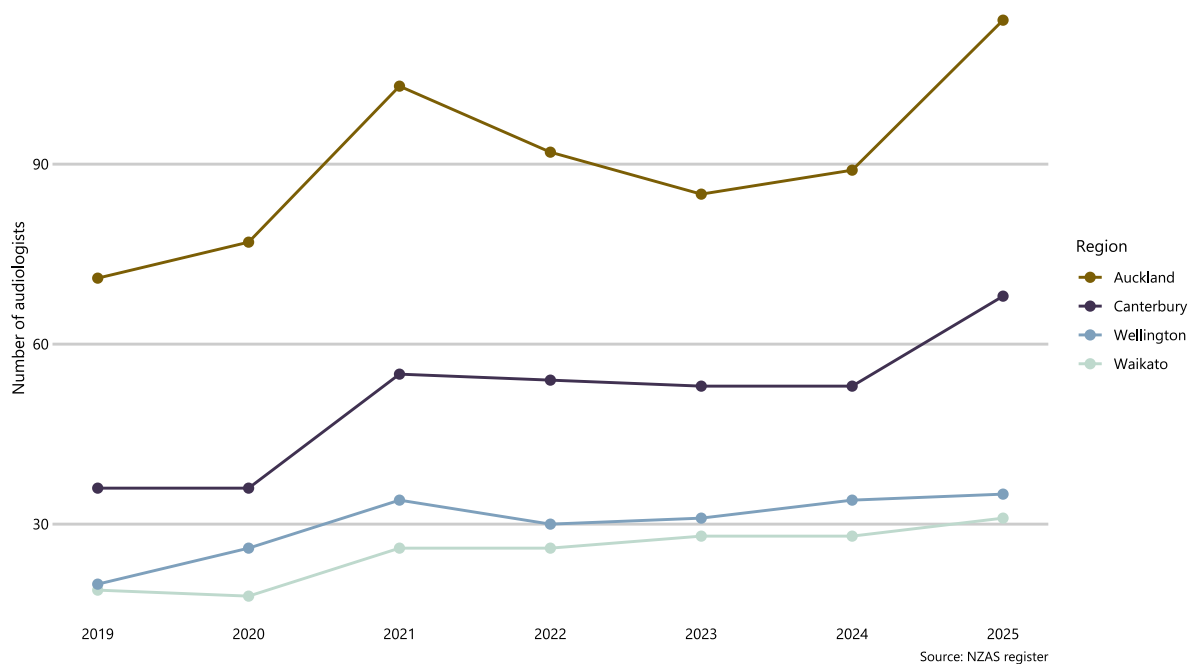
Overall, the supply of audiologists across regions shows a clear pattern of growth leading into 2021, a notable dip in 2022, and subsequent recovery to levels now exceeding those observed pre-Covid.

There are some noticeable differences across regions:

- Auckland, Canterbury and the Bay of Plenty show large swings. Auckland and Canterbury have had significant long-term growth, while Bay of Plenty has not recovered to their 2021 level of supply.
- Waikato, Wellington, Nelson-Tasman and Otago show consistent upward trends with relatively smaller fluctuations.
- Manawatu-Whanganui has faced decreasing levels of supply over recent years.
- Gisborne has remained with low levels of audiologist supply, with a slight increase over recent years, while the West Coast has had low levels throughout.

Figure 11: Trends in the number of NZAS registered audiologists by region, 2019-2025

Panel A: Large regions



Panel B: Other regions

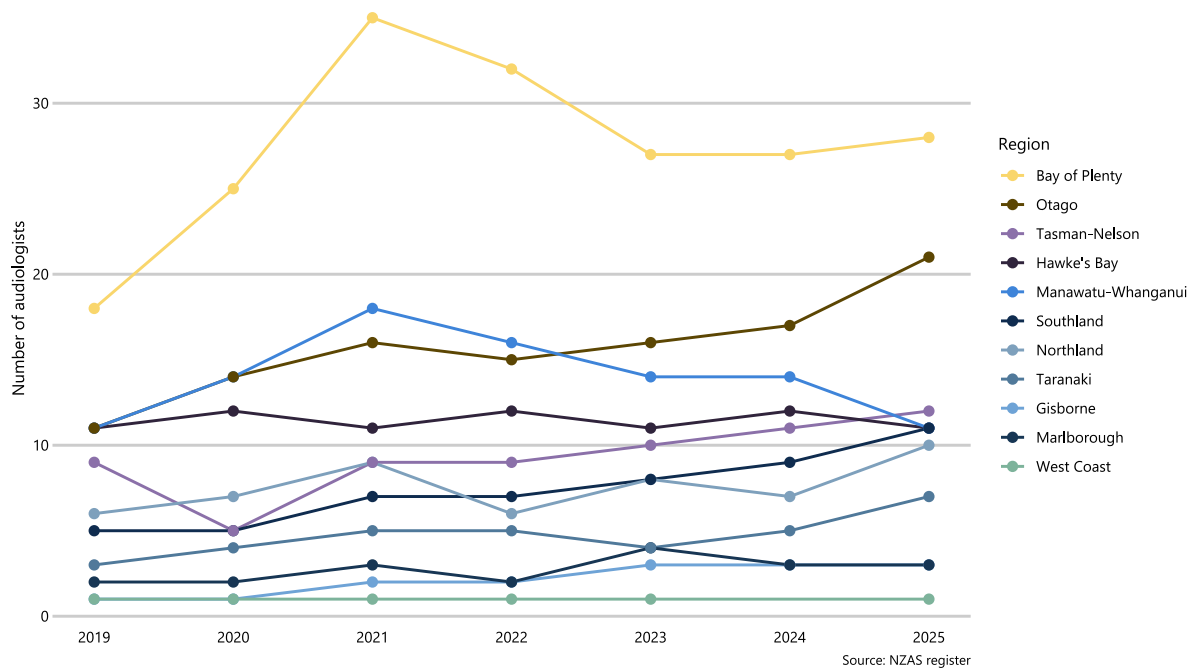


Figure 17 of Appendix E shows the rate of audiologists per capita varies considerably across New Zealand, ranging from 0.3 to around 1.1 per 10,000 population across the period examined. The West Coast consistently records the lowest rate, with Northland, Manawātū-Whanganui,⁶ and Taranaki also at the lower end averaging around 0.4 practitioners per 10,000 population. shows that the density of audiologists to population has generally been increasing since 2019, with some exceptions such as Manawātū-Whanganui, and the West Coast.

Nelson-Tasman, Southland, and Canterbury record the highest rates of audiologists, each reaching above one audiologist per 10,000 population by 2025. Auckland, despite having the highest number of audiologists, sits in the middle of the distribution at around 0.53 to 0.66 per 10,000 population.

Appendix E shows the relationship between audiologist supply and age structure. There appears to be a broad association between older regional age profiles and higher audiologist rates. Regions with older populations such as Nelson-Tasman and Marlborough tend to have above-average audiologist rates, though rates are notably lower in the West Coast. This broader observation is consistent with audiologist need being strongly concentrated in age groups from middle-age onwards. The broader market size and/or relative isolation may be impacting the West Coast and, albeit to a lesser degree, Northland and Taranaki.

However, the relationship is not uniform, with the West Coast being a notable outlier: despite having the oldest age profile of any region, it records the lowest audiologist rate throughout the entire period. Conversely, Canterbury has grown to among the highest audiology rates nationally despite

⁶ We note that population estimates from 2019 to 2023 are interpolated linearly, and therefore the rates from 2020 to 2021 are potentially biased due to Covid.

having a relatively younger age profile. This suggests that factors such as urban service concentration, training pipelines, and provider location decisions play a significant role alongside demographics.

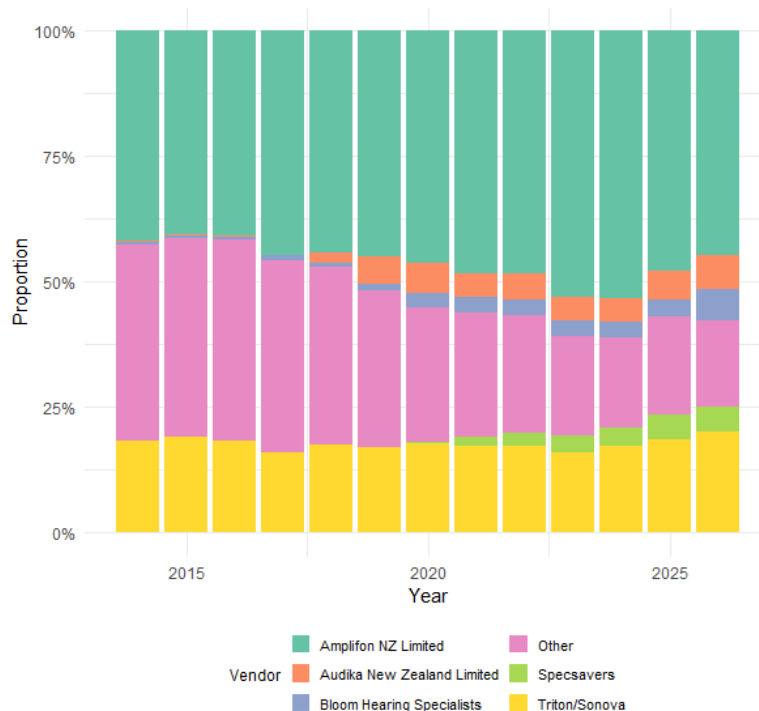
While there is broad association between age and audiologist supply, there is a contrast between age structure which remains stable within regions across the period, and audiologist rate variability, which is driven by the small absolute number of audiologists.

3.4 ACC claims are concentrated by provider

We provide a fuller analysis of ACC claims data in Appendix F. In the absence of data on the wider distribution of sales across different providers, we look here at the shares of claims made to ACC by different providers.

The ACC supplier market is highly concentrated. In 2025, Amplifon NZ Limited accounted for approximately 50 per cent of service activities with accepted claims, followed by Triton/Sonova at around 20 per cent. The remaining 30 per cent was split between the other three of the top five providers: Audika, Bloom Hearing, and Specsavers accounting for approximately 12 per cent, and all other vendors accounting for approximately 18 per cent of accepted claims as shown in Figure 12. The NZAS survey responses indicated products supplied were brands owned by/associated with Sonova (four brands, Phonak most reported), Dermant (three brands, Oticon most reported), WS Audiology (three brands), GN (four brands) or Starkey, with a smaller portion supplying Specsavers/Advance.

Figure 12: Vendor activity by calendar year - accepted claims only



Other observations looking at ACC claims data are summarised in section 3.7 and described further in Appendix F.

3.5 Different funders in New Zealand

Public funding for audiology services and hearing aids is provided under three main schemes: ACC, Veterans' Affairs and the Disability Support Service (DSS), with private insurance contributing to the private market (through contents insurance replacements rather than through health insurance). These schemes and their eligibility and entitlements are summarised in Figure 13 and in set out in more detail in the sections below.

Figure 13: Overview of funders in New Zealand

Area	ACC	Veterans Affairs	DSS	Private insurance
Eligibility	No fault personal injury cover for hearing loss caused by (ACC, 2025): - a specific accident or trauma - a treatment injury - a work-related gradual process injury, such as occupational noise-related induced hearing loss (ONIHL).	Veterans' Affairs funding is eligible to those who can satisfy the requirements for (Veterans' Affairs, 2026): - qualifying service - hearing loss or tinnitus. This can be either a suitable audiogram or their GP's attestation that the veteran has a hearing loss.	DSS funding is available for those with permanent hearing loss who are not entitled to ACC or Veterans' Affairs funding. Additional detail on the eligibility for the specific schemes under DSS are below.	N/A, private insurance schemes will have different eligibility and entitlements for replacement hearing aids under different contents insurance policies
Entitlements	Contribution towards a hearing aid and fitting up to \$2,541.62 for monaural and \$4,535.19 for binaural. This may be apportioned between ACC and DSS. Coverage for services such as assessment fees, moulds, ear toileting, hearing therapy and repair and maintenance.	Veterans' Affairs funds up to \$7,866 (including GST) in total including: - hearing assessments - up to two hearing aids - fitting fees and trial management - approved consumables - contributions to rechargeable batteries and drying equipment where required.	The Hearing Aid Funding Scheme the price of a hearing aid once every six years. The target price per hearing aid is \$1,300. The Hearing Aid Subsidy Scheme covers \$511.11 every six years. DSS funding does not cover assessment or fittings.	

3.5.1 ACC funding

ACC provides no-fault personal injury cover for hearing loss caused by (ACC, 2025):

- a specific accident or trauma
- a treatment injury
- a work-related gradual process injury, such as occupational noise-related induced hearing loss (ONIHL).

ACC hearing aid contributions are governed by the Hearing Loss Regulations. Contributions are capped maximums and depend on:

- monaural versus binaural fitting
- percentage of hearing loss attributable to ACC cover
- interaction with funding from DSS within the Ministry of Social Development contributions where relevant.

ACC contribution levels for hearing aids are banded and additional items are subject to maximum fees that are set out in a fee schedule (ACC, 2025).

The fee schedule for hearing aids can be found in Appendix G.

3.5.2 Veterans' Affairs

Veterans' Affairs funding is eligible to those who can satisfy the requirements for (Veterans' Affairs, 2026):

- qualifying service
- hearing loss or tinnitus. This can be either a suitable audiogram or their general practitioner's attestation that the veteran has a hearing loss.

Veterans' Affairs funds up to \$7,866 (including GST) in total including:

- hearing assessments
- up to two hearing aids
- fitting fees and trial management
- approved consumables
- contributions to rechargeable batteries and drying equipment where required.

In addition to a maximum total funding amount, a schedule of fees sets out the approved maximum for each element of funding (*Hearing Aid Schedule of Fees*, 2023). This schedule of fees can be found in Appendix D.

3.5.3 Disability Support Services funding

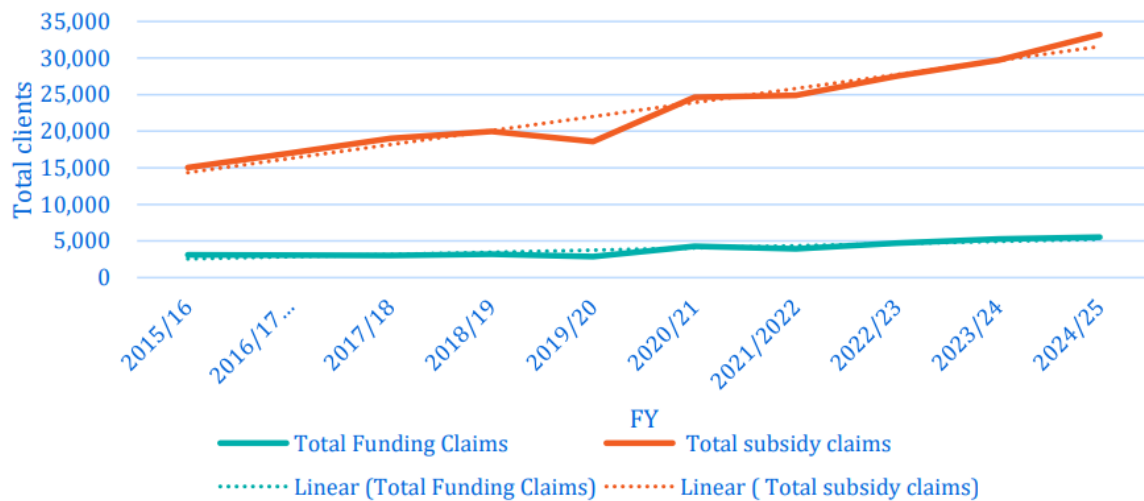
DSS is the funder, commissioner, and steward of disability support services across New Zealand. DSS is the primary funder of disability support services, though there are many other community-based disability support services across the country. DSS works alongside those to deliver supports to people with disabilities.

DSS funds a range of hearing-related services including funding of hearing aid devices, aural rehabilitation services, interpretation services, disability information for people who have hearing loss, and cochlear implant services.

DSS funding mechanisms includes the Hearing Funding Scheme (HAFS) and the Hearing Aid Subsidy Scheme (HASS). It contracts Enable New Zealand to administer and manage the allocation of funding to applicants to the HAFS and HASS. In the 2024/25 financial year, the total approved HAFS claims were 6,500⁷ and the total approved HASS claims were 33,214 (DSS, 2026). Figures sourced from DSS indicate that claims for the HASS have increased over the last ten years (DSS, 2026). We understand that DSS provide funding of approximately \$43 million per year for HAFS and HASS, and that there is another approximately \$7.4 million it contributed to the joint ACC/DSS scheme.

⁷ This figure has been provided by DSS noting that any differences with Figure 14 are due to timing of information provision/reporting by providers.

Figure 14: Total approved subsidy and funding claims for past ten financial years



Hearing Aid Funding Scheme

The HAFS covers the cost of hearing aids for eligible children and adults who are New Zealand residents and who are ordinarily resident in New Zealand (DSS, 2025a). Adults are eligible if they:

- have had significant hearing loss from childhood
- have hearing loss and significant visual impairment, or hearing loss and an intellectual disability or a physical disability that limits their ability to communicate safely and effectively
- have a community services card and meet relevant criteria.

The HAFS covers the price of a hearing aid—it does not cover assessment, fitting fees or batteries. Funding for a hearing aid is available for adults once every six years, and three times every six years for children (DSS, 2025a). The average target price for each hearing aid funded through the HAFS is \$1,300 excluding GST (Enable New Zealand, 2026).

Hearing Aid Subsidy Scheme

The HASS provides partial funding for adults who (DSS, 2025b):

- are over the age of 15
- have permanent hearing loss and require a hearing aid
- are New Zealand residents who ordinarily live in New Zealand and are not covered under the HAFS.

The HASS provides \$511.11 and is available once every six years. It does not cover additional costs such as hearing assessments or hearing aid fitting services (DSS, 2025b).

During interviews, some stakeholders referenced differences in coverage across the different funding agencies and stated that there was essentially a tiered approach in terms of the support available from Veterans' Affairs, to ACC and DSS (HAFS and then HASS).

Accessories supported by Disability Support Services

DSS noted that products purchased through its Hearing Aid Funding Scheme and Hearing Aid Subsidy Scheme included:

- adapters
- bone anchored hearing aid/bone conduction hearing aids
- battery chargers
- Bluetooth streamers
- cordless phones
- ear moulds/shells/domes or tubes
- electronic drying conditioners
- phone adapters
- remote controls
- remote mics
- RM receivers
- television adapters.

3.5.4 Private and other funding

In addition to the public funding discussed above, as noted Health New Zealand/Te Whatu Ora will also provide some services, that would be expected to be without charges to clients. Further, clients are able to purchase audiology services/devices privately and when receiving public funding, many also contribute beyond the public funding available, often significant portions of the overall cost (as illustrated in section 3.73.7). Further, private insurance are also associated with the purchase of hearing aids which we understand is typically through coverage under contents insurance. Looking at the indications provided on the number of hearing aid sales relative to reporting on units/claims by ACC and DSS, this implies that private funding, including through insurance is likely to be a significant component of the funding picture.

3.6 Ethnic and Indigenous disparities

Prior research indicates that Māori experience both higher prevalence of hearing loss and lower access to hearing healthcare services. Māori adults are over-represented in self-reported hearing loss statistics but are underserved by services designed primarily around non-Indigenous models of care (Lowe et al., 2025). Barriers identified include cost, cultural safety, service design, geographic accessibility, and lack of services aligned with Māori worldviews (Lowe et al., 2025; McCarthy et al., 2025). These ethnic disparities appear in the ACC claims data as discussed in the following section. Information from DSS indicates that 3 per cent of HASS requests were from Māori in the year to 30 June 2025, while 22 per cent of HAFS requests were from Māori requesters, consistent with other sources (Tatham, n.d.).

3.7 Overview of ACC-funded audiology services

In addition to the vendor breakdown from ACC claims data provided above, key observations in relation to ACC-funded audiology services are summarised below, with claims analysis described further in Appendix F.

3.7.1 Audiology-related claims and associated scheme costs

Key observations from ACC claims data include the following:

- Accepted service claims have grown steadily, rising from approximately 80,000 in 2015 to around 110,000 in 2025. This growth has been driven primarily by onsite servicing of devices, which accounted for about half of all accepted service claims in 2025 and more than doubled relative to 2015 levels. All other service categories remained broadly stable in their absolute contribution to total accepted claims over this period.
- Accepted claims are most concentrated in the 55 to 64 age group, followed by the 65 to 74 and 45 to 54 age groups (though the portion of distinct claims that are declined increases with age). Demand is heavily skewed toward males relative to females and other genders, and toward Europeans relative to all other ethnic groups (these groups also have a higher rate of claim acceptance, considered further in Appendix F).
- Cost has grown (though with a dip in Covid years) but not at the rate of the increase in service volumes, and the cost per active claim may have declined recently (though the mix of claims will contribute to this, with a significant reduction in ENT reports for instance, and doubling of onsite servicing claims). The key cost drivers are fitting-related services, re-aids of existing hearing aids, and funding of new hearing aids, which together account for approximately 85 per cent of all accepted claim costs in 2025.
- The majority of claims appear to come from ONIHL, with lower portions relating to treatment injuries or traumatic injuries (though with a large number not assigned to any of these groups).
- A greater portion of costs can be attributed to urban rather than rural locations, however the average cost per claim is slightly higher in rural areas (and highest in more remote areas such as the Chatham Islands).

In addition, NZAS survey response comments in relation to ACC funding included some respondents indicating that they felt aspects of the scheme's administration had improved and that the scheme supports a level of access. However, others suggested that funding may not always be considered sufficient (with client choice constrained as a result) and that potentially more could be done to improve administration, support, and value for money.

3.7.2 Insights on costs to clients

Using the sample of ACC claims, clients were reported to pay between \$184 and \$3,437 in co-payments for devices, with an average of \$3,437. On average in this sample, it appeared that clients were contributing 56 per cent of the total costs (noting some of the data limitations set out in Appendix E).

3.7.3 Insights on the costs of service provision

In this sub-section, we draw on results from the survey undertaken by NZAS and from our interviews to provide insights into costs for delivering audiology services, and drivers of those costs. We also reference ACC data on the overall costs of providing a fitting, and the support activities around the fitting.

Portion of clients receiving ACC funding

NZAS survey responses indicated that on average, 28 per cent of clients of the respondents surveyed were reported as having an element of ACC funding. There was a wide range, however, with some respondents reporting less than 10 per cent, and some practices reporting up to 80 per cent of their clients having some element of ACC funding. Respondents from large nationwide private companies reported a greater portion of clinic revenue, and clients receiving funding, from ACC.

Aspects ACC pays for

When respondents to the NZAS survey were asked about ACC-funding, they indicated that on average over half of this revenue is from hearing aid fittings. In fact, when considering all the revenue related to the client hearing journey, all but around 10 per cent on average was reported to be related to assessment, fitting, and post-fitting activities. These statistics are consistent with indications provided during interviews. The list of procedures that were specifically asked about included: assessments, ear wax removal, fittings, adjustments, servicing and maintenance, and repairs (see our summary of survey question 26 in Appendix H).

Further, it was indicated to us during interviews that around three to five follow-ups may be needed (on average) post fitting, and that other interventions were hard to predict in number.

Costs of providing services

Responses to the cost components survey question were unfortunately difficult to answer and interpret. A key reason for this, we believe, is that there is insufficient clarity on how the cost of the hearing aid is accounted for—for instance it may often not be treated as a cost to the clinic.

Analysis of the sample claims data indicated that the average cost to ACC of a set of fitted hearing aids is around \$4,700, excluding GST.

The highest proportion of costs (using averages) was reported by survey respondents to be workforce costs (see our summary of survey question 29 in Appendix H), which will principally relate to audiologist salaries. This is common where there is a large service component to what the client is receiving. There is understood to be a wide range of audiologist salaries. Seek estimates that the average salary nationwide is between \$80,000 and \$95,000. However, main centres have higher salaries and some practices we talked to offer significantly higher salaries to try to ensure employee retention.

In our view, there are some shortcomings with the cost items as surveyed, which means we must note some caveats in relation to particular items (below). In addition to possible interpretation of (and categorisation across) items surveyed, there are also risks that items may be missing (for instance one

respondent commented that travel costs were another item), and responses may not have the underlying information at hand but be based on impressions instead.

Table 4: Caveats of cost analysis

Item	Caveat of possible interpretation
Workforce	Does this include administration staff and owner's management time?
Premises	If premises are owned, has a lease cost been interpreted?
Equipment	Does this include the cost of the device, the testing equipment, IT equipment, and soundproofing?
Goods sold	Is this the cost of the device?
Administration	Is this separate from workforce costs?
Franchise fees	Is this applicable in every case?

The other key issue is that of utilisation, i.e. how much time is taken up in consultations relative to other uses of time. In interviews, audiologists tended to note they are fairly busy (for instance, reports of being client-facing around 80 per cent of the time), but we would need a great deal more data to conclude a working number.

One significant area of costs for audiologists that is unique to the profession is the cost of specialised equipment and fitout. In interviews, we were advised of the need for soundproofing, and capital equipment related to the testing and fitting processes. We understand that the initial outlay for each of these is in the order of low six figures (but it is important to note that current prices may differ). We also note that calibration of equipment and assessment of soundproofing is needed on a regular basis. There are significant costs involved with paying for technicians to undertake testing and assessment, which will include travel.

Summary of key costs of service provision

During our engagements, service providers and manufacturers noted that like most services, there were both costs that varied with the level of service activity, and fixed or semi-fixed costs (which are required to sustain the service regardless of volume in the short to medium term). More explicitly, one stakeholder stated that the full set of inputs required to deliver hearing rehabilitation services to ACC and professional standards would include four broad categories:

- **Clinical activity/labour-related costs** (considered the dominant variable cost): including not just consultation time, but the broader clinical pathway such as assessment, interpretation, fitting, counselling, and ongoing care.
- **Workforce capability** (considered material system costs): the time and cost required to train and supervise clinicians to independent practice, as well as ongoing professional development and clinical governance.
- **Infrastructure and equipment** (fixed or semi-fixed costs): including sound-treated rooms, calibrated diagnostic equipment, and ongoing maintenance and compliance.
- **Administrative and system support**: including ACC-related processes, documentation, compliance, and general operational support required to deliver services to many clients.

Insights limited in relation to the underlying product costs

We were unable to obtain information in relation to the underlying costs across the supply chain for hearing aids in New Zealand, but note prior reference in section 2.5.4 in relation to costs in the US found in a 2017 study.

Perspectives provided on the potential drivers of cost

There were differences in views among those we interviewed in relation to the drivers of overall cost growth for ACC in relation to audiology services. We note the following in particular:

- A number of interviewees referred to costs prior to changes in ACC and wider funding settings in New Zealand, and some raised concerns around how ACC's claims liability was estimated and the assumptions underpinning this.
- Funders, regulators, or schemes in other jurisdictions were more likely to suggest that provider behaviour and system settings may have an impact on overall costs (e.g. maximising to caps, early replacement, weak repair incentives, and contacting clients when possible to receive new funding). Some of the potential risks around such behaviour were also noted in interviews with other stakeholders.
- Audiology service providers and manufacturers were more likely to reference labour costs and shortages, operating requirements (e.g. technology investments, regulatory requirements, etc.), supervision costs, access challenges, and the potential for latent demand to be surfacing post Covid and with an aging population.

4. Products, pricing and New Zealand costs of audiology services

This section looks at the pricing of hearing aids, and then batteries and accessories in New Zealand relative to other key markets. It also looks at the key costs of providing audiology services and drivers of these costs.

4.1 Products and pricing compared internationally

Below we set out the cost of hearing aids, then of replacements and accessories.

4.1.1 Hearing aid prices align with international prices

This analysis does not capture whether prices are similarly uniform when viewed through the lens of purchasing power parity, i.e., accounting for differences in what consumers could buy in different countries relative to income levels. The relatively uniform nominal price might represent heavier burden for consumers in lower income countries (noting that all comparators are high income countries), which may hold implications for access, consumer welfare, and distributional effects of pricing policy in medical devices.

Table 5 shows that, after conversion, subsidy-exclusive New Zealand prices for those entities that publish this information (Audika and Specsavers, which represent around 71 of the 434 clinics identified in section 3.3) align broadly with international prices, particularly in the mid to premium segments of the market. The global range is roughly \$4,000 to \$11,000, consistent across the US, UK and Australia. While there is a risk that those that publish online may be more likely to offer cheaper prices, this range broadly aligns with other guidance and estimates—such as \$2,000 to \$12,500 for a pair (Hearing Association New Zealand, n.d.)—and is consistent with the sample ACC data presented in Appendix F, which ranged from \$1,000 to \$2,000 through to around \$11,500.

Specsavers New Zealand provides a significantly lower entry point—around \$1,500 to \$5,000—sitting below most published international private-market pricing. Specsavers New Zealand provide a significantly lower entry point, around \$1,500 to \$5,000, sitting below most published international private market pricing. Premium offerings in New Zealand, such as higher levels of the Oticon Intent at Audika reach similar levels to the highest international prices (e.g. Phonak in the US).

This analysis does not capture whether prices are similarly uniform when viewed through the lens of purchasing power parity, i.e., accounting for differences in what consumers could buy in different countries relative to income levels. The relatively uniform nominal price might represent heavier burden for consumers in lower income countries (noting that all comparators are high income countries), which may hold implications for access, consumer welfare, and distributional effects of pricing policy in medical devices.

Table 5: International price comparison of hearing aid models (NZD)

Brand	Product	US – HearingTracker	US - Zip	NZ	AU	UK
Oticon	Zeal	8,200	–	–	–	8,200
Oticon	Intent	4,900 – 8,300	–	1,500 – 10,000	–	5,200 – 8,200
Phonak	Audéo Infinio Ultra	4,250 – 11,050	4,250 – 7,800	5,275	5,400 – 7,000	5,000 – 7,750
Phonak	Audéo Infinio Ultra Sphere	–	6,100 – 8,300	–	–	–
Phonak	Virto Infinio	–	4,250 – 7,500	4,275	4,850	5,000 – 7,350
Phonak	Lumity Slim	–	–	4,775	4,850 – 5,950	4,400 – 6,900
Phonak	Naída Lumity	–	4,750 – 7,800	–	–	–
Phonak	Infinio 70 / Lumity 70	–	–	5,299	4,850	–
Phonak	Infinio 90 / Lumity 90	–	–	6,499	5,900	–
Signia	Pure Charge&Go IX	–	4,600 – 5,800	–	–	3,350 – 7,100
Signia	Styletto IX	–	4,600 – 5,800	–	–	3,350 – 7,100
Signia	Silk Charge&Go IX	–	4,100 – 5,800	–	–	3,350 – 7,100
Signia	Pure 312 AX	–	4,400 – 7,500	–	–	–
Signia	IX / AX (5 level)	–	–	5,300 – 5,800	4,850 – 5,400	3,350 – 7,100
Signia	IX / AX (7 level)	–	–	–	5,900 – 6,500	3,350 – 7,100
ReSound	Vivia	4,800 – 6,500	4,800 – 6,500	5,300 – 5,800	4,850 – 7,000	5,200 – 7,100
ReSound	Enzo Q	–	5,400 – 7,800	–	–	–
Widex	Allure	4,800 – 6,600	4,800 – 6,600	–	–	4,400 – 7,800
Widex	Moment	–	4,800 – 5,800	–	–	4,000 – 7,300
Starkey	Omega AI	6,800	–	–	–	5,400 – 7,300
Specsavers	Standard	–	–	1,499	1,600	–
Specsavers	Standard (Rechargeable)	–	–	1,999	2,150	–
Specsavers	Plus	–	–	2,199	2,150	–
Specsavers	Premium	–	–	2,899	2,700	–
Specsavers	Super	–	–	3,499	3,250	–
Specsavers	Elite	–	–	4,099	3,800	–
Specsavers	Elite + AI	–	–	4,999	4,850	–

Source: Price lists from various websites, including hearingtracker.com, ziphearing.com, specsavers.co.nz, specsavers.com.au, audika.co.nz, and hearingaid.co.uk

Note: Prices converted to NZD using exchange rates as at 2 April 2026. New Zealand prices exclude subsidies. New Zealand prices are primarily from Specsavers, except for the Oticon Intent which is from Audika. Prices in their original currency are shown in Appendix D.

4.1.2 Batteries and accessories

Hearing aid accessories play a crucial role in improving real-world listening beyond what hearing aids alone can do, especially in environments such as noisy restaurants, while taking phone calls or watching television. Bluetooth and wireless connectivity have also become increasingly important. These allow audio (calls, music, television) to stream directly into hearing aids, creating a more personalised and clearer listening experience.

A range of hearing aid accessories are available in New Zealand. The most popular products range from high-frequency products like wax guards, domes (ear tips) and batteries, to medium-frequency products like cleaning tools and drying kits, to lower frequency products like receivers and wireless accessories. For wireless accessories, these include television streamers, remote microphones, table microphones, remote controls, captioned telephones, captioning apps, loop systems (telecoils), and emerging Auracast technology. Each serves a different purpose, ranging from improving one-on-one conversations and group discussions to enhancing phone accessibility and public venue listening. Appendix D provides a breakdown of these accessories and indicative pricing.

New Zealand prices for these types of products are typically more expensive compared to Australia, the UK and the US. Accessories are relatively more expensive in New Zealand for lower-price and higher frequency use items. For example, disposable batteries are 35 per cent to 100 per cent more expensive, and domes are 65 per cent to 150 per cent more expensive. Further, the prices for some of the larger (particularly wireless) items are not available with New Zealand retailers but can be bought online from global retailers or from clinics as bundles.

Table 6: International comparison of hearing aid accessory prices

Product category	NZ	AU	UK	US
Disposable batteries (6-pack)	\$0.90 – \$1.05	\$0.50 – \$0.65	\$0.40 – \$0.60	\$0.55 – \$0.70
Wax guards / filters (8-pack)	\$1.40 – \$1.90	\$0.60 – \$1.00	\$0.50 – \$0.85	\$0.70 – \$1.10
Domes / ear tips (10-pack)	\$3.00 – \$3.50	\$1.20 – \$1.80	\$1.00 – \$1.60	\$1.50 – \$2.40
Replacement receivers	\$100 – \$150	\$70 – \$105	\$60 – \$95	\$85 – \$135
Television streamers / connectors	\$320 – \$400	\$260 – \$340	\$240 – \$330	\$270 – \$360
Remote microphones (clip-on)	\$360 – \$450	\$280 – \$360	\$270 – \$340	\$300 – \$380
Table microphones (multi-speaker)	\$600 – \$900	\$450 – \$700	\$420 – \$680	\$480 – \$760
Remote controls	\$170 – \$320	\$140 – \$220	\$130 – \$210	\$150 – \$250

Sources: Price lists from various websites, including tritonhearing.co.nz, bloomhearing.co.nz, audiologysouth.co.nz, [Goldhealth.co.nz](https://goldhealth.co.nz), hearnz.co.nz, hearingsavers.com.au, harmonyhearing.com.au, hearingaidaccessories.co.uk, bootshearingcare.com, hearcairect.co.uk, amazon.com, and embracehearing.com

Notes: The table compares like for like products for comparability, and therefore not all hearing aid accessories are available in every country. Prices are presented on a per-unit basis, as actual retail prices, converted to NZD using exchange rates as at 22 April 2026, including local consumption taxes, and no adjustments for shipping or customs. Some products had low transparency with a website not providing pricing information, therefore they may not be representative (such as table microphones, some Auracast systems, microphones and receivers).

5. Challenges and potential options to explore

This section briefly sets out some of the broader insights and perspectives raised in relation to the audiology market in New Zealand, before exploring what that means in terms of challenges, and setting out objectives in light of these challenges. It then discusses potential options to explore further to help address these challenges and achieve intended objectives.

5.1 Broader points raised in relation to the audiology market in New Zealand

Among our interviews and survey responses, the following are some of the key themes raised (many of which echo international themes):

- **Benefits of audiology services:** these need to be understood and form important context to the review. As noted in section 2.2, benefits include improving quality of life, ability to communicate, balance, ability to work and productivity at work, as well as reducing risks of loneliness, depression, cognitive decline and dementia. This is consistent with prior surveys and some reported research (Anovum, 2022; Resonate, 2025).
- **Complexity and span of audiology services:** relating to the above points and as discussed in section 2, each case is individual and there are differences in the likes of, for instance, anatomy, lifestyles, and cognitive processing that mean that services and treatment needs can be complex, case-specific, and in need of review.
- **Technology and clinical needs:** this area had the most variation and depth in views. A number of stakeholders stated that hearing loss does not neatly map to the tier of technology required, with some suggesting that lifestyle and work context matter more. Most stated that premium/higher technology devices add value mainly in noise-heavy or complex listening environments. A number of NZAS survey respondents indicated that some clients may benefit from higher technologies than are able to be afforded. One manufacturer stated that newer technologies were tested to ensure improvements over existing products, while others questioned whether improvements were necessarily material to users or might be considered sufficient to justify additional costs in many instances. For example, some of those with the latter perspective stated/referenced the following:
 - Cox et al. found that well-fitted hearing aids provided noticeable improvement to those studied in real world contexts, but differences between hearing aid technologies examined were not statistically significant (2016).
 - Given the market structure, ownership, and funding arrangements, there are likely to be commercial incentives to recommend more advanced/higher technology and typically more expensive products than may be needed to meet client needs. Interestingly, in the NZAS survey, a higher portion of those with 21+ years' experience reported being more likely to recommend premium products than other experience levels. Further, 88 of 106 responses to the survey indicated that being able to receive ACC funding (or not) would not change their recommendations, and greater growth was reported in entry-level products compared with particularly premium but also mid-range products.

- **Provider behaviour and incentives:** a number of those interviewed commented that providers face an incentive to supply devices at least at the highest reimbursable level, suggesting there was a degree of systematic upselling. A number commented that hearing aids may be priced to subsidise underfunded professional time. In relation to re-aiding, some stakeholders stated there were instances where audiology clinics would track clients' eligibility for funding for re-aiding and prompt clients to consider seeking new hearing aids, even if these may not necessarily be well utilised or there was no established need for change. This included reports that repairs may sometimes be framed as uneconomic, leading to replacement where maintenance may have sufficed. However, we note that ACC claims data provided to NZHIA indicates that the average years between hearing aid fittings has increased from 6.2 years in 2020/21 to 6.8 years in 2025/26 (year to March 2026). Further, 8 survey respondents indicated clients were taking longer to upgrade/re-aid, with one noting this was the case especially for non-ACC-funded clients.

The potential for cold-calling, targeting certain populations, and use of free hearing tests were raised by some stakeholders as potentially inefficiently driving demand in some cases. Further, it was stated by at least one stakeholder that non-use rates were high. On this, research undertaken in 2022 suggested that 7 per cent of those who own hearing aids do not use them at all, and 15 per cent use them for less than an hour a day (Anovum, 2022).

- **Market structure:** numerous stakeholders commented on the high degree of vertical integration across businesses as discussed in section 2.5.1, and a sense of strong market share among the largest entities (which would be consistent with the ACC claims data). Some suggested that Amplifon's recently announced acquisition of GN hearing (Amplifon, 2026) indicated further market concentration. Concerns were raised by some parties in relation to the level of independence of audiologists, potential sales incentives, and the degree to which this could pull against client needs. Concerns were also raised by a few in relation to a sense that growth among larger retailers was displacing smaller independent audiology service providers.
- **Growth:** consistent with our analysis in section 2.5.2, some stakeholders noted there had been growth in the audiology market and growth in the audiology premises. Some stakeholders stated that New Zealand was seen as a profitable market by international entities, with technology innovations flowing to New Zealand and some new and potentially disruptive models growing, such as Specsavers and Resonate. Certain respondents in the NZAS survey also reported new entrants and growth in the market, while others raised concerns about tougher economic times.
- **Re-aiding timeframes:** there was some comment about the six-year replacement cycle with questions raised over the justification for this. It was noted that technology can change a lot within six years, and typical manufacturer warranties (and potentially support) may be three to five years. On the other hand, several stakeholders commented that they had repaired hearing aids much older than six years that could still serve the needs of the individual, and depending on the use of the hearing aids and the level of degradation, longer time periods could be appropriate. It was also noted that not all eligible clients re-aid (including many that do not follow through when prompted as to eligibility by audiology clinics) and that many delay or never replace devices even when they would be entitled to (with possible trends on replacement discussed above).

- **Growth in rechargeable hearing aids:** many parties noted that rechargeable hearing aids were becoming more common. One party queried whether this might concentrate or pool the risk that if anything went wrong, the whole hearing aid may need to be replaced. However, on testing this with other stakeholders we did not come across any evidence that rechargeable hearing aids were any more likely to need repair or to suggest that they might not last as long.
- **Data, transparency and bundling:** several stakeholders stated there were sensitivities and difficulties in terms of understanding cost/pricing and volume information for particular products as well as linking outcomes to funding decisions. Views on bundling were mixed, with a number stating this obscures drivers of cost and a view of what money is spent on, while others suggested this may be of benefit if it supports a focus on outcomes and reduces administrative overheads. A further potential value could be in pooling risk to suppliers. As noted above, there were questions of transparency of service relative to product costs, and broader questions of transparency in relation to commercial relationships/incentives and client information or rights. For instance, audiogram results were required to be shared with ACC but may not necessarily be provided to clients to keep.
- **Equity of access:** several stakeholders stated that some population groups were less well represented or likely to receive audiology services, or where they did, were more likely to receive lower end solutions. Concerns were raised that Māori, Pacific peoples, females and regional or more remote workers were expected to be underrepresented in ACC claims (which is observed in Appendix F). Barriers to access were considered to include cost, administrative complexity, geography and physical proximity or points of access, and a lack of information. Further, there were also views of constraints in terms of audiologists, with some stating there was a small training pipeline, high burden in terms of supervision, and geographic maldistribution of audiologists. Among the NZAS survey responses, concerns around equity of access due to cost was raised by some, with some stating that for those unable to contribute on top of ACC-funding, this may limit what is provided (and the extent to which their needs are met) relative to others that could provide co-payments.
- **Prevention, pathways, and desired end-state:** several stakeholders commented that the system is heavily oriented towards treatment with less incentive or investment in prevention of noise-induced hearing loss. Further, one commented that hearing protection was inconsistently effective and needed to be well fitted and maintained or replaced, and that there was limited enforcement of good practice and limited education or incentives to invest in this area. Further, some stakeholders commented on a lack of, or unclear, pathways for treatment and rehabilitation from more complex conditions, including the ability to identify and integrate across different client needs. There was general support for enabling needs-based care and protecting outcomes such as return-to-work and social participation. Certain NZAS responses also queried the management of more complex needs and commented on the importance of prevention efforts.
- **Ease of administration, clarity on criteria:** Among the NZAS survey responses, answers to questions 15-20, indicated that on average between 15 and 30 minutes of time and around 15 per cent of the costs of hearing assessments/hearing aid fittings related to administration. Further, these costs were considered to be around 6 per cent of clinics' overall costs by respondents. Concerns were raised by 18/67 respondents to the question on opportunities in

relation to the administration burden, with suggestions that processes may be able to be streamlined, eligibility criteria and assessment outcomes clarified, with opportunities for improved equity. This was in the context of a similar number noting benefits from improvements that have been made.

5.2 Challenges

Drawing on the above, a resulting problem statement might be that current arrangements may result in greater funding pressures and reduced targeting of investment to needs than what might be able to be achieved under different models. Specifically, challenges that have been identified in our analysis or raised with us as part of our engagement centre around the following:

- **Potential for commercial incentives to be at odds with client focus or funding sustainability:** for example, through focusing offerings on where there are commercial links, risk of upselling beyond clients' direct needs (both products sold and frequency of replacement), potential to lock clients into a particular supplier (e.g. through product offering, or ease or support for particular products), or lack of disclosure.
- **Ease, predictability, and process to access funding:** where there was a sense of variability in whether similar claims were approved, difficulties accessing client information on eligibility, and potential for delays and inefficiencies in accessing ACC funding and differences in the scope of support across government funding agencies. In addition, a separate issue was raised regarding incentives to access funding while clients were younger as their needs would be assessed more favourably, even if there was less interest in using hearing aids, simply to ensure the client would continue to be eligible for funding assistance in future.
- **Inequities in access and outcomes:** where certain groups that may be eligible for support are less likely to apply for or receive it, were more likely to achieve lower technology support (particularly if co-payments would otherwise be required), or may have faced similar noise exposure but may be treated differently in terms of eligibility or less likely to perceive themselves as eligible for support.

Additional challenges that were raised that potentially extend beyond the scope of this review or ACC's role include the following:

- **Insufficient focus on prevention and education:** a few stakeholders we engaged with raised a concern that there was a predominant focus on hearing aids, potentially partly as the funding model, responsibilities and pathways were clearest and may incentivise this. They felt that it was important that a holistic solution include investment in prevention from potentially damaging noise exposure and education of the risks, and investments in wider management (including the likes of recognising that ear protection degrades over time and fitting is important for effectiveness).
- **Lack of broader pathways to provide wider support:** in addition to hearing support, several parties acknowledged that the span of services and client needs is wider than hearing aids or other products and that pathways to identify, treat, and support individuals with various hearing conditions needed to be available in order to maximise the effectiveness of treatments.

5.3 Objectives

In the context of ACC's role and the challenges that have been identified or raised as part of this review, we suggest that the following objectives are used to help identify and assess potential options for addressing these challenges:

- **Sustainability of funding:** funding arrangements maintain long-term financial viability for ACC, while continuing the appropriate level of service.
- **Intervention based on client needs:** providing the appropriate level of care and achieving outcomes based on client need.
- **Costs to clients are manageable and do not deter access/choice:** funding covers sufficient access and choice, where a high degree of co-payments is not required by clients.
- **Equitable access:** clients have fair and consistent access to services or devices regardless of geographic location, socioeconomic status, ethnicity, or other demographic characteristics.
- **Administrative efficiency:** funding arrangements minimise unnecessary administrative burden for ACC, providers, and clients.

5.4 Options

Based on analysis of models applied both internationally and the identified challenges with the current ACC model, there are several options available for ACC to consider. We focus on the options for contracting and funding, and separately identify additional considerations alongside or as additional components of the contracting and funding options.

We note that these options are at a high-level and intended to be a basis for wider consultation with the profession, device manufacturers, retailers, and representative groups.

5.4.1 Contracting and funding options

Option 1: Active management of market

This option largely follows the model used in Victoria and elements of the New South Wales model. In this option, hearing devices are managed through an approved list that is managed centrally by ACC (or another party), with clinical input to ensure the correct range of devices is available. Management of the device list may be feature based or cost-cap based, the former providing less certainty of cost but potentially more consideration of clinical need.

A hearing device list may also be managed by Pharmac, drawing on the recent experience of the first nationwide list of medical devices (Pharmac, 2025). The Hospital Medical Devices List forms part of the Pharmaceutical Schedule, with Pharmac working with Health New Zealand and medical device suppliers. A difference in this option to the Hospital Medical Devices List is that Pharmac would not negotiate national terms; it would simply update the list through either the feature or cost-cap based approach. Nationally negotiated terms and conditions, as with the Hospital Medical Devices List, fall under Option 2 discussed below.

Potential benefits of this option are:

- **stronger cost control and budget predictability:** an approved device list that is developed using a cost cap provides an effective ceiling on hearing aid expenditure and limits price variation between providers. Even under a feature-based model, central list management allows ACC to influence price negotiations with manufacturers and monitor cost changes over time.
- **alignment with clinical need:** centralised list management with clinical input helps ensure that approved devices reflect evidence-based practice and are appropriate for the needs of workers. A feature-based approach allows ACC to prioritise capabilities over brand differentiation.
- **improved equity and consistency for claimants:** an approved list reduces variability in access to hearing devices across providers and regions. There may be a reduction in risk that chosen devices are driven by provider preference, commercial relationships or geographic location.
- **reduced risk of up-selling:** by limiting the range of reimbursable devices, ACC can reduce incentives for providers to recommend premium or non-essential devices if they exceed clinical requirements.

Potential challenges of this option would include the cost of initial setup and transition to such arrangements, as well as the administration of the list and any negotiations over associated costs. However, there may also be opportunities to consider potential broader efficiencies if this was considered together with DSS who, together with Enable New Zealand, operate a similar approach.

Other considerations with this option include the risk of reducing clinical discretion or slower access to technology innovation that becomes available. To mitigate this risk, approved lists should be developed with input from clinicians to make sure that they cover an appropriate range of devices, with regular reviews to account for technology changes. This will also act as mitigation for additional administrative burden associated with exception requests, recognising that exceptions will still be required for complex or atypical cases.

Option 2: Mass tendering

Option 2A: Mass tendering for supply (potentially for all funders)

Under Option 2, hearing devices would be procured through a single nationwide tendering process (this could be administered by the likes of Pharmac or another party, and may achieve greatest impact if applied on behalf of all public funders, including ACC, DSS and Veterans' Affairs). The central purchasing agency (e.g. Pharmac, ACC or another party) would aggregate demand across participating schemes and issue competitive tenders to hearing aid manufacturers. To maintain clinical appropriateness, input would be sought in designing the tender to ensure that devices on the tender cover different requirements or features.

Audiology service providers would continue to assess clients and recommend hearing aids from the tendered range, but device choice would be constrained to the suppliers and models selected through the process. We expect that like other approaches we looked at, there may be a need to ensure there is an allowance for exceptional circumstances (either as part of the tender or in enabling choice beyond what is covered in the tender).

Option 2B: Mass tendering for supply, centrally managed distribution

In addition to a mass tendering of devices and management of the purchase and range of devices, there is also an option to manage distribution of devices. This option is similar to the management of hearing aid device distribution by Enable New Zealand on behalf of DSS (or Pharmac).

Potential benefits of Option 2A and 2B include:

- **greater leverage with manufacturers and suppliers:** consolidating demand through a tender process improves ACC's negotiating position with manufacturers. This may lead to better unit pricing, clearer warranty terms, and improved value for money.
- **national price consistency and equity of access:** a single tendered device range ensures consistent pricing and access to hearing devices regardless of claimant. National price consistency also allows for more cost certainty over hearing device costs.
- **administrative efficiency:** if applied widely, there is reduced duplication of effort across agencies as individual funders no longer need to manage separate device lists, negotiate with manufacturers or monitor device pricing.

Like Option 1, key costs under this option would include the initial setup and transition to such arrangements as well as ongoing tendering.

Option 3: Contracting

Option 3A: Contracting for services, audiologist manages procurement of devices

Under this option, ACC contracts for the provision of audiology services and does not manage or procure hearing devices. Similar to the current ACC model, audiologists are responsible for sourcing, purchasing, and supplying hearing aids through their own commercial arrangements.

An additional element that could be included to manage costs is the introduction of contracted and non-contracted providers (with continued potential for co-payment but requiring a no co-payment option). Contracted providers would enter into formal agreements with ACC through a procurement process and would be eligible to access higher reimbursable service rates. In exchange, contracted providers would be subject to enhanced oversight, performance management, and reporting requirements. These requirements could include increased scrutiny over device choice compared to clinical need. Non-contracted providers would remain eligible to deliver services under ACC funding but would be reimbursed at lower, standardised maximum rates.

Potential benefits of Option 3A include:

- **stronger oversight of services:** for contracted providers, ACC is able to have more oversight and ensure alignment between device recommendations and clinical need.
- **clinical flexibility over device selection:** audiologists maintain discretion over recommended devices (up to a cost cap) and are not limited to a list or tendered range.
- **reduces procurement complexity for ACC:** ACC avoids the need to manage device lists or negotiate with manufacturers, although there may be increased burden through oversight of contracted providers.

Like other options, key costs under this option would include the initial setup and transition to contracting arrangements, as well as ongoing monitoring against the contract and management of it.

Option 3B: Contracting for services only, ACC manages procurement of hearing devices

In this option, ACC contracts for the provision of audiology services but becomes responsible for managing and procuring the supply of hearing devices. To manage and procure the supply of hearing aids, ACC may consider a mass tendering process set out in Option 2. This option therefore retains the incentives of a contracted provider approach, with additional control over the devices that are available.

Potential benefits of Option 3B include:

- **retains stronger oversight of services:** ACC is able to have more oversight of the services and devices provided to consumers through built-in monitoring provisions in contracts.
- **potentially greater leverage for manufacturers and suppliers:** if ACC follows the mass tendering option, it will have greater leverage to be able to negotiate prices with hearing device manufactures.
- **reduced administrative or commercial burden for services providers:** providers will no longer have the responsibility to negotiate with suppliers or manage device procurement. This may reduce administrative burden and also provide lower barriers to entry for new service providers.

5.4.1.1 Targeted considerations

Addressing the challenges identified with the current system may require changes beyond those considered in the contracting and funding options above. Targeted considerations may be required in addition to a preferred option(s) to address other identified challenges. These considerations include the following:

Broader system considerations

- Easing access and processes requirements by making more products available (potentially through different means as well).
- Investing in education and prevention or management of noise exposure.
- Identifying pathways for wider support needs and providing guidance around these.
- Monitoring client outcomes and provider practices.

Unbundling services and separating services from products

- Providing payment for audiologist/audiometrist time as distinct from products—the supply and costs of which there is more central guidance for and monitoring of.
- Reviewing which services require an audiologist, audiometrist or alternative/no requirements to support access and be eligible for funding. This is to free up skilled labour to where it adds most value and reduce pressures on the profession, as well as put downward pressure on prices.

Increasing transparency and reducing provider incentives

- Requiring the provision of information, including audiograms to clients and transparency of their rights.
- Disclosure of commercial interests in relation to recommendations.
- Requiring a trial of the lowest cost option that could fit client needs.
- Considering restrictions on marketing.
- Requiring disclosure of base usage or benefits from prior hearing aids in order to qualify for new funding, while similarly allowing for eligibility to be established without limitation on when it may be drawn on (to avoid seeking early claims if there is not an intention to utilise a product).
- Requiring that software associated with products is available free of charge and without restrictions or any conditions to all audiologists, with third party verification that the software is safe to use and targeted at its intended purpose only.

Information sharing and exploring potential process improvement

- Considering the potential to support knowledge and use of ACC's portal to enable audiologists to check client eligibility, funding, and claims status to free up time and ease financial management. The use of this will need to consider potential for system gaming and targeting of clients for marketing (so may require appropriate restrictions on use and/or monitoring).
- Reviewing ACC's guidance, forms and processes with the intention of reducing time and costs for clients and audiologists, and improving predictability of outcomes where appropriate.
- Examining locations for access and working with at-risk and under-represented stakeholders to see if routes of access could be improved by targeted incentives to locate in underserved areas, and/or using models that are more likely to attract underserved populations.

5.5 Preliminary analysis of high-level options

We have undertaken a preliminary assessment of the contracting and funding options against the earlier objectives and the risks and implementation/transition considerations. We suggest this would be a good basis for considering whether any options or combinations of options might be developed and considered further. These options would need clinical inputs in terms of more detailed design, so the purpose here is more to understand which (if any) may warrant further consideration as to how they might work in the New Zealand context. Their potential benefits relative to costs could then be considered, if deemed worthy of further, more detailed analysis.

Below, each of the options from the prior section are assessed relative to the current arrangements using the scale of assessment set out in the box below. The reasoning for the assessment is described in each of the assessment tables.

++	Much better than doing nothing/the status quo/counterfactual
+	Better than doing nothing/the status quo/counterfactual
0	About the same as doing nothing/the status quo/counterfactual
-	Worse than doing nothing/the status quo/counterfactual
--	Much worse than doing nothing/the status quo/counterfactual

The criteria used to assess each option considers the impacts on ACC, the client and providers:

- **Sustainability of funding:** if funding arrangements maintain long-term financial viability for ACC, while continuing the appropriate level of service.
- **Intervention based on client needs:** if the option provides the appropriate level of care and achieves outcomes based on client need.
- **Costs to clients are manageable and do not deter access/choice:** if funding arrangements cover sufficient access and choice where a high degree of co-payment is not required by clients.
- **Equitable access:** if clients have fair and consistent access to services or devices regardless of geographic location, socioeconomic status, ethnicity, or other demographic characteristics.
- **Administrative efficiency:** if funding arrangements minimise unnecessary administrative burden for ACC, providers and clients.
- **Risks:** the risk of moving to and using the proposed option, including the transition risk and risks to the longer-term services provided to clients.

Analysis of adjustment options

Table 7 shows our qualitative assessment of the options against objectives and other relevant considerations.

- We expect that all options would (or could for Option 3A) improve funding sustainability relative to the status quo, with the mass tendering options offering the greatest potential opportunity in relation to funding sustainability.
- Options 1, 3A and 3B are expected to improve provision of the appropriate level of care and achieving client outcomes, while Option 2A and 2B have risks to manage in order not to score worse on this criteria.
- Under all options, costs to the client are expected to be more manageable than the status quo, with Option 3B offering potentially the greatest opportunity for improvement in this area.
- All options are expected to improve equity of access, with Option 2B having potential to improve it most significantly.

- In terms of administrative efficiency, Option 3A adds some administrative costs. Option 1 and 3B have the potential to be less administratively efficient, while Option 2A and 2B have the potential to improve administrative efficiency.
- Each option involves a greater degree of risk to be considered in terms of transitioning to the intended arrangements and provider and client dynamics under them. Option 2A, 2B, and 3B represent the greatest level of risk with significant shifts in arrangements that would need to be managed.

Table 7: Analysis of options against objectives

Option	Funding sustainability	Intervention based on client needs	Costs to clients are manageable	Equitable access	Administrative efficiency	Risk
1: Active management of market	+ An approved device list using a cost cap provides effective ceiling on hearing aid expenditure and limits price variation between providers. Also, under a feature-based model, central list management allows ACC to influence price negotiations with manufacturers and monitor cost changes over time.	+ Centralised list management with clinical input would help ensure that approved devices reflect evidence-based practice and are appropriate for the needs of workers. A feature-based approach would allow ACC to prioritise capabilities over brand differentiation. Either option would require evidence-based guardrails and allowances for exceptions where recommendations may go beyond the list if required.	+ By limiting the range of reimbursable devices, ACC can reduce incentives for providers to recommend premium or non-essential devices if they exceed clinical requirements. Either form of list is expected to reduce potential pressure for clients to co-pay for upgrades beyond their evidence-based base needs.	+ An approved list reduces variability in access to hearing devices across providers and regions. There may be a reduction in risk that chosen devices are driven by provider preference, commercial relationships or geographic location.	0 / - This option adds a process in relation to audiology service provision that is not currently present and the potential for increased monitoring and administration of the list and exceptions management. Overall administrative efficiency will depend on the extent to which this allows for increased efficiency in individual claims management.	- Low/moderate risk – depends on list governance, if the list and exceptions framework allows for sufficient choice to meet client needs. Assuming different brands are able to be represented would address any concerns on impacts on the supply of services. At present, to consider against cost and access risks.

Option	Funding sustainability	Intervention based on client needs	Costs to clients are manageable	Equitable access	Administrative efficiency	Risk
2A: Mass tendering of supply	++ Strong potential to control prices. Consolidating demand through a tender process improves ACC's negotiating position with manufacturers. This may lead to better unit pricing, clearer warranty terms, and improved value for money.	0/ - The impacts here depend on the scope of what is included in the tender, the management of exceptions and the treatment of breakthrough innovations. The risks that would result in this option being worse than the status quo would be if the tendering provided for too small a range to meet client needs or locked in a range that meant delays in benefiting from material innovations in future.	+ Lower base device costs. A tendered device range ensures consistent pricing and access to hearing devices regardless of claimant. National price consistency also allows for more cost certainty over hearing device costs.	+ As with the prior column, increases national device consistency.	0/+ Centralised procurement efficiency. If applied widely, there is reduced duplication of effort across agencies as individual funders no longer need to manage separate device lists, negotiate with manufacturers or monitor device pricing. Without distribution, there could be a risk of needing separate coordination across audiologists and device manufacturers as well as the tenderer.	-- Moderate risk – risks from the work to set up and transition to this approach, and in design and management to ensure that risks around reduced individual fit are managed as well as risks that a number of audiology suppliers might need to make significant adjustments in their training, supplier relationships, etc. At present, to consider against cost and access risks.
2B: Mass tendering of supply, central distribution	++ As under 2A but this has the potential for maximum cost control and predictability potential.	0/ - As with 2A.	+ / ++ Potential for lowest direct client costs and greatest consistency of pricing and access through managing distribution as well.	+ / ++ Uniform device access should improve equity.	0/+ Potential for the lowest administrative burden if managed effectively. However, will depend on design and how operated.	-- Moderate to high risk – given the scale of change with the same risks as 2A in addition to needing to manage establishing / adjusting the management of distribution and inventory management arrangements. At present, to consider against cost and access risks.

Option	Funding sustainability	Intervention based on client needs	Costs to clients are manageable	Equitable access	Administrative efficiency	Risk
3A: Contracting for services, audiologist manages procurement of devices	0 / + Depends on service price discipline. For contracted providers, ACC is able to have more oversight and ensure alignment between device recommendations, services, and clinical need. Gains from this would need to outweigh any increase reimbursement fees designed to incentivise behaviour and additional administration and monitoring costs.	+ Strong incentives for alignment with clinical need.	+ Services accessible and costs potentially more transparent.	+ Supports diverse business models.	- Requires active contract monitoring.	- Low/moderate – would require developing contracting arrangements and bedding these in and monitoring. If settings do not achieve desired results, could be a need to adjust contractual settings.
3B: Contracting for services, ACC manages procurement of devices	+ / ++ Servicing costs as for 3A, while potential to place downward pressure on costs in the central procurement of devices should improve sustainability of funding.	++ Likely strongest incentives for alignment with clinical need given any commercial incentives/pressures are reduced.	++ Services accessible and potential incentives to upsell much more muted.	+ Supports diverse business models and expected to encourage access.	0/- Requires active contract monitoring and procurement of devices. However, there is also the potential for efficiencies under this system in the procurement of devices.	-- Moderate to high risk as adjusting the settings across both devices and services, and differentiating suppliers under contract relative to regulations.

Combinations of options

The table above presents our analysis of specific contracting and funding options relative to current arrangements. However, these options are not mutually exclusive. Combinations, both among the options themselves and with elements of the identified targeted considerations, are possible and may better support a whole-of-system shift needed to achieve the desired outcomes.

In practice, Option 3B would likely be most effective when combined with Option 2A or 2B (similar to arrangements in Ontario). Option 3A could also be implemented alongside Option 1. However, where Option 2A or 2B is adopted—particularly in combination with Option 3B—the rationale for Option 1 may be diminished.

Broader considerations, such as improved information sharing and process enhancements, could be applied across any of the funding and procurement options. Options 3A and 3B introduce elements of service unbundling and the separation of services from products, although these concepts could also be explored within other options.

Increasing transparency and reducing provider incentives may also align well with Option 3A (and/or Option 1A). In some cases, components of these objectives may already be partially addressed through other options. For example, potential commercial conflicts may be largely mitigated under Option 3B. Nevertheless, additional aspects would still warrant separate consideration.

5.6 Recommended next steps

Having provided a summary of the audiology market in New Zealand and how our pricing and offering compares with key overseas markets, we looked at other purchasing models that have been applied and drew on these to inform potential options to address identified issues with current arrangements.

In our high-level preliminary assessment of identified options, we judged that at this stage, there appears the potential to consider options that might improve funding sustainability (both to ACC and clients), equity in access to audiology services, and the degree to which interventions are based on client needs and focused on client outcomes. We note, however, that this is a very high-level preliminary assessment.

We recommend the following from here:

1. **ACC reviews this report and engages with key stakeholders including:**

- a) internally and across relevant government agencies (DSS, Veterans' Affairs and potentially Pharmac) in terms of potential scope of opportunities, both in relation to broader system considerations raised such as education, prevention and wider support, as well as for interest in potential wider funding and commissioning options (such as Option 2A or 2B)
- b) with the expert audiologist reference group (reference group) being established (ACC, 2026) to consider any potential to hone and elaborate on our challenges, objectives and options, and in particular on possible design features/considerations and any dependencies or critical success factors for the options we have identified.

2. **Determine which if any options/combinations of options to undertake detailed design on,** and develop up how a proposed package might work in detail, in consultation with:
 - a) the reference group (with appropriate conflict management arrangements) and any other appropriate stakeholders (such as client-focused/community providers)
 - b) stakeholders operating similar models to those being explored, drawing on the coverage in our report and seeking to follow-on our engagements with the relevant stakeholders.
3. Once designed, **assess the relative costs and benefits of any proposed package** and determine appropriate implementation, transition, and monitoring and review arrangements.
4. **Support decisions on whether to proceed with any proposed package, and if so, how.** This would include any policy, legislative/regulatory, and operational changes needed to support changes.
5. Subject to these decisions, **work with stakeholders to communicate any changes**, what they aim to achieve, and how they will be implemented.
6. **Implement the changes and monitor** (even if no change is made) the future demands for audiology services, audiology service availability, pricing, quality and outcomes. If changes are made, we suggest planning for a:
 - a) short term review of changes to check if they are expected to achieve the desired impacts and/or if adjustments may be of value
 - b) longer-term review once more evidence may be available of the impacts of the changes, to assess whether the envisioned benefits are being realised. Subject to sufficient information flows, consider where changes are having the greatest impact and if any further improvements may be possible.

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Appendix A List of stakeholders

Table 8: List of stakeholders

Category	Stakeholder
Representative bodies	New Zealand Audiological Society
	New Zealand Hearing Industry Association
	Independent Audiologists NZ
	Hearing NZ
Other New Zealand funders / agencies	DSS
	Enable New Zealand
	Veterans' Affairs
	Pharmac
International schemes	Return To Work South Australia
	I-care (New South Wales)
	WorkSafe Victoria
	WSIB (Ontario)
	Amgros (Denmark – by email)
	WCB (Alberta – by email)
Manufacturers / hearing clinics	Audika
	Triton
	Amplifon
	WS Audiology – Wholesale and retail
	Sonova
	GN Hearing
	Specsavers
	Resonate Health
Independent hearing clinics	Three independent clinics
Other	Consumer NZ

Appendix B Detailed scope of review

This section summarises the scope of work sought in the original request for proposal. This has shaped our focus, with efforts then focused on areas of greatest interest and information. Included in the timeframe, was gathering information on claims and conducting interviews.

The scope looks at both New Zealand and international links, commissioning models for hearing aids and associated products, as well as supporting audiology services. The scope includes the following:

The shape of the audiology market nationally and internationally:

- A summary of the New Zealand market. Looking at access/service provision across New Zealand including both the private and public market.
- A description of current global hearing aid manufacturers, including their market share, relationships with audiology providers, and supply chains.
- A compilation of information on international service models and funding mechanisms
 - e.g. how hearing aids and associated audiology services are provided and funded, such as bundled services/packages of care, and funding of follow-up services (maintenance, repairs outside warranty etc).
- A review of similar jurisdictions, (e.g. UK, Australia, Canada, Denmark), including any issues with hearing aid provision/audiology services and any relevant solutions in place to address these. This will include:
 - a description of other workplace injury/personal injury schemes for hearing loss including how these are commissioned and funded.
- Any relevant comparisons between New Zealand and other jurisdictions on hearing aid provision and cost, as well as audiology services more broadly.

Hearing aid summary:

- Manufacturer provision of label versus non-label hearing aids, and associated costs.
- Range and quality of hearing aids (entry-level/basic hearing aids versus complex/high-level hearing aids).
- Like for like unit costs (New Zealand compared to other markets) and volumes within a population.
- How hearing aids are procured by funders, such as government/public funders, insurance providers, including Central procurement versus distributed procurement models.
 - Determine if there are different processes for procuring hearing aids depending on complexity of hearing loss.
- How cost, quality, and volume of hearing aids is managed by funders (public funding versus insurance providers) and what legislative, contractual levers are in place.
- How eligibility is managed for schemes that are publicly funded versus insurance providers.
- Where possible, a specific focus on injury-related hearing loss (e.g. trauma-related, medical misadventure, occupational noise-induced hearing loss).

- Find if re-aiding of clients occurs and how the process works (e.g. timeframes, eligibility, how age-related change is incorporated).

Accessories and batteries:

- Determine how accessories and batteries are procured and distributed, the associated costs, and what is provided versus client purchased.
- Costs associated with these.
- What is provided versus what the client is expected to purchase

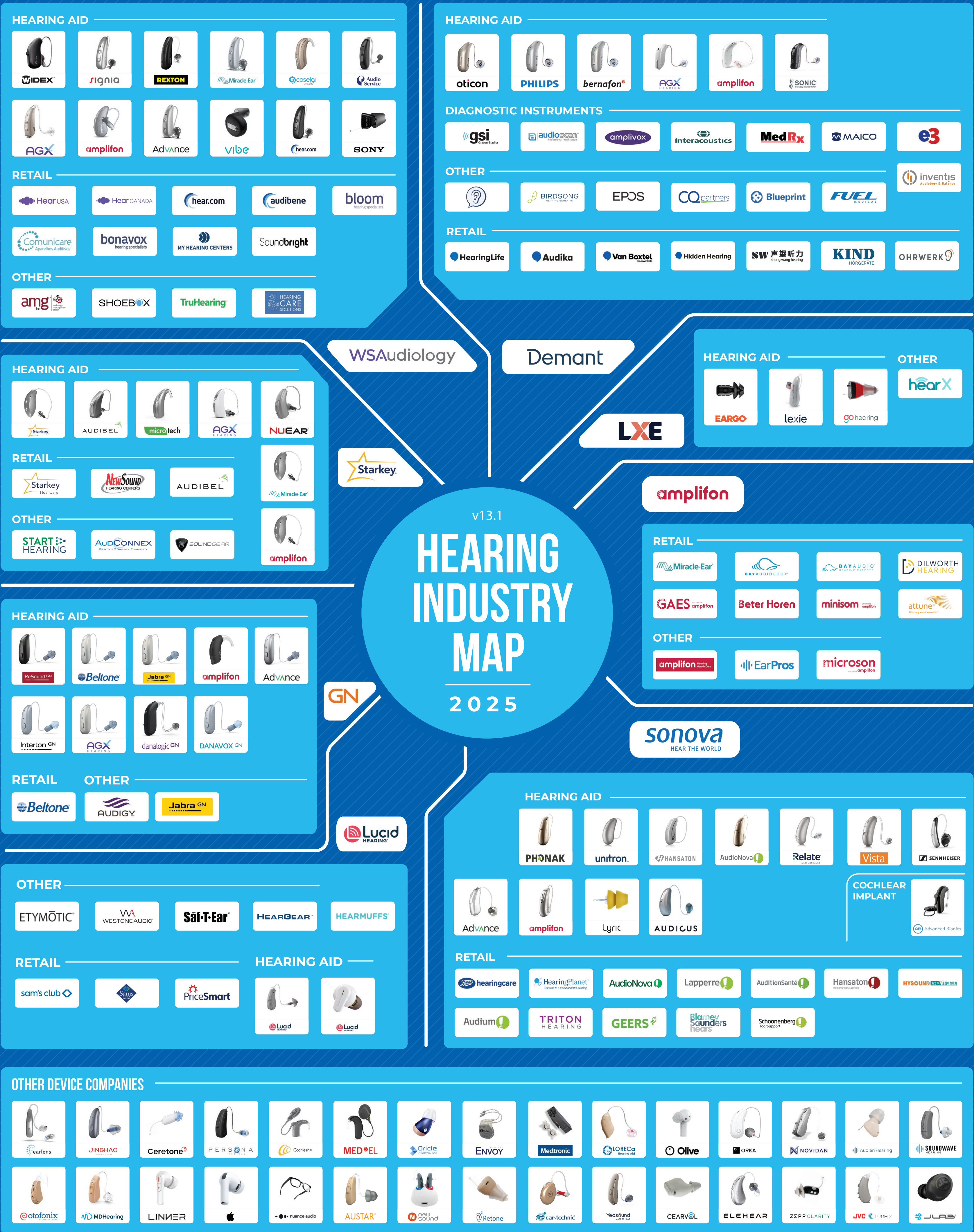
Audiology assessment / fitting fees:

- Review the costs of assessment, fitting and adjustment of hearing aids.
- Find how cost, quality and volume of audiology assessment / fitting fees is managed.
- Assess how eligibility is managed.

Considerations of disparities in clients' access, experience and outcomes, specifically those with the highest needs:

- Provide a view on the current state of service provision disparities (hearing aid purchasing, audiology service provision, associated funding mechanisms).
- Explore international examples of equitable service provision in relevant areas and their cost-benefit implications.
- More complex services, such as cochlear implants, were agreed to be outside the scope of our review.

Appendix C Hearing industry map



Appendix D International models

Australia

Workplace injury compensation in Australia is covered by 11 main schemes (Safe Work Australia, 2025). Each scheme covers a state in Australia and has its own policies and guidelines. This review focuses on three states: New South Wales, Victoria and South Australia.

Hearing loss coverage provided by each workplace injury scheme is often split into coverage of medical expenses or devices and lump sum payments for permanent impairment. Eligibility for both differs across states.

South Australia

In South Australia, workplace injury insurance is managed by the ReturntoWorkSA. In 2024, it was reported that ReturntoWorkSA received 2,305 hearing loss claims, a number that has doubled since 2018 (ReturntoWorkSA, 2025a).

Eligibility

Eligibility for noise induced hearing loss is included in the Return to Work Act 2014. The Act specifies that when a worker suffers from noise induced hearing loss and was exposed to noise during their employment then it is presumed that the noise induced hearing loss arose from the employment, in the absence of contrary evidence.

A worker is also entitled to a lump-sum payment for non-economic loss if they have sustained Whole Person Impairment⁸ of greater than 5 per cent (ReturntoWorkSA, 2025a).

Entitlements

The ReturntoWork scheme covers necessary medical costs that are reasonably incurred in consequence of the work injury. This includes audiology and audiometry services, hearing aid fittings and replacements (ReturntoWorkSA, 2025a). A maximum fee schedule is published by the Minister for Industrial Relations in the South Australian Government Gazette. This outlines the maximum fees that can be chargeable to ReturntoWorkSA, excluding GST. Table 9 outlines the maximum fee schedule for common costs.

Table 9: Maximum fee schedule for South Australia as at 1 July 2025

Category	Maximum fee (AUD) or entitlement
Audiology services	Audiologist: \$244.60 flat fee
	Audiometrist: \$219.60 flat fee

⁸ Whole Person Impairment is a standardised percentage measure of the permanent functional impact of an injury or condition on a person as a whole (ReturntoWorkSA, 2025b)

Category	Maximum fee (AUD) or entitlement
Hearing aids	\$2,020 (ReturntoWorkSA, n.d.).
Fittings	Monoaural: \$897.40 Biaural: \$1317.20 Fittings include the supply and fitting of the hearing aid, instructions around appropriate use, subsequent follow-up for one year and one-year supply of batteries.
Repairs	Reasonable cost. A claims manager only considers payments for repairs that are due to normal wear and tear and not covered under warranty.
Replacements	The expected life of a hearing aid is five years. A replacement prior to five years may be approved if there is loss or damage that is not covered by a warranty or insurance, or the current device cannot be adjusted to meet the hearing requirements.
Batteries	\$101 per device per year, applicable 12 months after the fitting of the hearing device.

Source: ReturntoWorkSA, 2025b

New South Wales (NSW)

Workplace injury compensation in New South Wales is managed by the State Insurance Regulatory Authority who licenses and regulates the Nominal insurer (icare), and all self and specialised insurers in the NSW compensation scheme (State Insurance Regulatory Authority, 2024c).

Eligibility

Under the Workers Compensation Act 1987, all workers in New South Wales have the right to claim workers compensation if they suffer a work-related injury or disease. Workers who claim for hearing impairment are required to demonstrate that their hearing loss is due to a noisy environment.

For lump sum compensation, an assessment must be conducted by an ear, nose and throat specialised who is a trained assessor of permanent impairment. Claims for lump sum compensation made on or after 19 June 2012 have a threshold of 11 per cent or more permanent impairment (State Insurance Regulatory Authority, 2024b).

Entitlements

Table 10: Maximum fee schedule for New South Wales as at 1 February 2024

Category	Maximum fee (AUD) or entitlement
Hearing needs assessment	Audiologist: \$237.70 Audiometrist: \$195.90
Hearing aids	Cost price of hearing aids, including remote control, charger, batteries and consumables to a maximum of \$2,500 per aid. Batteries and consumables are for the first 12 months.

Category	Maximum fee (AUD) or entitlement
Fittings	\$686.90 per aid including: - fitting and assessment that the device is suited to the worker - instructions and education on use of the device and accessories, tailored to the needs of the worker - a device management plan.
Hearing rehabilitation	\$686.90. Includes assessing, planning and delivering tailored best practice hearing rehabilitation.
Repairs	Up to \$461.50
Replacements	Replacement can be applied for if a hearing aid has been lost or damaged and is not covered by warranty or other insurance, or the worker can no longer communicate effectively using the current hearing aid.
Batteries	\$141.60 per hearing aid to cover a 12-month supply. This cannot be supplied until after 12 months from the initial supply of the hearing aid.

Source: State Insurance Regulatory Authority, 2024a

Victoria

WorkSafe is Victoria's workplace health and safety regulator and workplace injury insurer.

Eligibility

Claims for medical expenses and aids do not have a specific level of hearing loss required but requires a hearing loss assessment by a Worksafe approved audiologist or audiometrist.

Permanent impairment claims require 10 per cent whole person impairment.

Entitlements

WorkSafe enters into contracts with hearing services practices through a tender process, however if new providers wish to enter into a contract, then Worksafe will consider this request on an ad hoc basis. Fees that these practices can charge back to Worksafe are commercial in confidence, however, are at a higher rate than the maximum fees for non-contracted providers set out in Table 11.

Table 11: Maximum fee schedule for non-contracted providers as at 1 July 2025

Category	Maximum fee (AUD) or entitlement
Hearing needs assessment	Audiologist: \$216.13 Audiometrist: \$187.47
Hearing aids	Price agreed between the manufacturer and Worksafe for aids that are on the WorkSafe approved hearing device list (WorkSafe Victoria, 2025b).
Fittings	Monoaural: \$1,001.82 Biaural: \$1,422.12 This amount is paid once per worker in any five-year period. Fittings include a 12-month supply of batteries.

Category	Maximum fee (AUD) or entitlement
Repairs	\$504.28
Replacements	Replacements will be provided five years after the initial fitting if the replacement is reasonable and/or necessary. Early replacement of devices can occur if the worker's hearing has changed significantly or the existing hearing device is no longer suitable.
Batteries	\$80 for a 12-month supply. This can be claimed 12-months after the hearing aid fitting.

Source: WorkSafe Victoria, 2025c

Management of the hearing aid list

WorkSafe manages an approved hearing aid list which includes all models of hearing devices, assisted listening devices and accessories. The list contains devices that meet WorkSafe's required features which have been developed alongside a clinical panel (WorkSafe Victoria, 2026). If a worker requires a device that is not on the approved list, the audiologist is required to submit clinical justification for this.

Canada

Alberta

The Workers' Compensation Act in Alberta is managed by a neutral administrator, the WCB.

The overall volumes of hearing aid, audiology appointments and repairs compensated for in the previous three years are outlined in Table 12.

Table 12: Volumes of services compensated for by WCB 2023 – 2025

Service type	2023	2024	2025
Audiology appointments	[Redacted]	[Redacted]	[Redacted]
Hearing aids	[Redacted]	[Redacted]	[Redacted]
Repairs	[Redacted]	[Redacted]	[Redacted]

Source: Workers Compensation Board - Alberta, 2026

Eligibility

There are three types of hearing loss that WCB may accept a claim for (WCB Alberta, 2025):

1. Occupational traumatic hearing loss: sudden or acute hearing loss caused by a work accident.
2. Occupational chemically induced hearing loss: hearing loss because of exposure to toxins or chemicals in the workplace or medications prescribed for a compensable condition.
3. Occupational noise induced hearing loss: the gradual loss of hearing due to prolonged exposure to excessive noise in the workplace. The occupational exposure limit for noise is 85 decibels averaged over an eight-hour day.

Entitlements

Table 13: Maximum fee schedule for Alberta as at March 2026

Category	Maximum fee (CAD) or entitlement
Hearing needs assessment	Initial assessment: - registered hearing aid practitioner or audiologist: \$105. Subsequent assessment: - registered hearing aid practitioner or audiologist: \$50.40.
Hearing aids and fittings	Monoaural: manufacturer cost up to \$900, plus \$40 shipping and handling. Plus, a \$498.40 fitting fee, for a maximum total of \$1,438.40. Biaural: manufacturer cost up to \$1,800, plus \$80 shipping and handling. Plus, a \$996.80 fitting fee, for a maximum total of \$2,876.80. Rechargeable devices: lithium-ion rechargeable hearing aids are permitted when clinically appropriate. Non-lithium rechargeable devices are not funded.
Repairs	- Out of office clinic fee: \$65/aid. - Manufacturer repair: Manufacturer cost. - In office after warranty period: \$30/aid. A maximum 2 times per aid in a 12-month period after one year from initial fitting date.
Replacements	A hearing aid is replaced only as required, regardless of age. If the hearing aid is less than five years old, prior authorisation is required (WCB Alberta, 2023).
Batteries	\$0.75 each, 60 per aid.

Source: Workers Compensation Board - Alberta, 2026

Commissioning approach for hearing aids

[Redacted

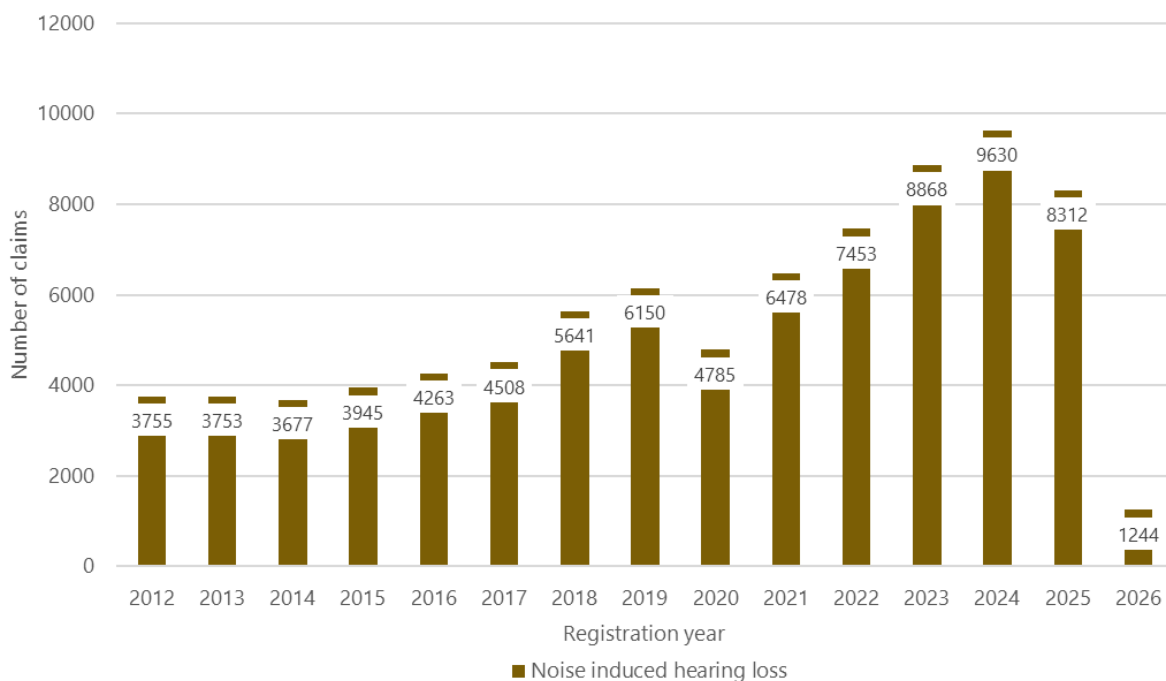
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Ontario

Workplace injury compensation is managed by the WSIB. In 2024, WSIB implemented a bundled hearing loss programme for services, aimed at improving access and quality of care (Workplace Safety and Insurance Board, 2024). Hearing aids and devices are managed through a separate procurement process (see below).

The overall volumes of noise induced hearing loss claims is outlined in Figure 15.

Figure 15: Allowed occupational disease claims - noise induced hearing loss



Source: WSIB Ontario, 2026

Eligibility

Workers are entitled to join the hearing services program after satisfying the following criteria (Workplace Safety and Insurance Board, 2025a):

- the worker has an allowed claim for work-related hearing loss
- has no additional injuries that prevent them from participating the programme.

Only those providers that are registered with WSIB are able to deliver the hearing services program.

Noise induced hearing loss include the following criteria (Workplace Safety and Insurance Board, 2026b):

- continuous exposure of 90dB of noise for eight hours per day, for a minimum of five years
- hearing loss of 22.5dB in each ear
- pattern of hearing loss is consistent with noise-induced sensorineural hearing loss.

The program also considers traumatic hearing loss which is a sudden or acute onset of hearing loss from a single traumatic event (Workplace Safety and Insurance Board, 2026b).

Entitlements

Table 14: Service bundles and hearing device entitlement for hearing services program

Category	Maximum fee (CAD) or entitlement
Year one – Initial services bundle	- Assessment: including audiometric testing, communication needs, selection of hearing aid technology, prescription and pre-fitting counselling and information. - Dispensing and fitting: includes a listening check, fit and sound quality check, patient education, verification using real ear measurements, programming and batteries. - In-house services (maintenance visits): cleaning, minor repairs and parts replacement, impressions clinic service and material fees and wax removal. - Trial follow-up: re-programming, physical fit adjustments, cleaning, repairs and remakes, patient's education/reinstruction.
Year two onward – Ongoing service bundle	- Mandatory physical inspection of the hearing aid, minor repairs and parts replacement, cleaning and maintenance of the device and physical ear check. - Additional services as needed, this may include: - hearing assessment and related audiogram - routine maintenance - performance testing - impressions clinic service and material fees - service related to manufacturer repairs and remakes - wax removal.
Additional follow-up as needed during the ongoing bundle – Mini bundle	- Applies when someone needs a new prescription within the five-year lifecycle. Services include: - hearing assessment - hearing aid selection - dispensing/fitting - impressions clinic service - programme - verification using real ear measurement - electroacoustic analysis.
Hearing devices	Price agreed with manufacturers on the hearing aid tender

Source: Workplace Safety and Insurance Board, 2025b

A worker who has work-related permanent impairment may also be entitled to a non-economic loss benefit. This depends on the degree of the permanent impairment (Workplace Safety and Insurance Board, 2023).

Management of hearing devices

WSIB contracts with hearing aid vendors selected through a competitive procurement process, guided by the following principles (WSIB Ontario, 2025):

- A wide range of quality hearing devices.
- Geographic coverage across Ontario.
- Improved warranties.
- Access to bundled devices and products.
- Value for money.
- Improved supplier relationship management and administrative efficiencies.
- Continuous education related to emerging technologies.

The hearing device contract covers five manufacturers and includes accessories and consumables. Through this process, workers can obtain entry- and mid-level authorised hearing aids without pre-approval, while exception-level devices may be considered on a case-by-case basis when clinically necessary and supported by assessment evidence.

British Columbia (BC)

Eligibility

WorkSafe BC will consider claims for hearing loss if a worker has experienced continuous exposure to hazardous noise at work in British Columbia for two or more years. The exposure must have been for at least eight hours per day and at 85 decibels or more (WorkSafeBC, n.d.).

Entitlements

Table 15: Maximum fee schedule for WorkSafeBC

Category	Maximum fee (CAD) or entitlement
Hearing needs assessment	\$130 per audiologist diagnostic assessment.
Hearing aids	Each manufacturer has a list (Price Grid) of hearing aids available to WorkSafeBC workers that are under the Hearing Aid Price Cap (WorkSafeBC, 2022b). Worker can also enter into a Cost Share Arrangement.
Fittings	\$620 flat fee per hearing aid.
Repairs	Manufacturer invoice cost including shipping.
Replacements	Hearing aids are not automatically replaced after five years and on or more of the replacement criteria must be met regardless of age (WorkSafeBC, 2022b). Replacement criteria includes: • inadequate gain available • improper fit resulting in feedback • significant change in hearing

Category	Maximum fee (CAD) or entitlement
	- hearing aid style inappropriate - manufacturer will not repair the hearing aid - excessive manufacturer repair history - injured worker has transferred from a Beltone clinic and the hearing aid provider is unable to program hearing aid. If the hearing aid is greater than five years old, prior authorisation is not required. If the hearing aid is less than five years old, prior authorisation is required.
Batteries	Up to \$1.15 per cell, maximum of one years' worth.

Source: WorkSafeBC, 2022a16

Denmark

Audiology service and hearing aids are delivered through publicly funded audiology clinics or private clinics. These clinics are located in 21 different public hospitals of 50 private providers who operate under agreement with the regions.

For the publicly funded market across five regions, a third-party organisation, Amgros, manages the procurement and supply of hearing aids and supplementary devices. Tendering processes are carried out in collaboration with the five regions and clinical experts (Amgros, n.d.-b). Clinics are able to order hearing aids from all suppliers on the tender through an e-commerce platform. The invoice is then provided to Amgros who will pay the supplier.

Replacement hearing aids are available after four years.

United Kingdom

Eligibility

Hearing aid provision is managed by the National Health Service (NHS) through the public health system. Workers receive free hearing tests and treatments through the NHS through referrals from a general practitioner to an audiologist. In addition pharmacists and opticians often have hearing specialists who may be able to provide hearing tests (*Hearing Tests*, 2017).

Entitlements

If required, a hearing aid is provided from the NHS on long term loan and remains the property of the NHS. Batteries and repairs are free and there is also no charge for any follow-up appointments or aftercare (NHS, 2021).

International price comparison of hearing aid models and accessories

Table 16: International price comparison of hearing aid models, original currencies

Brand	Product family / group	USD (HearingTracker)	USD (ZipHearing)	NZ (Specsavers - without MSD subsidy scheme)	NZ (Audika – MiniRITE)	AUD (Specsavers AU)	UK (HearingAid.org.uk)
Oticon	Zeal	\$4,798					£3,895 per pair
Oticon	Intent	\$2,898–\$4,898			Entry \$1,518; Essential \$2,522; Enhanced \$3,301–\$4,022; Premium \$5,522–\$7,022; Optimal \$8,722–\$10,022 (per pair)		£2,495–£3,895
Phonak	Audéo Infinio Ultra	\$2,498–\$6,500	\$2,498–\$4,598	\$5,275		\$4,995–\$6,495	£2,395–£3,695
Phonak	Audéo Infinio Ultra Sphere		\$3,598–\$4,898				
Phonak	Virto Infinio		\$2,498–\$4,398	\$4,275		\$4,495	£2,395–£3,495
Phonak	Lumity Slim			\$4,775		\$4,495–\$5,495	£2,095–£3,295
Phonak	Naída Lumity		\$2,798–\$4,598				
Phonak	Infinio 70 / Lumity 70			\$5,299		\$4,495	
Phonak	Infinio 90 / Lumity 90			\$6,499		\$5,495	

Brand	Product family / group	USD (HearingTracker)	USD (ZipHearing)	NZ (Specsavers - without MSD subsidy scheme)	NZ (Audika – MiniRITE)	AUD (Specsavers AU)	UK (HearingAid.org.uk)
Signia	Pure Charge&Go IX		\$2,698–\$3,398				£1,595–£3,395
Signia	Styletto IX		\$2,698–\$3,398				£1,595–£3,395
Signia	Silk Charge&Go IX		\$2,398–\$3,398				£1,595–£3,395
Signia	Pure 312 AX		\$2,598–\$4,398				
Signia	IX / AX (5 level)			\$5,299–\$5,799		\$4,495–\$4,995	£1,595–£3,395
Signia	IX / AX (7 level)					\$5,495–\$5,995	£1,595–£3,395
ReSound	Vivia	\$2,798–\$3,798	\$2,798–\$3,798	\$5,299–\$5,799		\$4,495–\$6,495	£2,495–£3,395
ReSound	Enzo Q		\$3,198–\$4,598				
Widex	Allure	\$2,798–\$3,898	\$2,798–\$3,898				£2,095–£3,695
Widex	Moment		\$2,798–\$3,398				£1,895–£3,495
Starkey	Omega AI	\$3,998	Product available but price not listed				£2,595–£3,495
Specsavers	Advance / Standard			\$1,499		\$1,495	
Specsavers	Advance / Standard – Rechargeable			\$1,999		\$1,995	
Specsavers	Advance / Plus			\$2,199		\$1,995	

Brand	Product family / group	USD (HearingTracker)	USD (ZipHearing)	NZ (Specsavers - without MSD subsidy scheme)	NZ (Audika – MiniRITE)	AUD (Specsavers AU)	UK (HearingAid.org.uk)
Specsavers	Advance / Premium			\$2,899		\$2,495	
Specsavers	Advance / Super			\$3,499		\$2,995	
Specsavers	Advance / Elite			\$4,099		\$3,495	
Specsavers	Advance / Elite + AI (Rechargeable)			\$4,999		\$4,495	

Source: Price lists from various websites, including hearingtracker.com, ziphearing.com, specsavers.co.nz, specsavers.com.au, audika.co.nz, and hearingaid.co.uk

Domestic and international price of hearing aid accessories

Table 17: Indicative price range of hearing aid accessories available in NZ

Accessory category	Typical unit	NZ price range (per unit)	Range size as % of highest price
Disposable batteries (single cell)	1 battery	\$0.85 – \$1.05	19.0%
Bulk batteries (single cell)	1 battery	\$0.75 – \$0.85	11.8%
Wax guards / filters	1 filter	\$1.30 – \$2.10	38.1%
Domes / ear tips	1 dome	\$3.00 – \$3.50	14.3%
Slim tubes / tubing	1 tube	\$10 – \$25	60.0%
Replacement receivers	1 receiver	\$100 – \$150	33.3%
Cleaning tool kits	1 kit	\$7 – \$15	53.3%

Accessory category	Typical unit	NZ price range (per unit)	Range size as % of highest price
Cleaning wipes / tablets	1 wipe/tablet	\$0.60 – \$1.00	40.0%
Drying capsules	1 capsule	\$3.00 – \$4.50	33.3%
Passive drying kits	1 kit	\$20 – \$35	42.9%
Electronic hearing-aid dryers	1 unit	\$140 – \$180	22.2%
Television streamers / connectors	1 unit	\$300 – \$400	25.0%
Remote microphones (clip-on)	1 unit	\$350 – \$450	22.2%
Table microphones (multi-speaker)	1 unit	\$600 – \$900	33.3%
Remote controls	1 unit	\$150 – \$320	53.1%
Neckloops / loop receivers	1 unit	\$40 – \$150	73.3%

Table 18: Indicative international comparison of hearing aid accessory prices by category and brand (NZD)

Product category	Specific product / accessory brand	Hearing-aid ecosystem	NZ – typical	AU	UK	US
Disposable batteries (6-pack)	Rayovac zinc-air	Cross-brand	\$0.90 – \$1.05	\$0.50 – \$0.65	\$0.40 – \$0.60	\$0.55 – \$0.70
	Power One zinc-air	Cross-brand	\$0.90 – \$1.05	\$0.50 – \$0.65	\$0.40 – \$0.60	\$0.55 – \$0.70
	ZeniPower zinc-air	Cross-brand	\$0.90 – \$1.05	\$0.50 – \$0.65	\$0.40 – \$0.60	\$0.55 – \$0.70
Wax guards / filters (8-pack)	CeruStop	Phonak	\$1.40 – \$1.75	\$0.60 – \$0.85	\$0.50 – \$0.70	\$0.70 – \$0.95
	ProWax	Oticon	\$1.45 – \$1.85	\$0.65 – \$0.90	\$0.55 – \$0.80	\$0.75 – \$1.00
	Signia Wax Guards	Signia	\$1.40 – \$1.80	\$0.60 – \$0.85	\$0.50 – \$0.75	\$0.70 – \$0.95
	NanoCare	Widex	\$1.60 – \$2.10	\$0.75 – \$1.00	\$0.60 – \$0.85	\$0.80 – \$1.10
Domes / ear tips (10-pack)	Phonak domes	Phonak	\$3.00 – \$3.30	\$1.20 – \$1.60	\$1.00 – \$1.40	\$1.50 – \$2.10
	Oticon domes	Oticon	\$3.20 – \$3.50	\$1.30 – \$1.70	\$1.10 – \$1.50	\$1.60 – \$2.30
	Signia domes	Signia	\$3.00 – \$3.30	\$1.20 – \$1.60	\$1.00 – \$1.45	\$1.50 – \$2.10

Product category	Specific product / accessory brand	Hearing-aid ecosystem	NZ – typical	AU	UK	US
	Widex domes	Widex	\$3.00 – \$3.50	\$1.30 – \$1.80	\$1.10 – \$1.60	\$1.60 – \$2.40
Replacement receivers (per unit)	Phonak RIC Receiver	Phonak	\$130.00	\$85.00	\$75.00	\$107.50
	Oticon RIC Receiver	Oticon	\$130.00	\$90.00	\$80.00	\$112.50
	Signia Receiver	Signia	\$120.00	\$85.00	\$75.00	\$105.00
	Widex Receiver	Widex	\$130.00	\$90.00	\$80.00	\$112.50
Television streamers / connectors	Phonak TV Connector	Phonak	\$355.00	\$295.00	\$280.00	\$310.00
	Oticon TV Adapter	Oticon	\$360.00	\$300.00	\$290.00	\$320.00
	Signia TV Streamer	Signia	\$340.00	\$290.00	\$280.00	\$310.00
	Widex TV Play / TV Streamer	Widex	\$340.00	\$290.00	\$280.00	\$310.00
Remote microphones (clip-on)	Roger On / Roger Mic	Phonak	\$420.00	\$320.00	\$305.00	\$350.00
	EduMic / ConnectClip	Oticon	\$415.00	\$320.00	\$305.00	\$350.00
	StreamLine Mic	Signia	\$395.00	\$310.00	\$300.00	\$335.00
	Widex SoundAssist / Com-Dex Mic	Widex	\$395.00	\$310.00	\$300.00	\$335.00
Table microphones (multi-speaker)	Roger Table Mic II / 3	Phonak only	\$750.00	\$575.00	\$550.00	\$620.00
Remote controls	Phonak RemoteControl	Phonak	\$230.00	\$180.00	\$170.00	\$200.00
	Oticon Remote Control	Oticon	\$260.00	\$185.00	\$175.00	\$210.00
	Signia MiniPocket	Signia	\$215.00	\$180.00	\$170.00	\$200.00
	Widex RC-Dex / Remote	Widex	\$240.00	\$185.00	\$175.00	\$210.00

Appendix E Audiologist supply relative to population and age structure

In the below figures we note that population estimates from 2019-2023 are interpolated linearly, and therefore the rates from 2020 to 2021 are potentially biased due to Covid.

Figure 17: Number of registered audiologists per 10,000 population by region

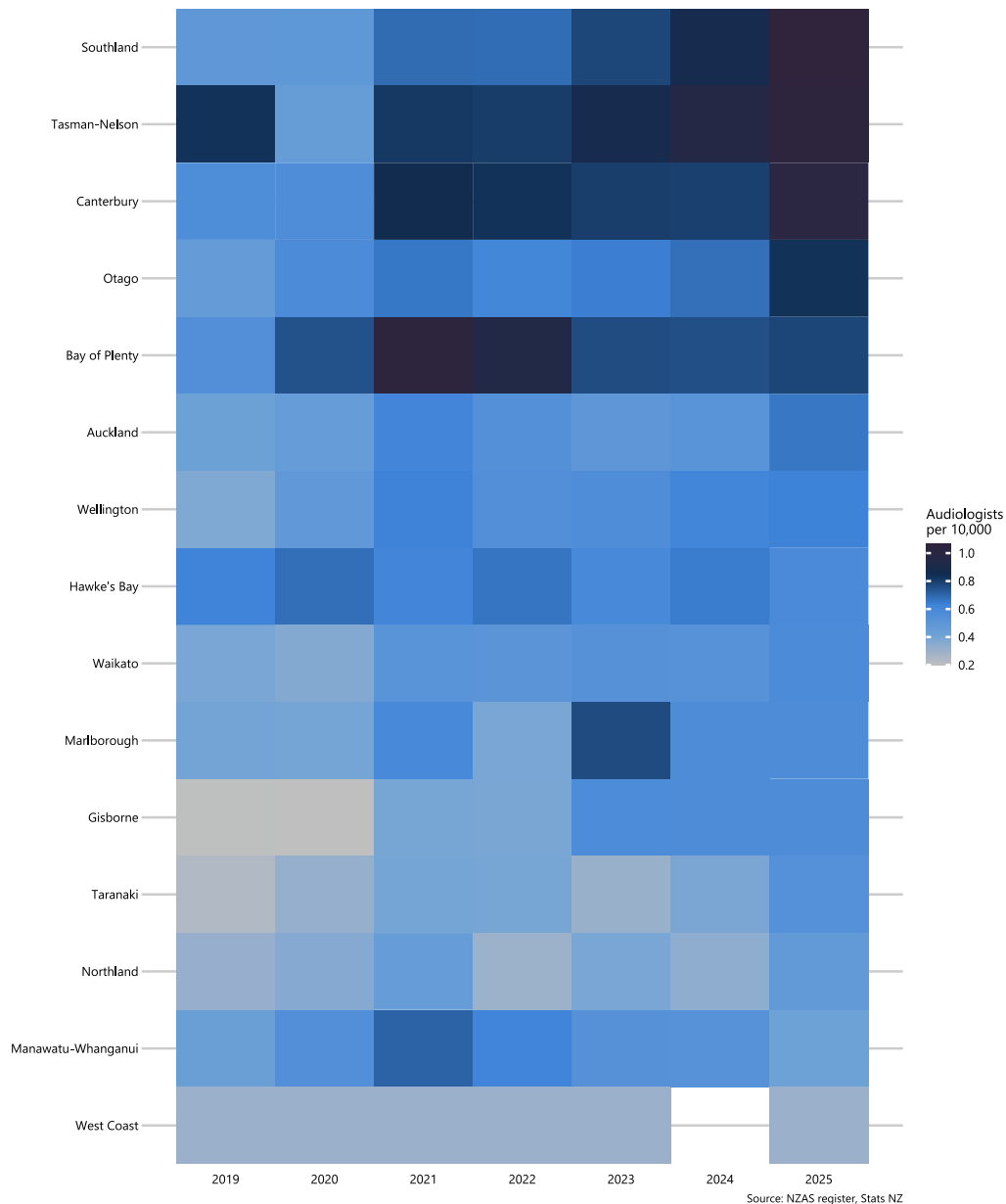


Figure 18: Choropleth map of audiologists per 10,000 population by region

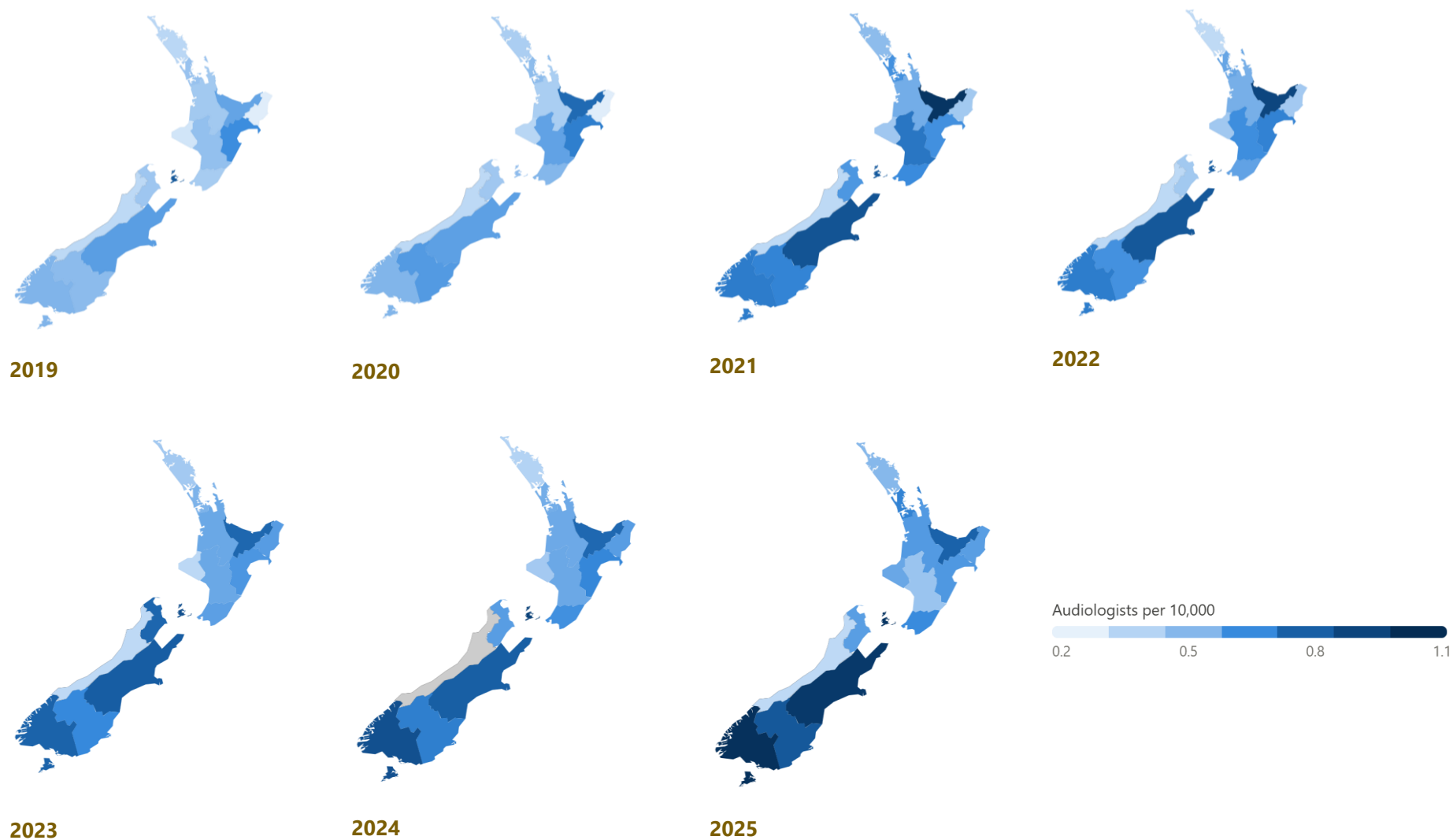
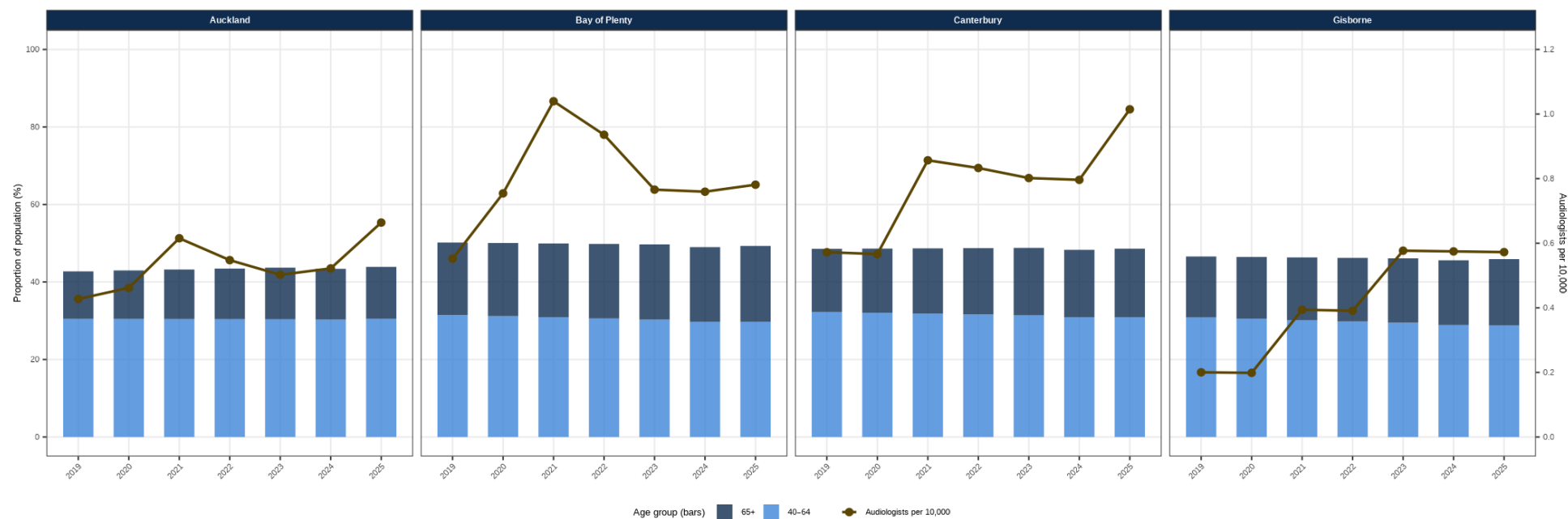
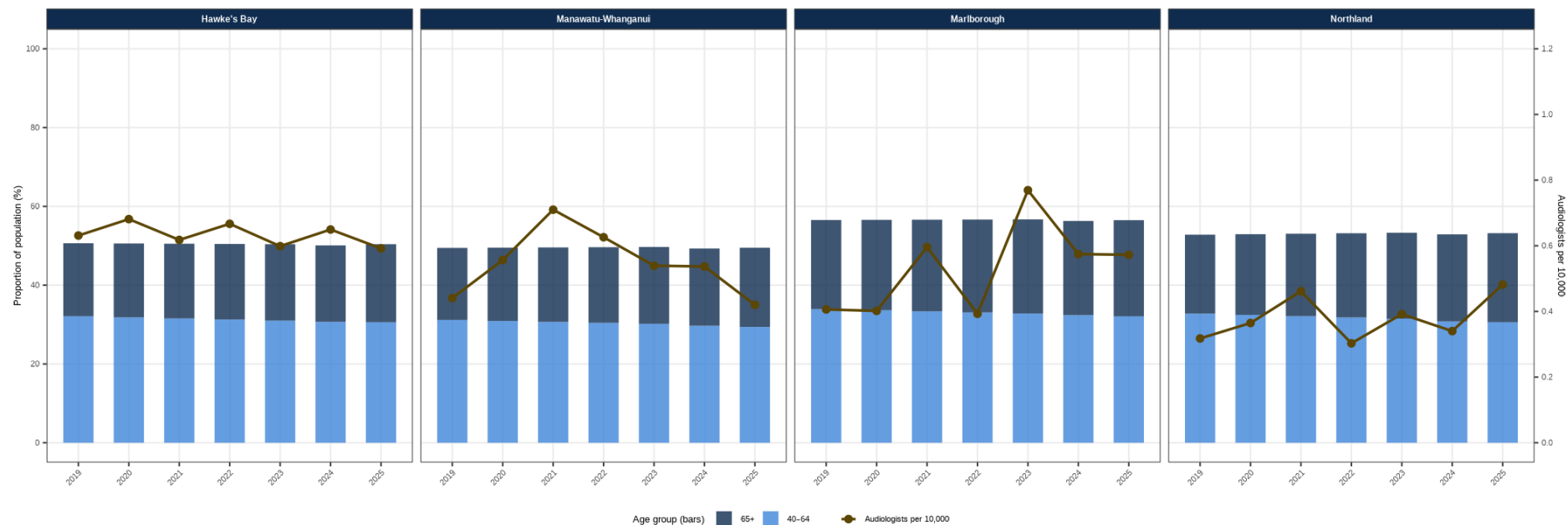


Figure 19: Regional age demographics and audiologist supply

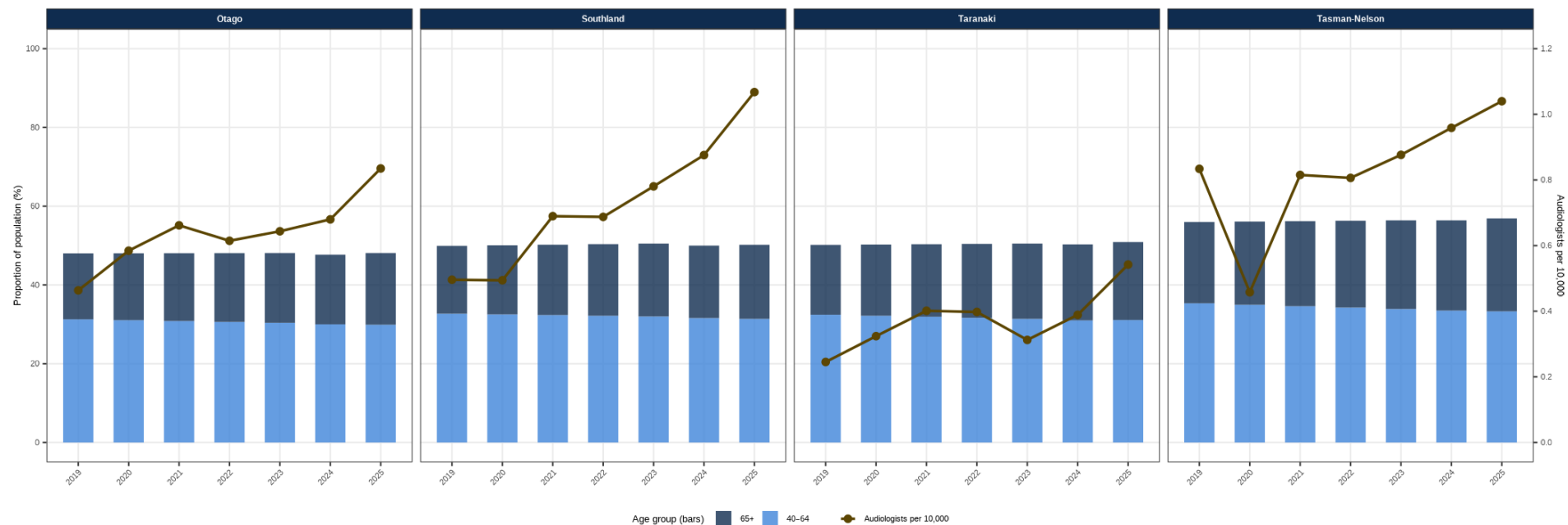
Panel A: Auckland, Bay of Plenty, Canterbury and Gisborne



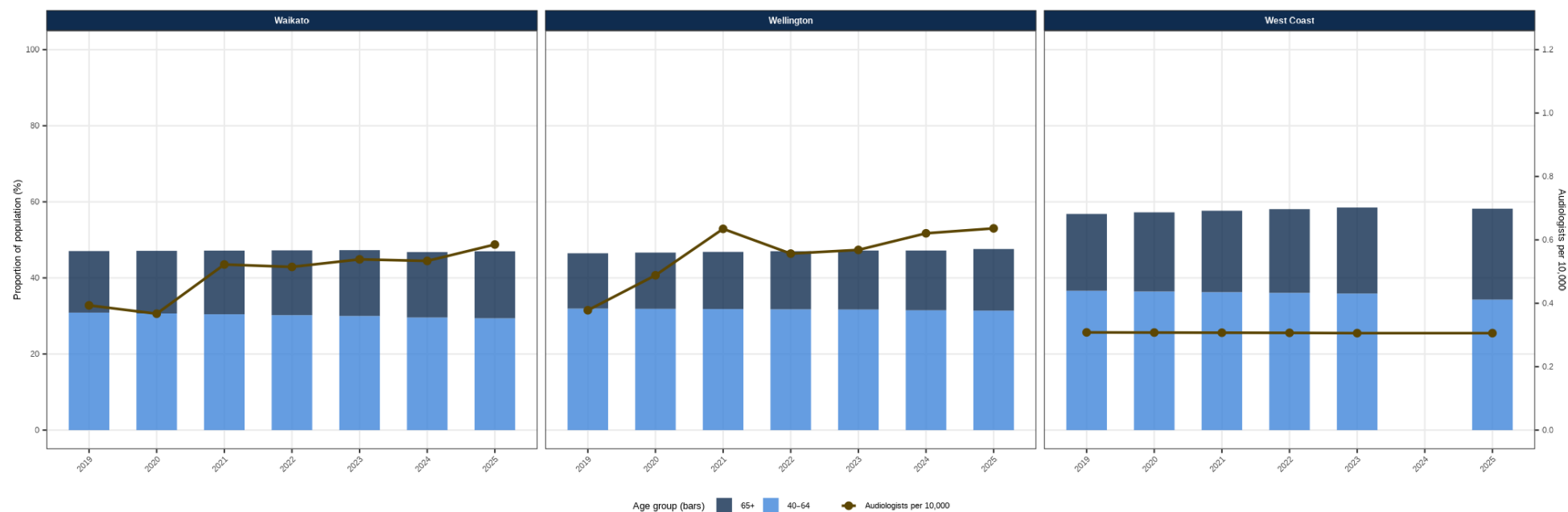
Panel B: Hawke's Bay, Manawatu-Whanganui, Marlborough and Northland



Panel C: Otago, Southland, Taranaki, and Nelson-Tasman



Panel D: Waikato, Wellington and West Coast



Sources: Stats NZ Census 2018 & 2023; Stats NZ ERP 2024–2025 (provisional)

Appendix F Insights from ACC claims data

In this Appendix, we look at implications of claim data for the ACC provision of audiology services and hearing aids. This section outlines our analysis of two datasets provided by ACC:

1. **Claims data:** claims data from 2014 until the most recent claim received at the start of 2026. We have reported on the full data but note that only partial data is available for calendar years 2014 and 2026. Findings from these two years are therefore excluded from our interpretation. Separate data on median age at first claim lodgement is also available since around 1970 and reported alongside claims data insights in relation to demographics.
2. **Sample claims details:** ACC collected further information over the first few weeks of the project. This included data from hearing aid trials, where available, to provide insight into total hearing aid costs, the types of hearing aids supplied (including whether they had rechargeable batteries), the source of ACC eligibility (e.g. treatment, trauma, or ONIHL), percentage of hearing loss, funding band, and the level of funding provided by ACC and DSS.

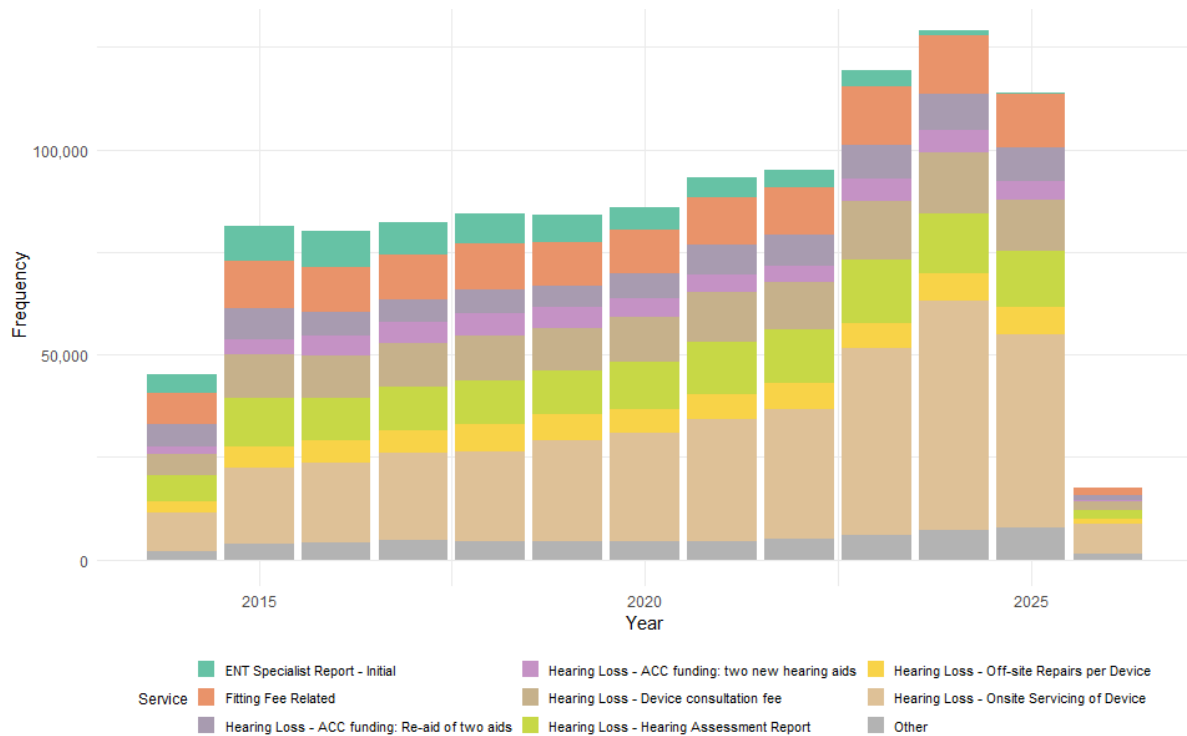
Analysis of ACC claims data

We use this data to look at service trends, demographics of claimants, costs, vendors, and nature of eligibility. More detailed breakdowns of some of this data is provided below.

Service trends

Accepted service claims have grown steadily over the period, rising from approximately 80,000 in 2015 to around 110,000 in 2025, with a peak in 2024 followed by a slight decline in 2025. This growth has been driven primarily by onsite servicing of devices which accounted for about half of all accepted service claims in 2025, more than double compared to 2015 levels. All other service categories remained broadly stable in their absolute contribution to total accepted claims over this period.

Figure 20: Frequency of service items by calendar year – accepted claims only



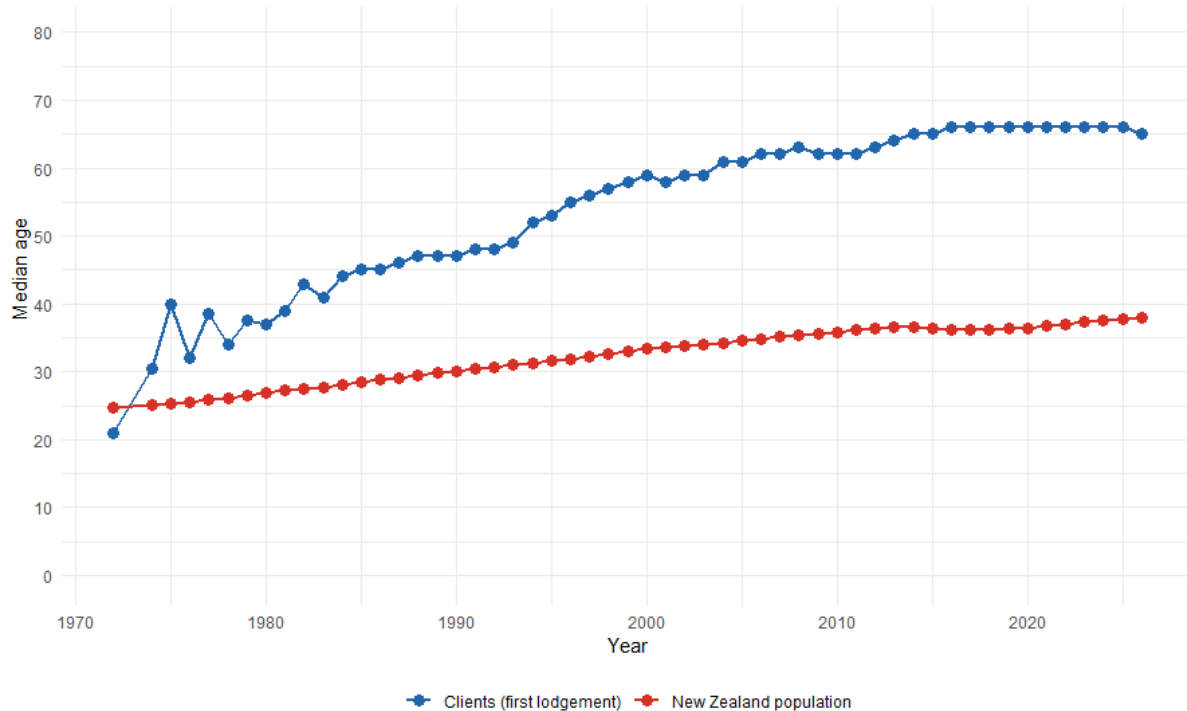
Service patterns by gender, ethnicity, and age band are presented in the additional charts below. These patterns are generally consistent across groups, with observed variations largely attributable to small sample sizes within certain subgroups, such as younger age bands, another gender, or Middle Eastern, Latin America and Africa (MELAA) ethnicity.

Demographics

Accepted claims are most concentrated in the 55–64 age group, followed by the 65–74 and 45–54 age groups. Demand is heavily skewed toward males relative to females and other genders, and toward Europeans relative to all other ethnic groups. Māori claimants represent the second-largest ethnic group, though they account for a small share of total claims (see Figure 36).

The median age at first lodgement has increased markedly over time from approximately 20 years in 1970, to around 45 in 1990, to approximately 60 in 2000, and to around 65 in the 2020s. The trend outgrew median age at national population level. ACC noted increases in median age over time could be driven by changes to rules and limits around funding eligibility. For example, setting a requirement of at least more than 10 years of work exposure for funding eligibility, which could partly explain the observed increase in median age over time.

Figure 21: Median age at first lodgement versus New Zealand population by calendar year



Additional analysis on the proportion of distinct claims that are declined by age-group, gender and ethnicity shows:

- 28 per cent of distinct claims are declined (46,938 declined and 121,728 accepted)
- the proportion of distinct claims that are declined increases with age: from 9 per cent for under 15-year-olds, over 21 per cent for 45 to 54, to 38 per cent for age 85 and over
- 23 per cent of distinct claims are declined for males compared to 55 per cent for female claimants
- 26 per cent of distinct claims are declined for Europeans compared to 30 per cent for other ethnicities, 37 per cent for Māori, 46 per cent for Pacific peoples, and 56 per cent for both Asian and MELAA.

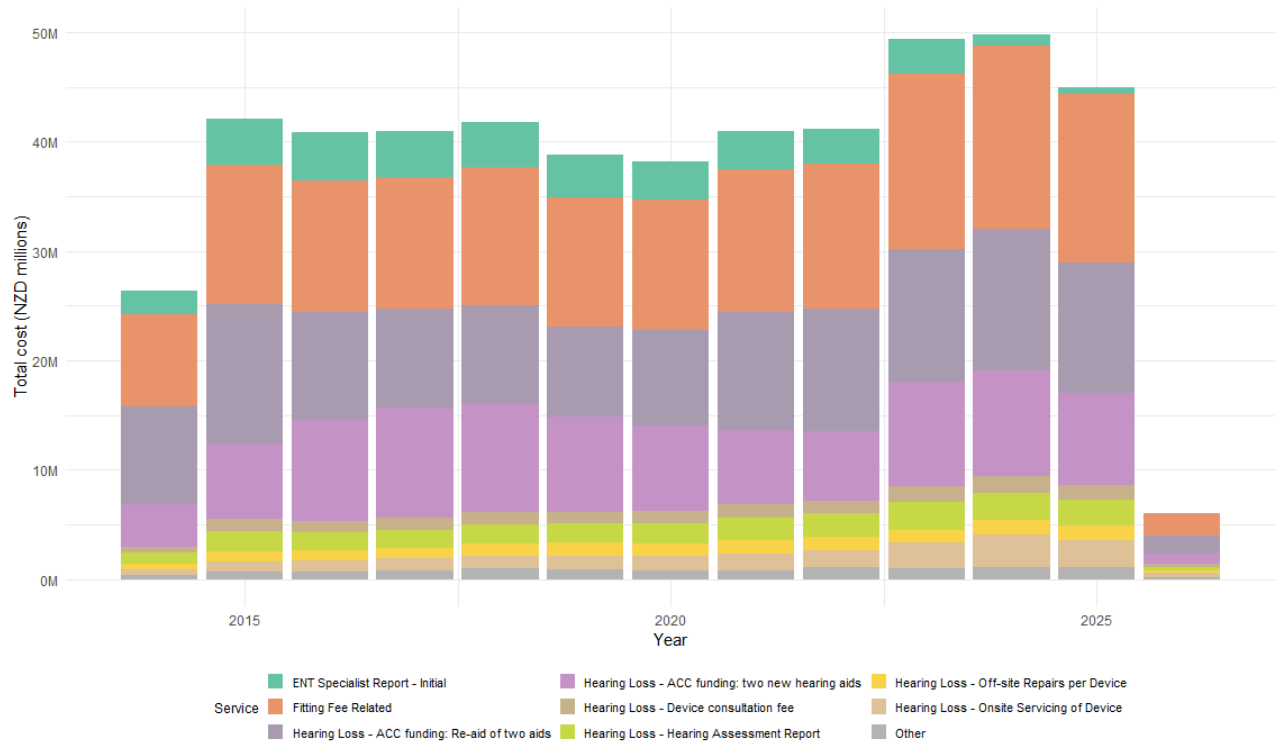
It has been outside our scope of engagement to undertake analysis to try to isolate the associations of demographic factors controlling for the likes of industry exposure. However, we note that while there are some indications of lower workplace injury claims for females, exposure and risk has been identified as typically being higher for Māori and Pacific peoples both in terms of injuries as well as in relation to noise-exposure (Denison et al., 2018; Meehan et al., 2021).

Costs

Costs have grown but not at the rate of the increase in service volumes. Total service costs in 2025 are at approximately NZD 45 million which is small and increase of NZD 5 million compared to 2015 levels. The overall cost distribution has been relatively stable over the past decade, with three notable exceptions:

- Costs associated with onsite servicing have doubled as a proportion of total accepted claim costs. ENT specialist report costs have fallen significantly in 2025.
- The key cost drivers are fitting related services, re-aids of existing hearing aids and funding of new hearing aids, which together account for approximately 85 per cent of all accepted claim costs in 2025
- There was a marked decrease in claims costs from 2019 to 2022 relative to other periods, likely reflecting a Covid interruption.

Figure 22: Service cost distribution by calendar year - accepted claims only



Nature of eligibility

When looking at the frequency of distinct claims by sources, claims classified as ONIHL dominate the distribution, with close to 100,000 claims (97 per cent) from 2014 to early 2026 making this by far the most common cause. In contrast, claims related to traumatic injury are much less frequent, numbering about 3,000 (traumatic injury makes up 3 per cent). Treatment-related injury claims are rare counted only around 300 claims (only about 0.3 per cent). We note that about 70,000 distinct claims have zero-values recorded for all three claim sources, implying neither of these three sources applies. Consequently, we did not include these claims in the percentage calculation of the distribution.

Looking at the number and costs of accepted claims⁹ across these sources over this time period (noting 2026 is a part year) we see that:

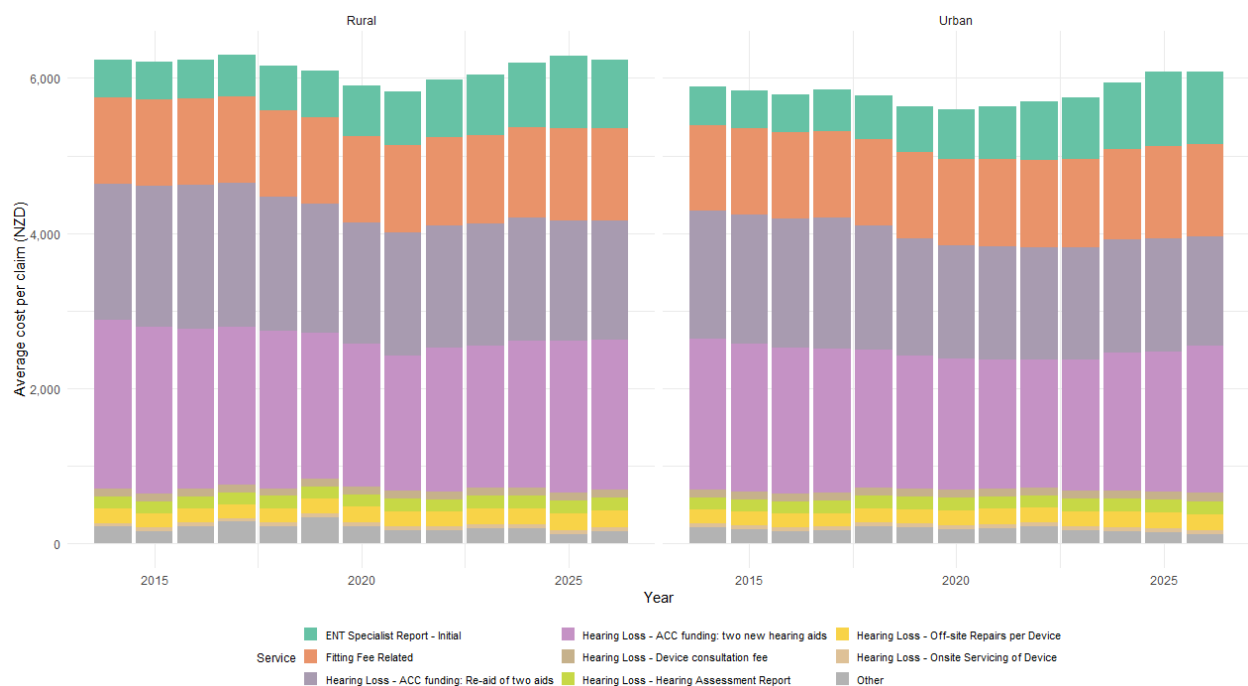
⁹ Note that the accepted claims shown here is to illustrate the increasing volume over the years, the frequency of claims here is not based on distinct count. For example, there are the same claim IDs appear in multiple years in the timeline.

- **Treatment injury claims:** increased from the early years through the late 2010s, peaking at around 4,500 to 5,000 claims per year, with noticeable fluctuations between years. Since 2020 the frequency of treatment injury claims for audiology services has been fairly flat.
- **Traumatic injury claims:** increase steadily from around 1,500 – 2,500 per year in the early years to approximately 4,000 to 4,600 claims per year in the mid-2020s (with less flattening in claims that observed for treatment).
- **ONIHL claims:** has steadily grown from around 10,000 in 2015 to over 40,000 in 2024, with costs also growing though less steeply from less than \$20 million to over \$35 million.

Geographic breakdown of claims

Looking at differences between claims across urban and rural locations, we see that a significantly greater portion of costs can be attributed to urban locations where there are more claims. However, if we look at the average cost per claim and compare rural and urban areas, we see that the figures are very comparable.

Figure 23: Distribution of average cost by rural and urban area per year



In our geographic analysis of the data, we note that there is noticeable missing data presented in the source we rely on. We note there are 77,960 claims with missing locations which amount to about \$33 million cost claimed (6 per cent of the total claims cost as recorded by ACC).

Figure 24 shows the average cost of accepted claims are highest in remote and rural areas. Chatham Islands (\$680 on average per claim) present a data outlier. Cost varies little from Gisborne, second highest, with about \$520 to Ruapehu District, the lowest of the leading 20 TA/LBs, with \$480. In comparison, Auckland has on average about \$80 cost per claim. The average across all TA/LBs sits at about \$453. The observed higher average cost in rural areas could be explained by additional expense of supplying audiology services to relatively remote communities. The outlier of the Chatham Islands

is likely influenced by the small number of observations, with a single extreme value in the population disproportionately driving the result.

Figure 24: Average cost per accepted claim by TA/LB, including leading 20 TA/LB and Auckland

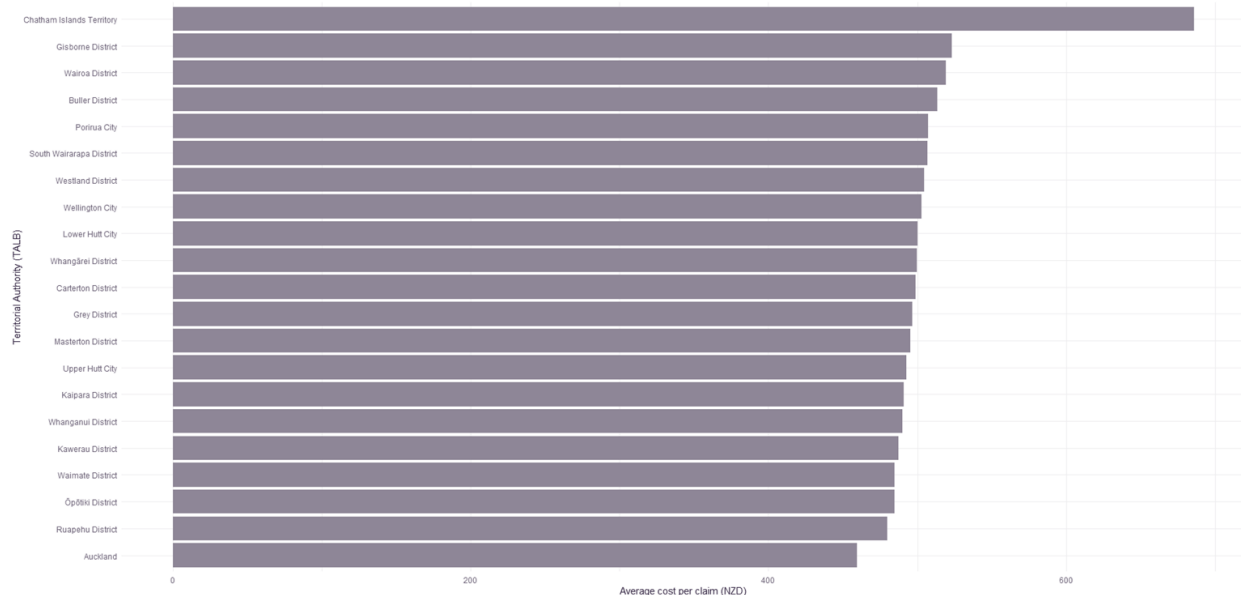


Figure 25 shows audiology claims per 1,000 population are dominated by rural and provincial districts. Gore District has the highest claims per 1,000 population, followed by Thames-Coromandel, Ashburton, Southland, and Hauraki—all areas with significant agricultural, farming, and trades workforces. Notably the major urban centres such as Auckland, Wellington, and Christchurch have significantly low claims per 1,000 population. Auckland has about a sixth of claims per 1,000 population compared to the leading Gore District.

Several factors may contribute to this pattern. Rural populations tend to be older on average, which may increase the prevalence of age-related hearing loss and associated service use. Occupational noise exposure may also be higher in rural industries such as farming and agriculture while rural providers of audiology service may service wider geographic catchments beyond their immediate populations. In addition, small population sizes in some rural districts can produce more variable rates, making comparisons with large urban centres more sensitive to small changes in claim numbers.

Figure 25: Accepted claim per 1,000 population of TA/LB, including leading 20 TA/LB and Auckland

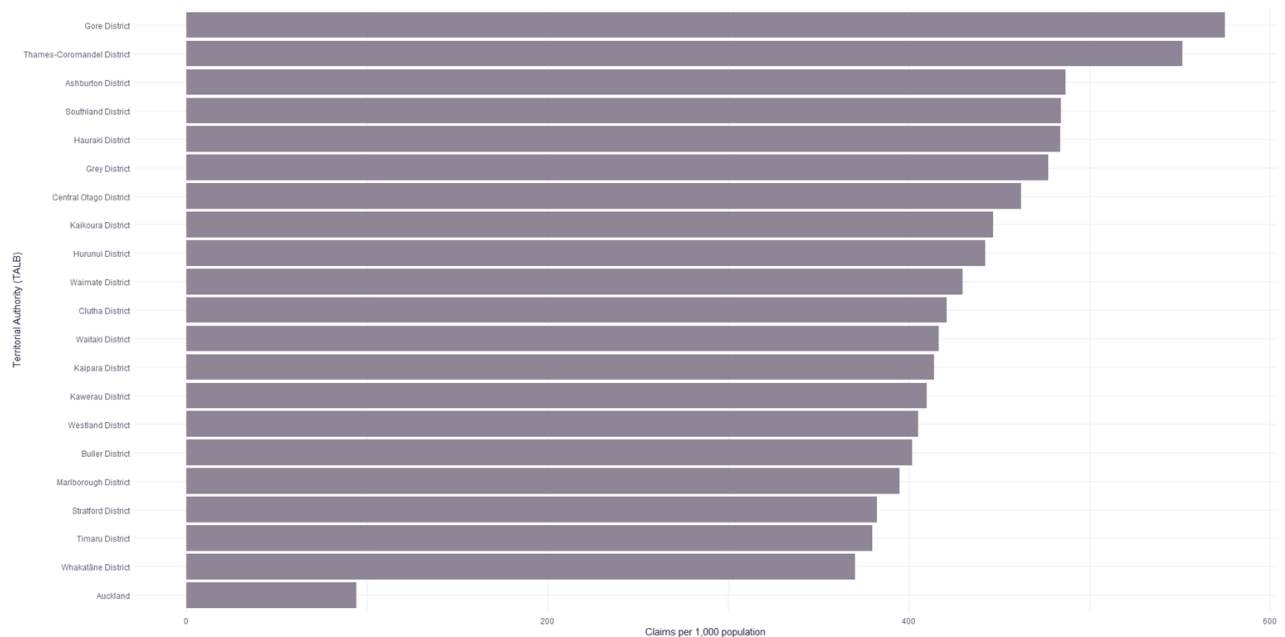
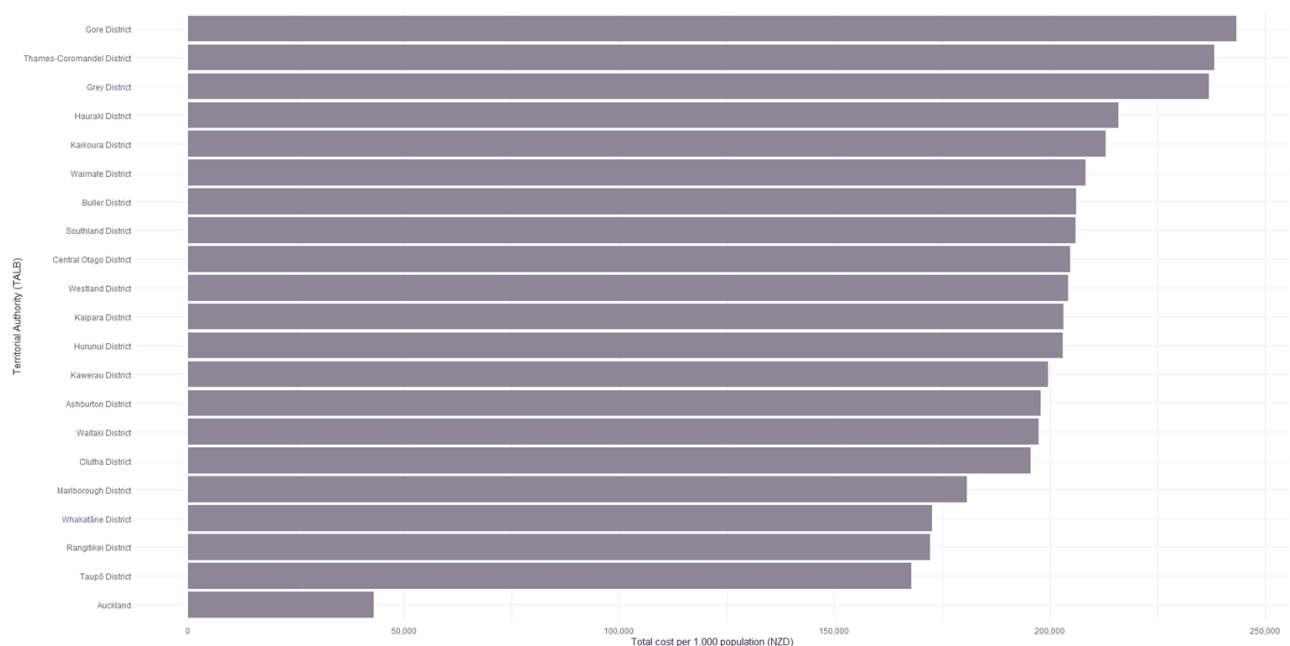


Figure 26 illustrates the cost of claims per 1,000 population which is consistent with the claims per 1,000 population shown above, with a very similar set of districts appearing across both rankings. Gore District again has the highest costs per 1,000 population, followed by Thames-Coromandel District and Grey District, so these areas generate more claims and have higher costs relative to their population. In comparison, Auckland has less than 20 per cent of cost of claims per 1,000 population compared to Gore District. Taken together, these charts suggest that rural districts tend to have more audiology claims and higher average (and total) audiology cost relative to their population size.

Figure 26: Total cost of accepted claims per 1,000 population of TA/LB including leading 20 TA/LB and Auckland



Analysis of sample claims details

As noted above, this section looks into the total costs, range of hearing aids and apportionment of funding between providers when looking at a sample of data provided by ACC where this additional information was compiled. We note that this data included a number of entries where the information examined was not available and therefore, we focus on where insights are able to be drawn. We note that in several instances information was not reported to ACC despite being information that ACC seeks.

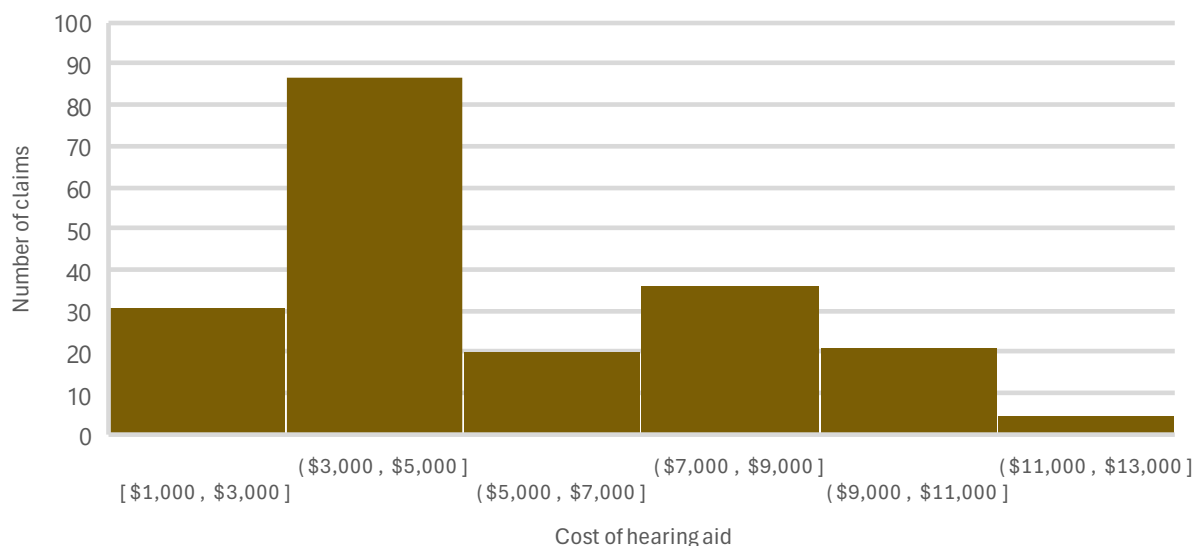
Hearing aid costs

Figure 27 shows the distribution of hearing aid costs, inclusive of GST. As noted above, this information was often not provided. Where total costs were reported as less than the identified contributions to hearing aids from ACC and DSS (noted as MOH as this had been from the Ministry of Health previously), we have used the sum of these figures as the expected total cost. Where the amount was reported as zero, we have excluded these results as this could either mean that there was no co-payment or it appears likely that in many cases, the information was not available.

With this context, looking at Figure 27, the distribution of hearing aid costs is right-skewed, with most claims are concentrated in the lower to mid-price ranges. In total, we analyse 205 claims where total costs are available or partially available.

The most common cost band is \$2,786 to \$4,386, accounting for 70 claims, followed by the \$4,386 to \$5,986 band with 48 claims. Together these two bands represent the bulk of recorded hearing aid costs. The lowest cost band of \$1,186 to \$2,786 accounts for 23 claims, suggesting a smaller proportion of lower-cost devices being prescribed.

Figure 27: Distribution of costs of hearing aid(s) inclusive GST, as recorded by ACC

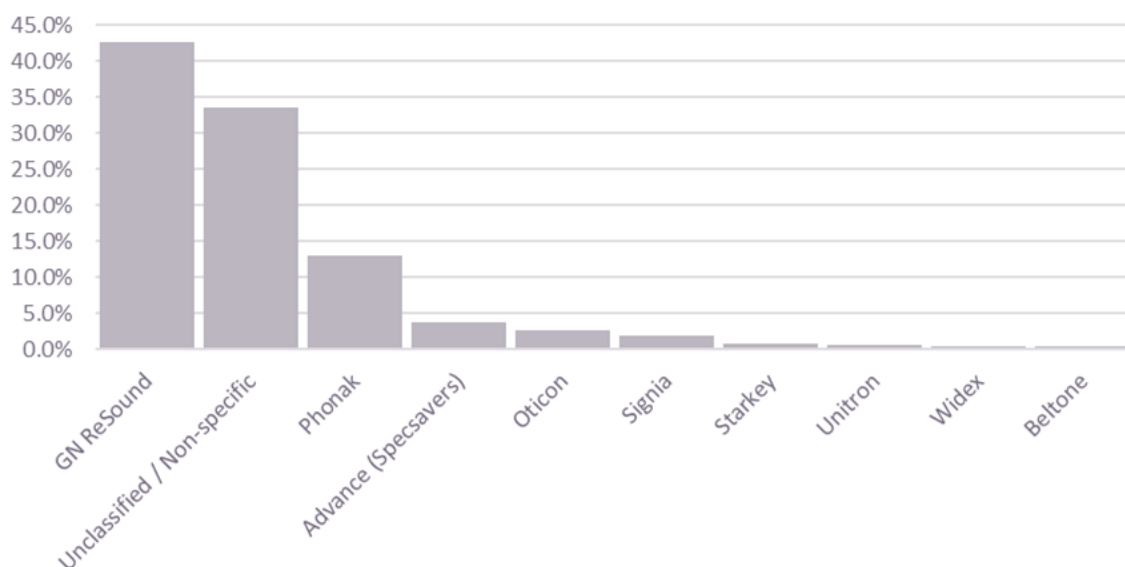


Hearing aid brands

As shown in Figure 28, of the 489 claims with hearing aid model data, GN ReSound is the dominant manufacturer, accounting for 209 entries (42.7 per cent), driven largely by the Ampli product range. Phonak is the second most recorded manufacturer at 64 entries (13.1 per cent), followed by Advance (Specsavers) at 18 (3.7 per cent), Oticon at 13 (2.7 per cent), and Signia at 10 (2.0 per cent). Starkey, Unitron, Widex, and Beltone each account for fewer than five entries.

A notable proportion of entries, 33.5 per cent which account to 164 claims, could not be attributed to a specific manufacturer as they contained non-specific descriptions such as "Binaural", "BTE", or "not mentioned" rather than identifiable model information.

Figure 28: Proportion of hearing aid by recorded manufacturers



Cost allocation across funders

For this claims sample, we see that of the public funders, ACC contributed just over 70 per cent of the funding for the hearing aids themselves (and 100 per cent: of the fitting fee), while DSS (labelled MoH) funded almost 30 per cent. This reflects different eligibility and coverage across the providers. Taken together with the hearing aid costs above, we see client contributions will also range from nothing through to several thousand dollars.

Additional claims data charts

Figure 29: Proportion of service items by calendar year – accepted claims only

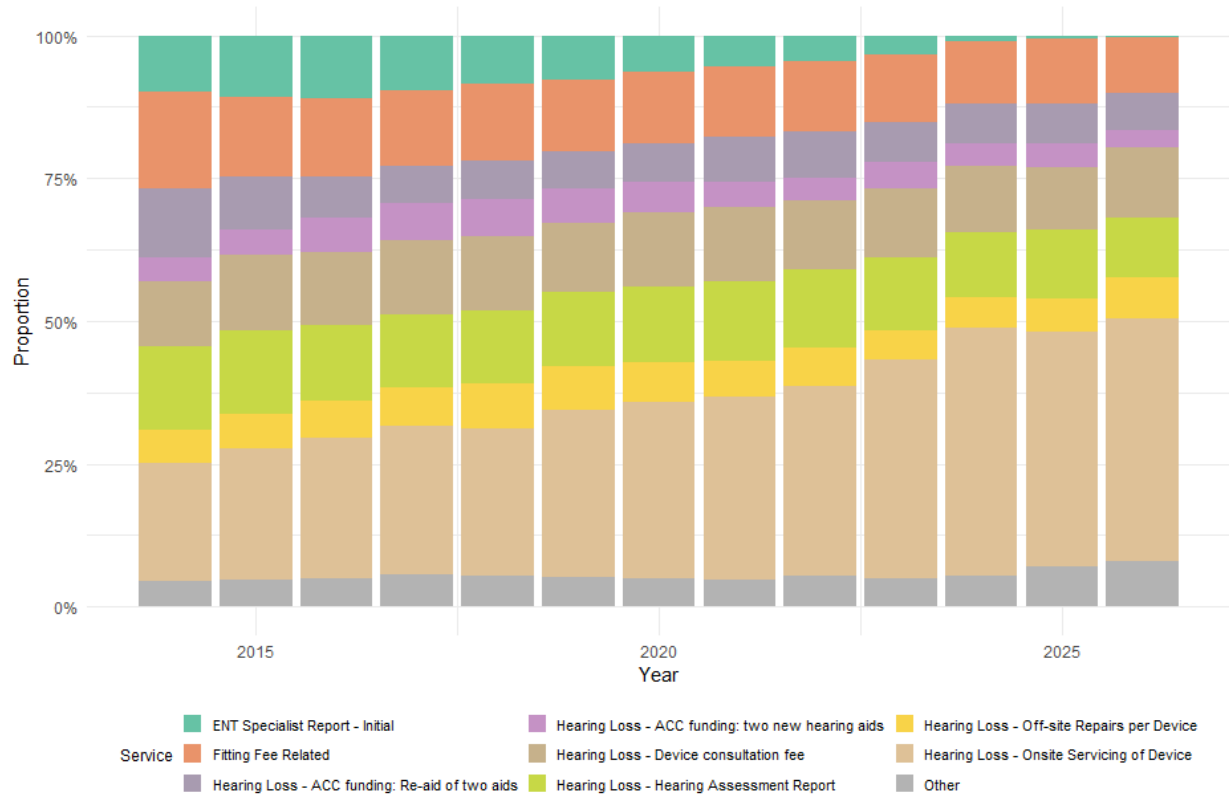


Figure 30: Proportional service cost distribution by calendar year - accepted claims only

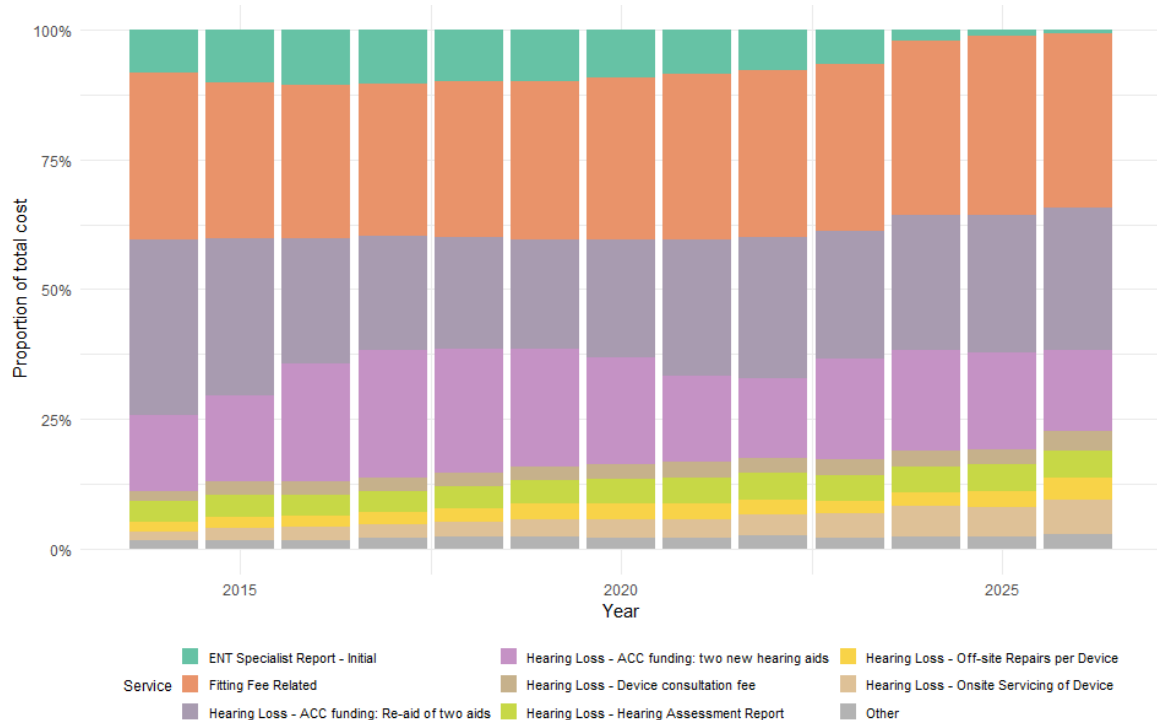


Figure 31: Frequency of accepted distinct claims caused by treatment injury and associated costs over 2014 – 2026 (current)

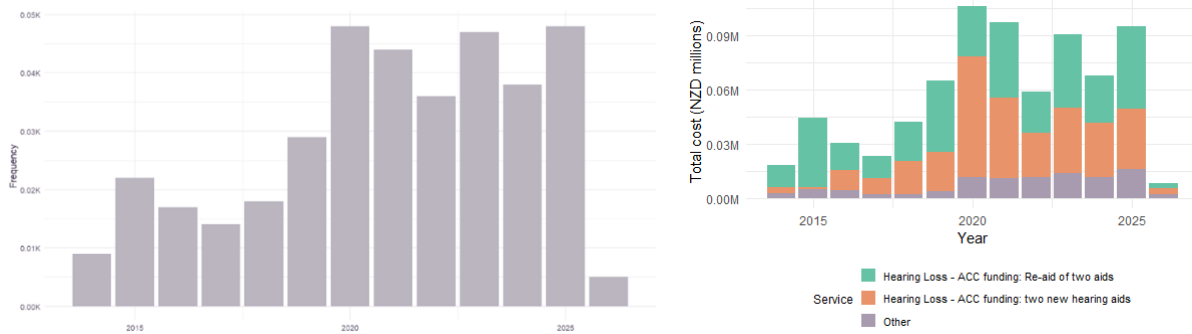


Figure 32: Frequency of accepted distinct claims caused by traumatic injury and associated costs over 2014 – 2026 (current)

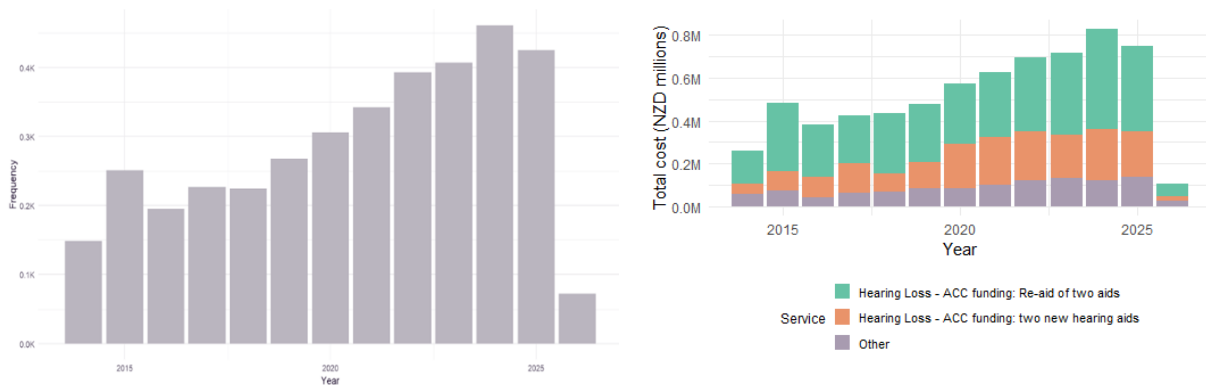


Figure 33: Frequency of accepted distinct claims caused by ONIHL and associated costs over 2014 – 2026 (current)

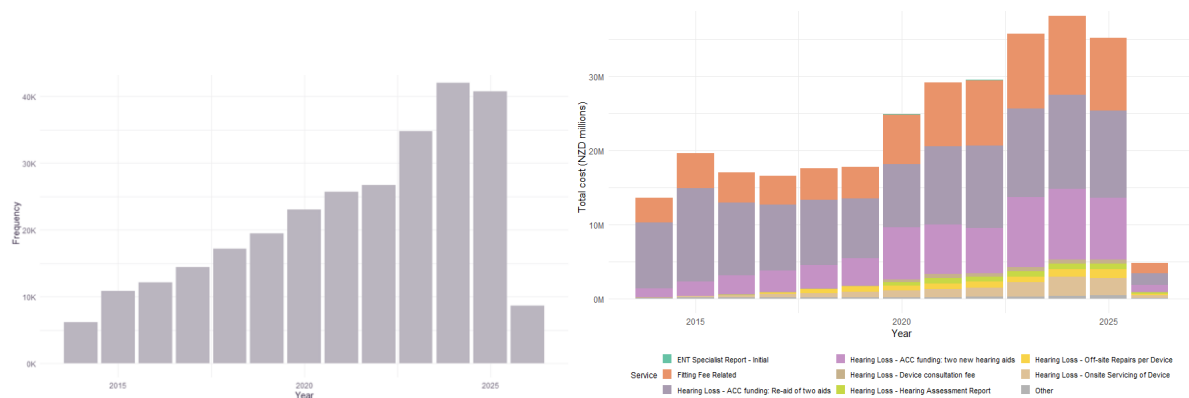


Figure 34: Average cost per service item by calendar year – accepted claims only

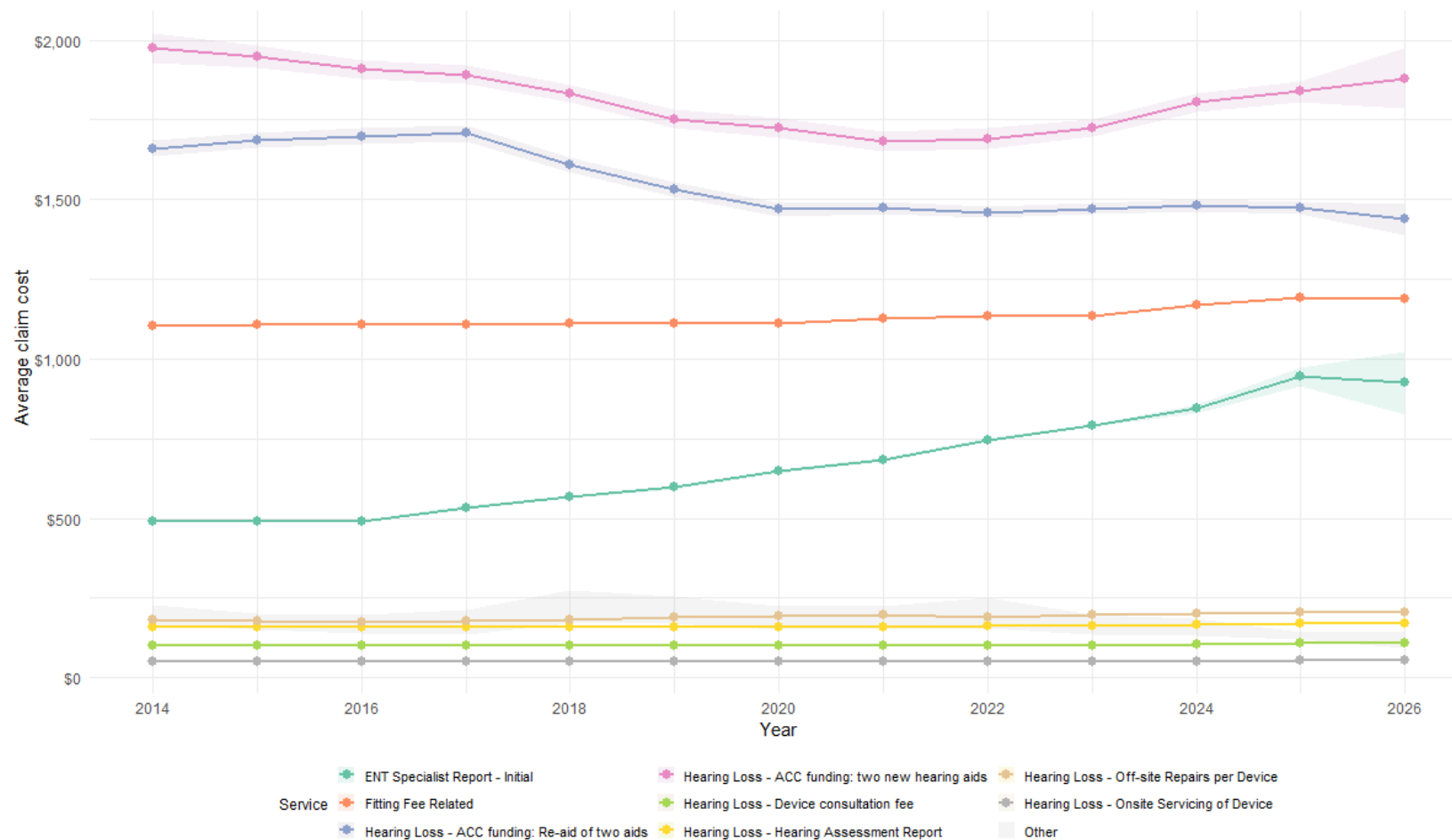
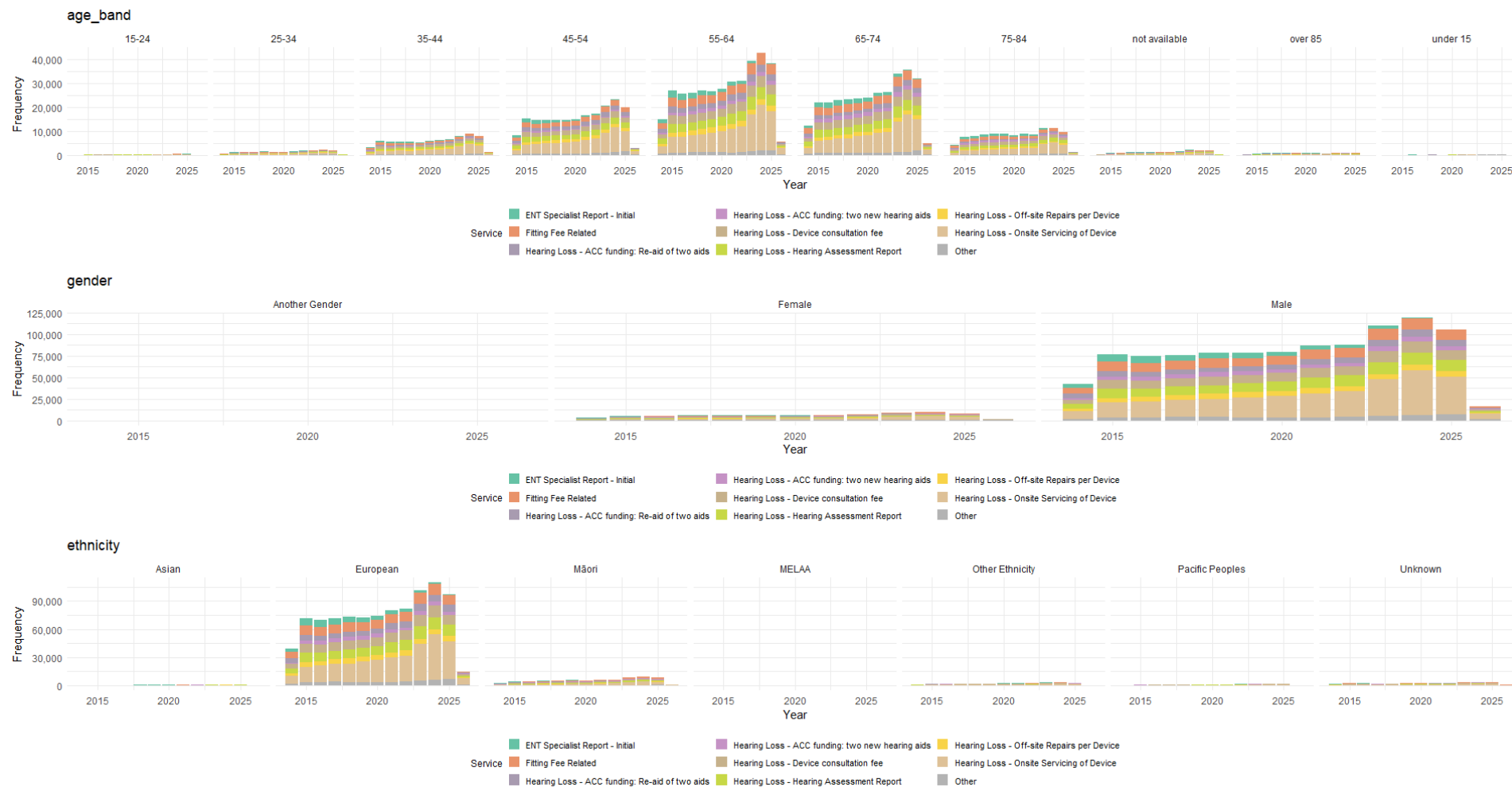


Figure 35: Accepted claims by proportion of service types split by age band, gender, and ethnicity over past 10 years.



Figure 36: Accepted claims by frequency of service types split by age band, gender, and ethnicity over past 10 years.



Appendix G New Zealand public funding providers

ACC fee schedule

The ACC contribution levels are defined in the Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010 (ACC, 2025).

Table 19: ACC and Whaikaha device contribution by band

Band	Apportionment	Fitting fee	ACC device contribution (\$ excl GST)	Whaikaha device contribution (\$ excl GST)	Total (\$ excl GST)
Monoaural					
101	<30%	873.45	480.40	355.00	1708.85
102	30-59%	873.45	960.79	222.00	2056.24
103	60-99%	873.45	1601.67	66.50	2541.62
104	100%	873.45	1668.17	0.00	2541.62
Biaural					
101	<30%	1198.85	960.80	710.00	2869.65
102	30-59%	1198.85	1921.58	444.00	3564.43
103	60-99%	1198.85	3203.34	133.00	4535.19
104	100%	1198.85	3336.34	0.00	4535.19

Veterans' Affairs fee schedule

A schedule of fees for Veterans' Affairs funding is based on recent purchasing history and reflects the standard hearing aid needs for the majority of veterans. The schedule accommodates the provision of suitable, cost-effective hearing aids for 90 per cent of veterans (Veterans' Affairs, 2023).

Table 20: Veterans' Affairs approved maximum fee schedule

Hearing aid set up	Approved maximum (incl. GST)
Initial hearing assessment including full need assessment	\$322
Hearing Aids: suitable for the veteran's hearing loss based on wholesale cost from the manufacturer (max of 2 aids)	\$2415 per aid Manufacturer's wholesale list price
Fitting fee	\$1403 (or \$920 for single aid)

Hearing aid set up	Approved maximum (incl. GST)
Consumables relating to fitting — moulds and impressions: Solid moulds.	Up to \$322 retail price
Consumables relating to fitting — moulds and impressions: Encased receiver moulds.	Up to \$506 retail price
Contribution to a battery charger where required	\$575 retail price
Contribution to an electronic drying machine where necessary	\$230 retail price
Failed fitting fee	\$862.50 (instead of fitting fee)
Total 'up to' amount	\$7,866

Appendix H Summary of NZAS survey responses

Audiology market review

Survey analysis summary

May 2026



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1. Context and limitations

We worked with NZAS (and consulted ACC) in developing the survey to cover off questions we were each interested in asking NZAS members. NZAS then distributed the survey to its members providing them with a SurveyMonkey link and the option to complete the survey (within a period of under 2 weeks).

We agreed with NZAS that/to acknowledge that:

- Ensuring confidentiality and anonymity was paramount and as such if there has been a chance in any of the responses that someone may be able to be identified from the contents of the response, information has been redacted to avoid this. Where appropriate we have also grouped responses to maintain anonymity.
- The survey does not encompass the wider range of audiology services, including diagnostic audiology, paediatric audiology, cochlear implant programmes, tinnitus and hyperacusis management, auditory processing assessment, and vestibular services.
- Survey results should therefore be interpreted as applying specifically to hearing aid provision and associated ACC-funded services and should not be generalised to the broader audiology profession or sector.
- The respondent group is predominantly made up of employed clinicians (over 70%), which limits the extent to which findings reflect business-level commercial decision-making or organisational strategy.
- Respondents work across diverse organisational settings, including large private chains, small independent practices, public hospital services, sole trader arrangements, and not-for-profit or government-contracted models. These settings differ materially in funding structures, cost bases, levels of clinical autonomy, and client populations.
- NZAS has had the opportunity to review and comment on draft contents in this survey summary for the purposes of ensuring accuracy of, and anonymity in, representation.
- We are purely using the survey data for the purposes of this Market Review and will securely delete the data once our project is completed.

We note not all members were able to respond to the survey. We understand some employers may have asked employees not to respond and potentially responded on behalf of their entities instead, which could introduce a degree of bias. Respondents might not have access to the information needed to answer certain questions with 100 per cent accuracy, so responses should be interpreted as respondents' views. Further response rates vary by question and respondent type meaning the confidence in answers may vary, and differences across stakeholders should be interpreted in this context.

For analysis of open-ended questions, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

2. Respondents

Overall, there were 195 survey responses. We cleaned the data and removed responses where only demographic data was filled out and no other questions were answered.

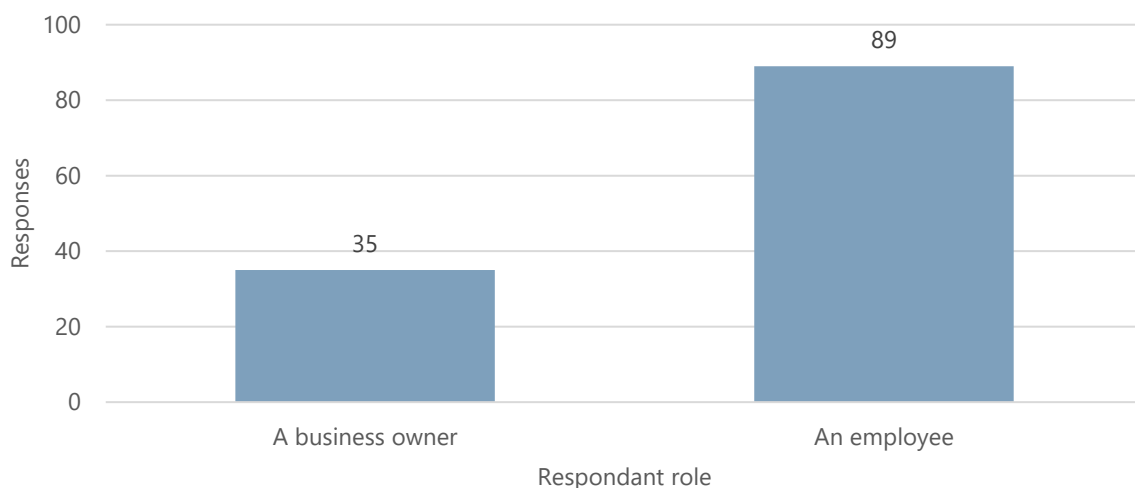
After cleaning the data, our sample size was **125 responses**.

1. Are you (business owner or employee)?

Total responses to Q1 - 124 responses

Respondents were mostly employees (89), with 35 business owners and one respondent who did not indicate which group they belonged to.

Figure 1: Respondent roles



2. In what work do you spend most of your time?

Total responses to Q2 - 124 responses

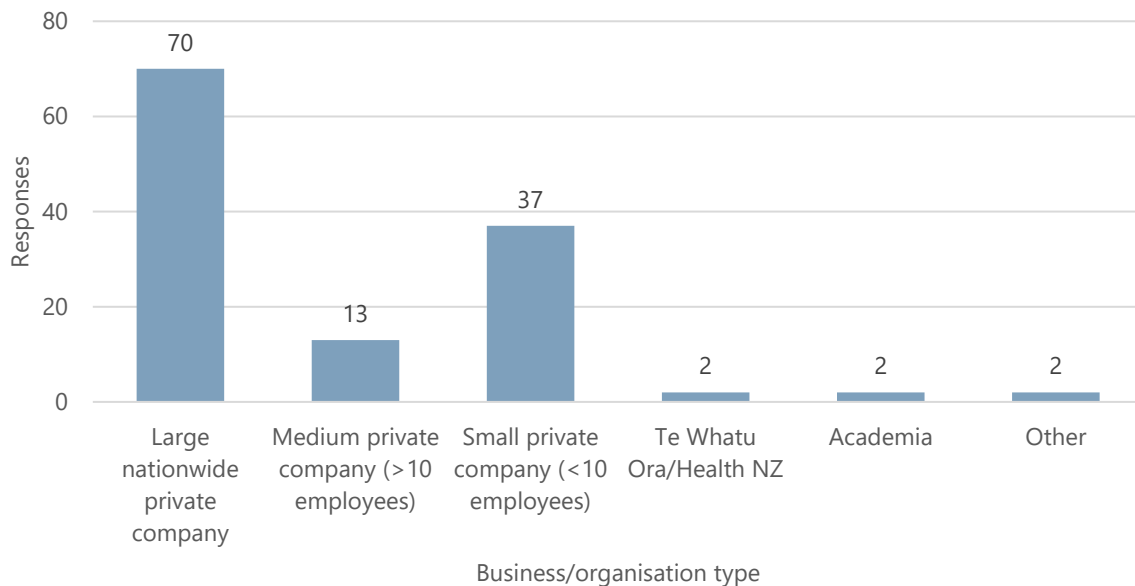
Two respondents indicated affiliations with two categories, so the results indicate 127 recorded responses overall (with those opting for multiple categories being included in the results for each category).¹

The majority of respondents were affiliated with large nationwide private companies (70 respondents). This was followed by small private companies with fewer than 10 employees (37 respondents) and medium-sized private companies with more than 10 employees (13 respondents).

¹ Note that the duplication (one respondent identifying with both a large and median private company, and one identifying as in a small private company and in academia) will appear in any figure broken down by company/work type

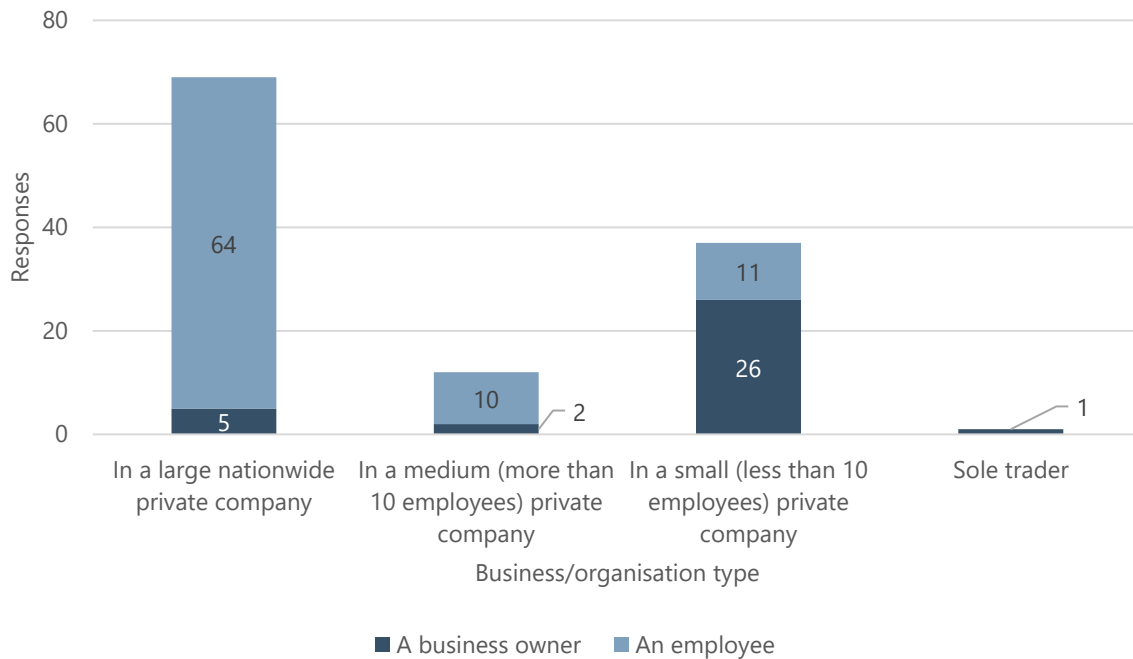
A small number of respondents reported their primary affiliation as Te Whatu Ora - Health New Zealand (2 respondents), academia (2 respondents), or other sectors (2 respondents). Other sectors included sole trade and manufacturing. One respondent chose not to share their affiliation.

Figure 2: Type of work respondents spend most of their time in



The responses indicate that where an employee responded, they were more likely to be working in a larger practice, whereas the responses from smaller practices (less than 10 employees) were likely to be made by the business owner. This is useful information for when reviewing the results as the business owner responses are more likely to reflect the experience of a smaller practice.

Figure 3: Type of work respondents spend most of their time in by role



Note that due to the small sample size of Te Whatu Ora/Health NZ, Academia and Other results often combine the three into a “Grouped other” category or exclude from reporting if answers would otherwise be displayed for two or fewer respondents.

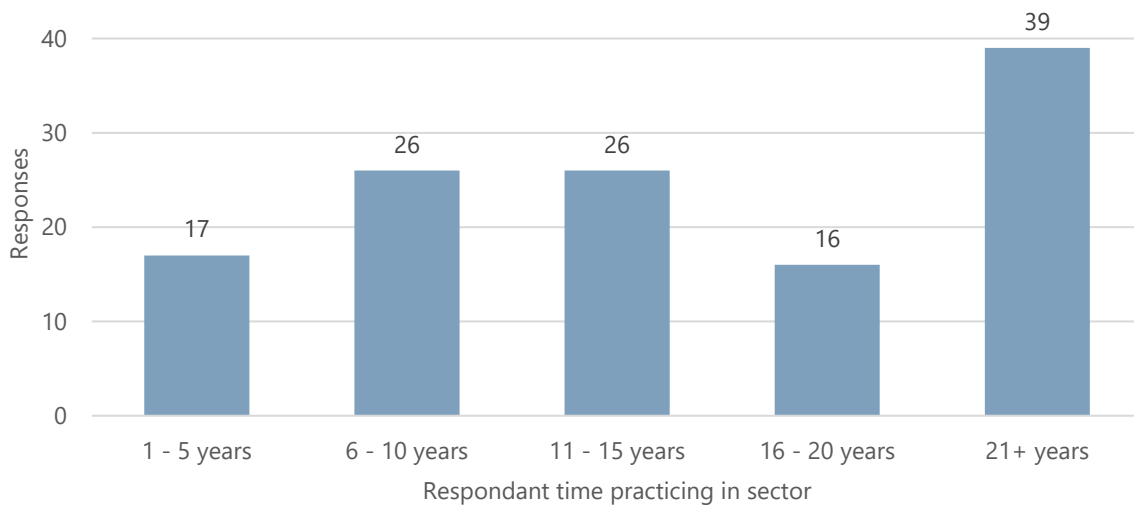
3. How long have you been practicing or working in the sector?

Total responses to Q3 - 124 responses

Respondents were highly experienced overall, with the largest proportion reporting more than 21 years of practice in the sector (39 respondents). Equal numbers of respondents reported 6–10 years and 11–15 years of experience (both 26 respondents).

A further 16 respondents indicated 16–20 years of experience, while 17 respondents reported 1–5 years practising in the sector. One respondent chose not to answer.

Figure 4: Respondents' length of time practising in the sector



4. In what region are you predominantly based?

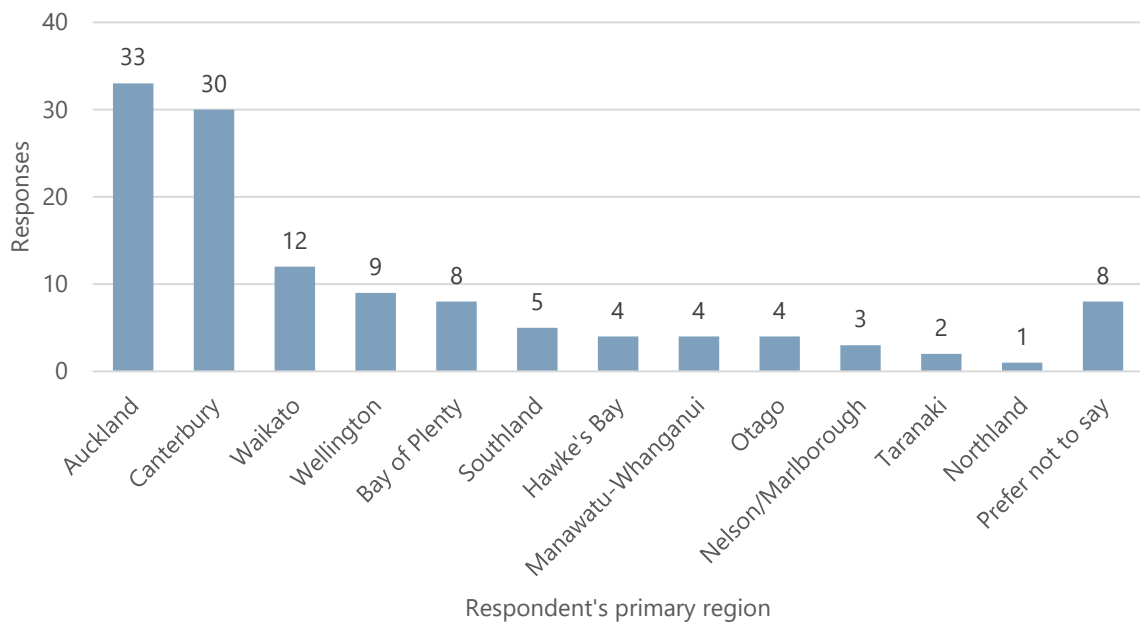
Total responses to Q4 - 123 responses

Respondents were distributed across New Zealand, with the largest proportions located in Auckland (33 respondents) and Canterbury (30 respondents). Other sizeable groups were based in Waikato (12 respondents) and Wellington (9 respondents).

Smaller numbers of respondents reported practising in Bay of Plenty (8), Southland (5), Hawke's Bay (4), Manawatū-Whanganui (4), Otago (4), Nelson/Marlborough (3), Taranaki (2), and Northland (1).

Eight respondents preferred not to say, and two respondents did not answer the question. We acknowledge that some respondents, and many entities they may be affiliated with, might operate across multiple locations. Nonetheless, this is useful in understanding the primary region of respondents themselves. Below we do not regularly report on results by region, but where we do, this caveats that respondents may operate across multiple locations and this purely represents where they are predominantly located.

Figure 5: Respondent's primary region



3. Trends in hearing aid sales

3.1 Trends observed in the past 12-24 months

5. What trends have you observed in hearing aid sales over the past 12-24 months?

Total responses to Q5 - 115 responses

Below we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Tighter budgets (41 responses)

"People wanting cheaper hearing aids (even if they don't meet their needs) and not as many people getting hearing aids."

"more low-cost hearing aid options for patients"

"Reduced uptake of devices, people have less money to spend and are more cautious about spending it. More people are willing to put up with decreased hearing and its consequences and try to put off spending money until hearing loss is really having a big impact on them."

"The hearing aid sales has been really dependent on NZ's economy. The perception of patients buying hearing aids also increases closer to the holiday events."

"Over the past 1-2 years, there has been a clear shift toward greater cost sensitivity, with more clients considering mid and entry level options while still expecting meaningful improvement in real world listening particularly in noise. At the same time, expectations around outcomes have increased, with clients seeking clear benefit during trial periods before committing. Clinically, appropriate matching of technology to individual needs remains critical, as under-fitting can lead to poorer outcomes and increased follow-up costs, whereas well-targeted initial funding supports better long term value through improved performance, satisfaction, and reduced ongoing service needs."

"Worked in a lower socioeconomic region previously and in the last 24 -36 months saw a significant majority of ACC clients choosing to stick with entry level fully funded. Hearing aid upgrades still seemed to be out of reach for most clients."

Lower demand for hearing aids (34 responses)

"I have noticed a slowing down of the market. Very few eligible ACC clients have come through the door"

"It has been declining, or has been very flat."

Increased competition/bigger market power of larger companies (26 responses)

"Greater competition and an increasing range of strategies for winning the business."

"Large companies with large buying power making it harder for smaller private companies to keep competitive."

"The volume and average sales price is down. Large chains are imposing themselves via insurance take over and aggressive marketing and anti-competitive offers."

"Sales have remained stable. I have been fitting various levels of technology, mostly RITE rechargeable. There is a lot of competition with new providers joining the market (Specsavers, Resonate, OPSM)."

"There has been downward pressure for prices in general, with some clinics offering free hearing aids and others low cost rental of hearing aids. The centralization of insurance replacement to one provider has had a detrimental effect on our business."

Focus on sales (13 responses)

"Competitive market, patients shopping around, some dishonest marketing claims, patients choosing more cost effective options due to cost of living crisis"

"Hearing aids for rent where the user ends ownership of their units the moment they can no longer afford the weekly rate. Clinics only promoting a single brand thereby reducing options and the chance to a fair hearing aid trial"

"Companies have become more sales oriented and some of the advertisement [sic] makes me feel that I walked into a shop like Noel Leeming or supermarket with offers. It should be rather like any other medical device otherwise people will think [of] it as only a gadget. It is kind of hard to accept as an Audiologist as it can sometimes makes me feel like a sales person [rather] than an Audiologist."

Improved technology (10 responses)

"I believe the value for money that clients get from lower or mid-level technology has improved. As such, I believe there has been a trend away from high-tech hearing aid sales towards more modest/affordable options."

"Younger client groups coming forwards to get help, more features for the same price point (or less), rechargeable hearing aids and those with full Bluetooth connectivity becoming the default products fitted"

"People have less money to spend. At the other end, some clients are very interested in AI powered HAs."

Increased expectation for audiological support (9 responses)

"Increase in people seeking out small independent clinics as they are disgruntled with the pricing and lack of audiological [sic] care at bigger chains. Once they are sold hearing aids at these bigger chains they only ever see the receptionist and so they appreciate the one on one with an audiologist in an independent clinic."

"More competition and different business models in the market. Big variety in pricing between clinics. More transparency in pricing starting to occur with clinics listing this online. Consumers want more transparency and is [sic] more informed about their options now. They come in knowing what they want rather than it being led by the audiologist at times."

"Clients are more picky about brands and sound quality - wanting to trial more than one brand of device/style of device etc. More discerning overall and willing to pay for a more personalized service, to get products that suit their specific needs."

Higher sales (4 responses)

"They are increasing due to more awareness about hearing health"

Stable sales (3 responses)

"We have remained stable"

3.2 Level of change in the use of different product tiers

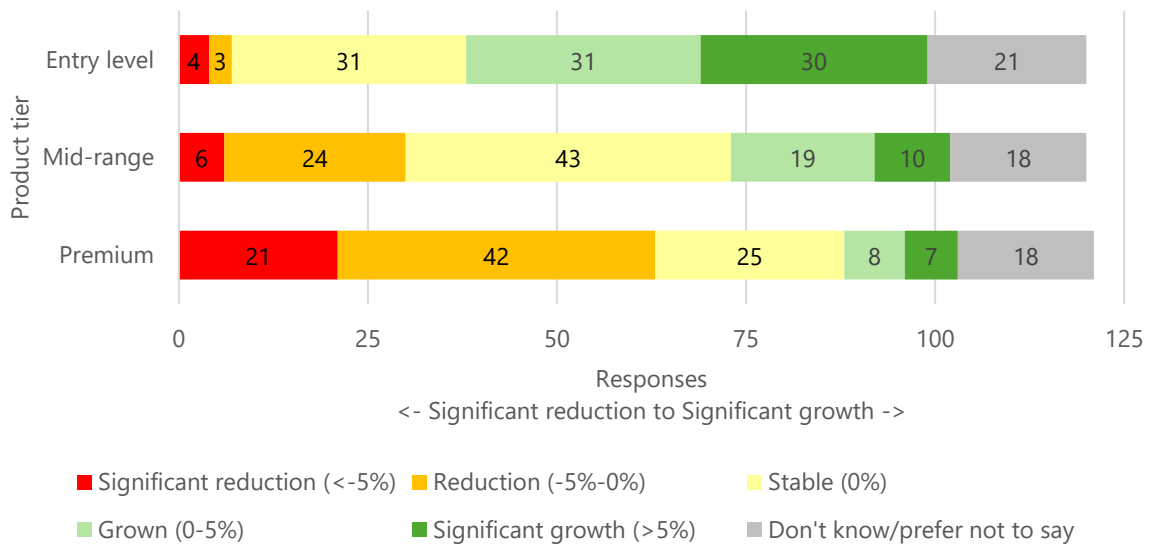
3.2.1 ACC-funded

6. What level of change are you seeing in the use of different product tiers for ACC-funded clients (annual growth over the last 3 years)?

Total responses to Q6 - 122 responses

120 responses were received for both entry-level and mid-range, with 121 respondents for premium. Overall, entry level was indicated to have shown the largest growth, with mid-range the most stable, and premium product tiers having the greatest reduction.

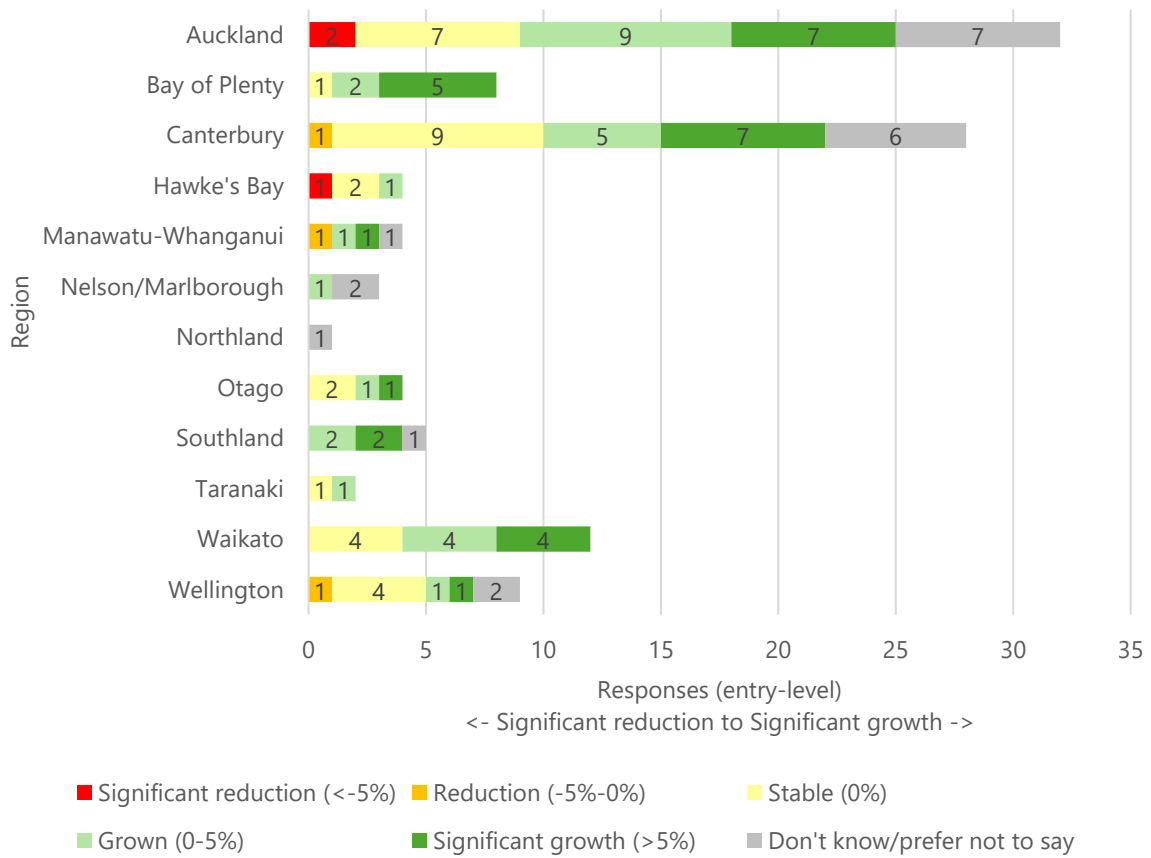
Figure 6: Level of change in different product tiers usage for ACC-funded clients (annual growth over the last 3 years)



Regional breakdown

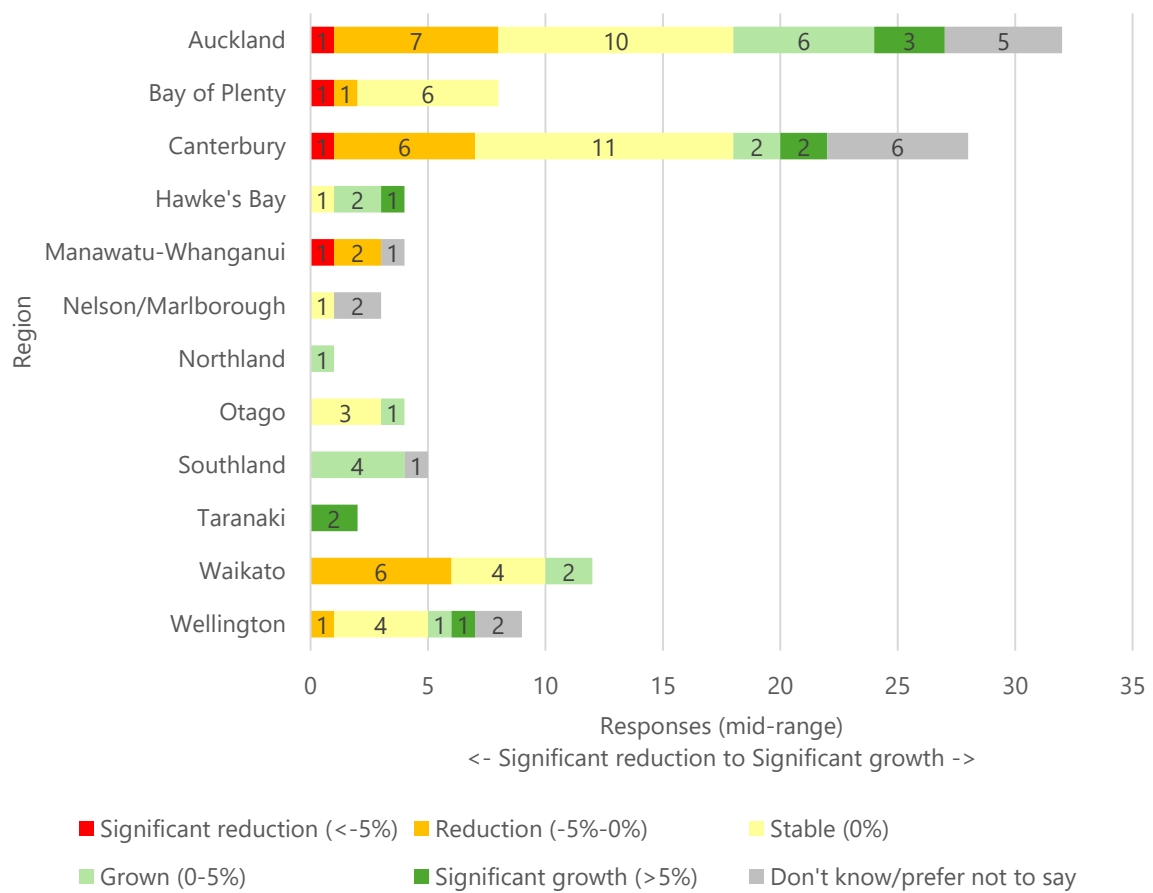
It appears respondents from most regions reported largely similar trends. Respondents report that the entry level product tier is seeing growth or is stable across the board, with few respondents reporting reduction.

Figure 7: Change in entry-level product tier usage by region



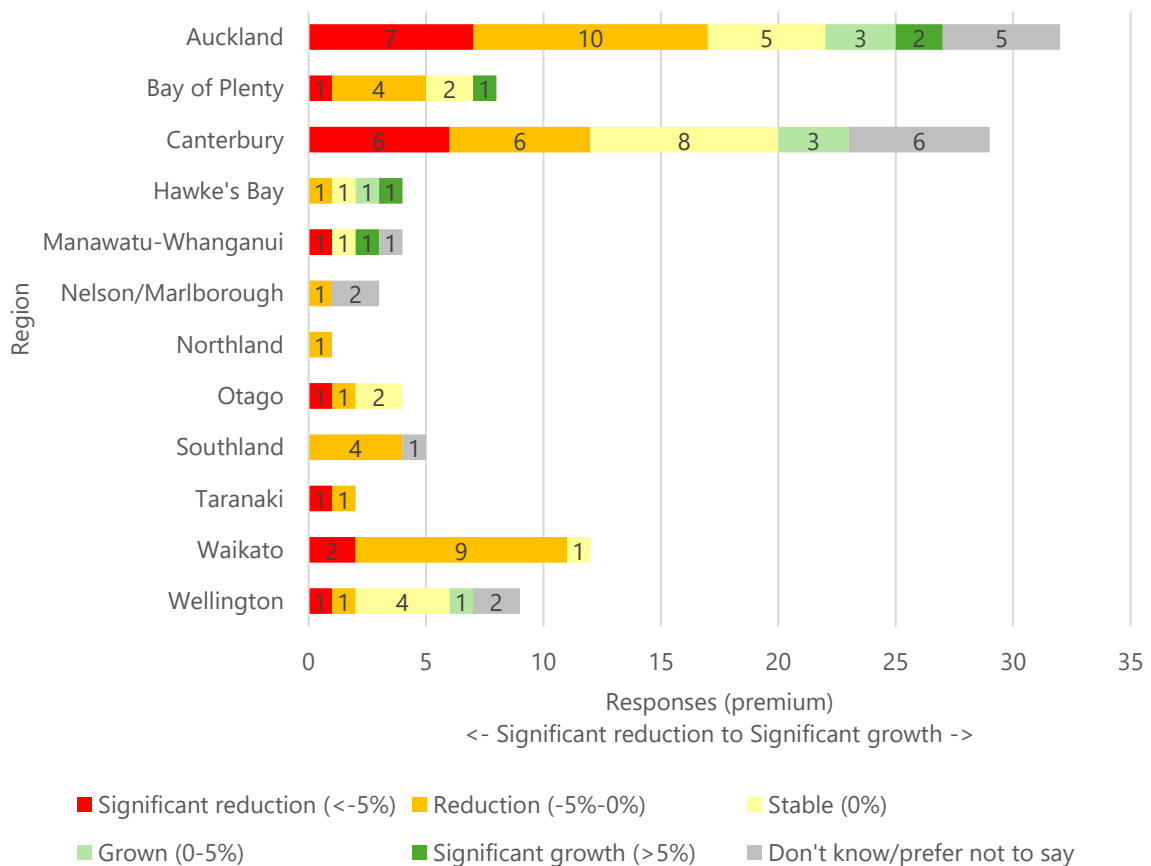
For the mid-range product tier, respondents report mostly stability, with some growth and some reduction. While very small samples (so this should be interpreted with caution and indicatively only), only growth was reported from respondents from Taranaki, Northland, and Southland (and predominantly for Hawke's Bay) while one respondent reported a reduction in Manawatu-Whanganui.

Figure 8: Change in mid-range product tier usage by region



For the premium product tier, respondents seem to report reduction or significant reduction in use, followed by stability, and a small number reporting growth.

Figure 9: Change in premium product tier usage by region

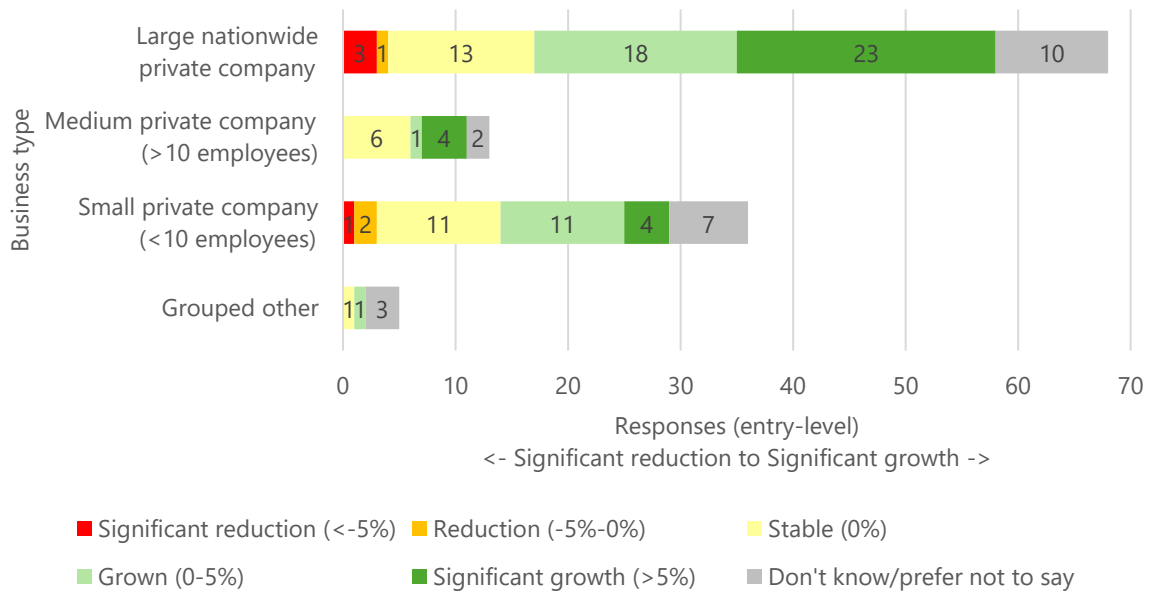


Business type breakdown

Note: Two respondents selected two company types, so are double counted.

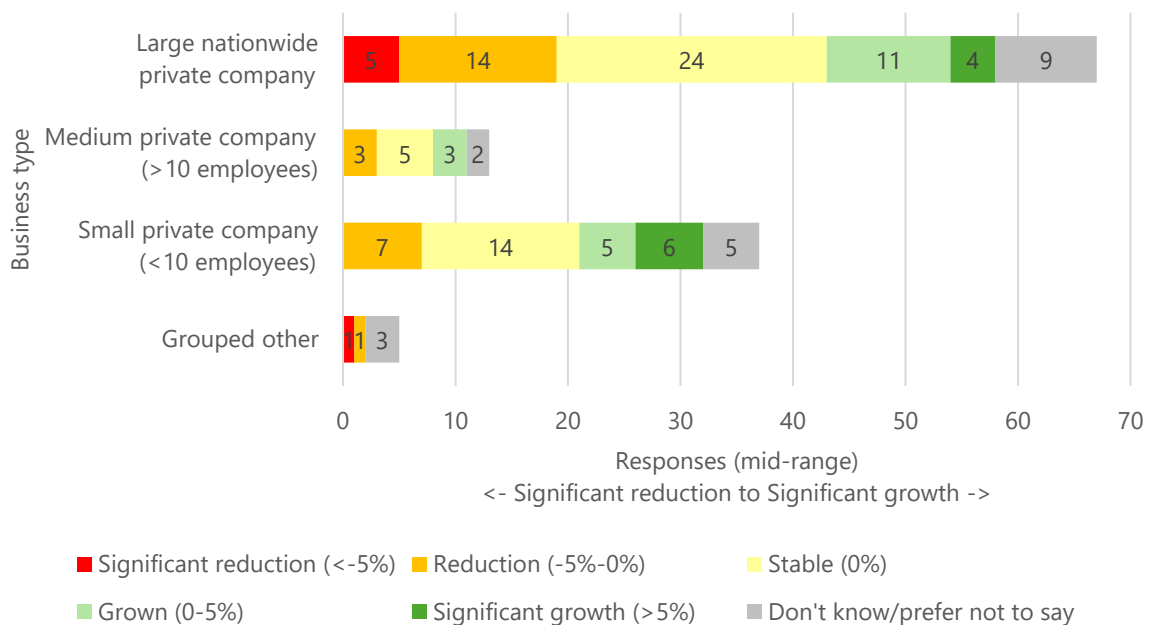
Entry-level devices were most commonly reported as either stable or growing across all private practice settings. Respondents from large nationwide private companies were particularly likely to report growth, with a substantial number indicating moderate (0–5 per cent) or significant (>5 per cent) growth. Respondents from small private companies also frequently reported stability or growth, while very few respondents across any business type reported reductions in entry-level recommendations.

Figure 10: Change in entry-level product tier usage for ACC-funded clients by business type



For mid-range devices, responses suggested a generally stable to slightly declining pattern. Across large and small private companies, the most common responses were stable (0 per cent) or minor reductions (–5 per cent to 0 per cent), although some respondents—particularly in small companies—reported modest growth. Significant growth in mid-range recommendations was relatively uncommon across all business types.

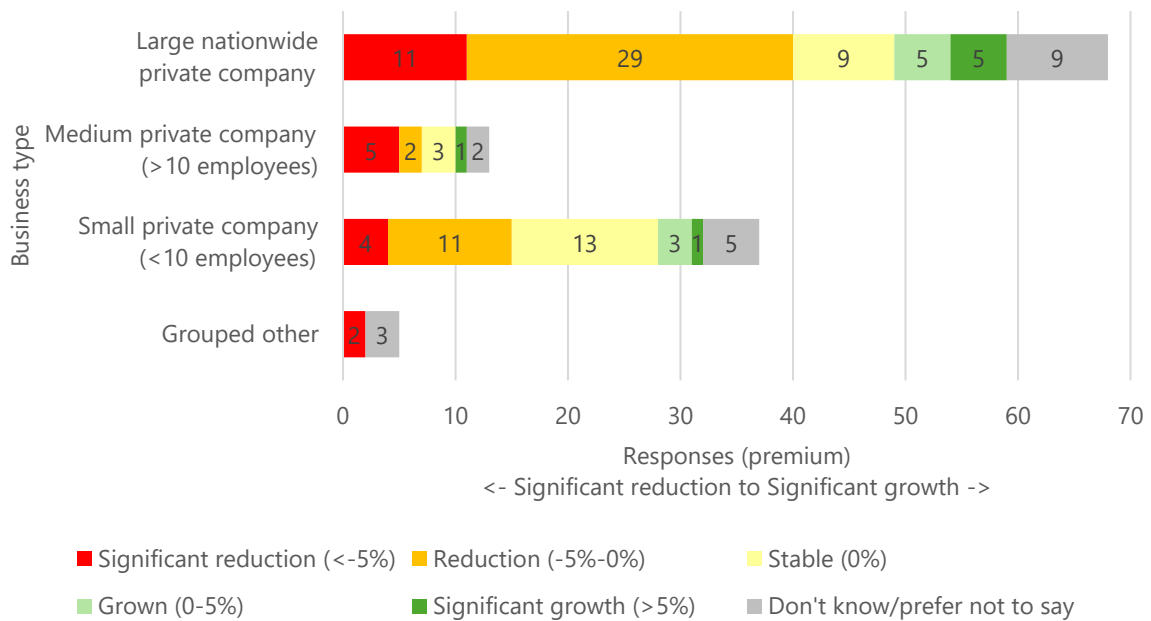
Figure 11: Change in mid-range product tier usage for ACC-funded clients by business type



In contrast, premium device recommendations were more frequently reported as declining, particularly among respondents from large nationwide private companies, where reductions (both minor and significant) were common. Respondents from small private companies showed a more

mixed pattern, with stability being the most frequently selected response, alongside a smaller number reporting growth. Only a limited number of respondents in any business type indicated substantial growth in premium recommendations.

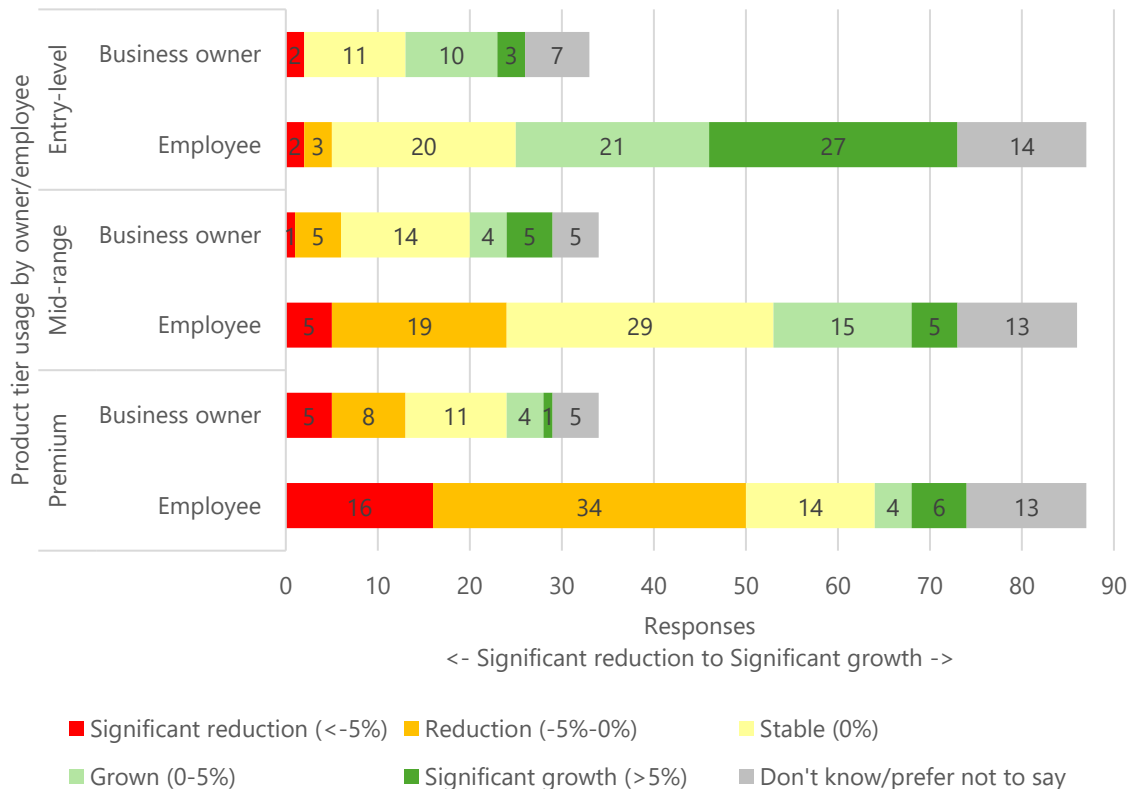
Figure 12: Change in premium product tier usage for ACC-funded clients by business type



Owner/employee breakdown

Overall, responses suggest a shift toward increased use of entry-level products, relative stability or softening demand for mid-range products, and a declining trend in premium product use for ACC-funded clients over the past three years, with these patterns more strongly reported by respondents that were employees than those that were business owners.

Figure 13: Change in product tier usage for ACC funded clients by owner/employee



3.2.2 Non-ACC-funded

7. What level of change are you seeing in the use of different product tiers for non-ACC-funded clients (annual growth over the last 3 years)?

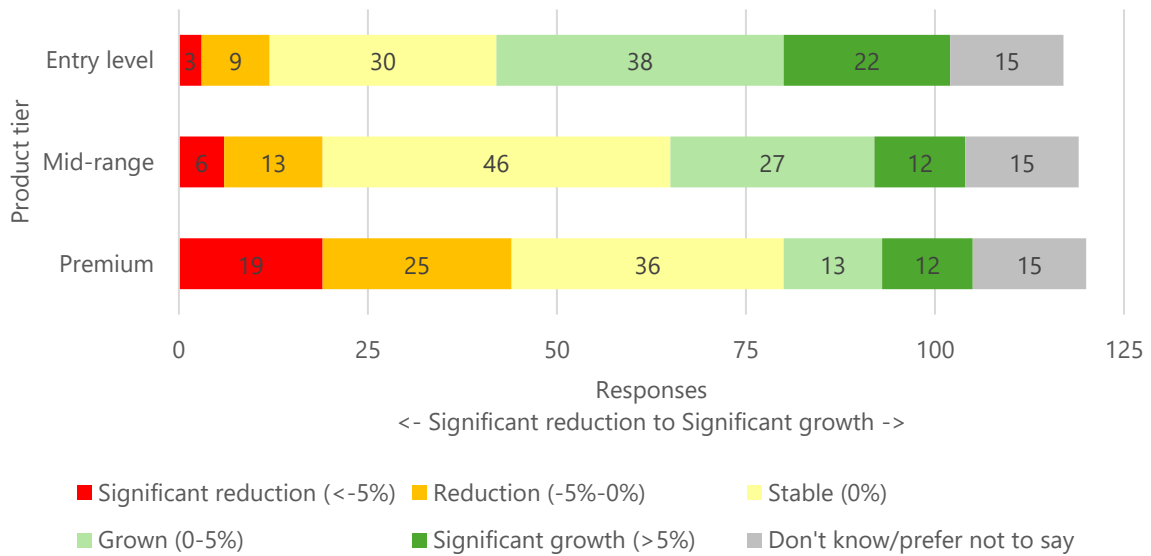
Total responses to Q7 - 121 responses

For entry-level products (n = 117), respondents mostly reported growth, with a combined 60 respondents indicating either moderate growth (0–5 per cent) or significant growth (>5 per cent). A further 30 respondents reported stability, while relatively few (12 respondents) reported reductions. Overall, this indicates an upward trend in entry-level product use among non-ACC-funded clients.

Mid-range products (n = 119) were most frequently described as stable, with 46 respondents reporting no change. Growth (39 respondents) exceeded reductions (19 respondents), suggesting broadly steady demand with some modest expansion over time.

In contrast, premium products (n = 120) showed a more mixed but softer pattern. While 36 respondents reported stable use, 44 respondents indicated reductions compared with 25 reporting growth, suggesting an overall downward or flattening trend for premium products among non-ACC-funded clients.

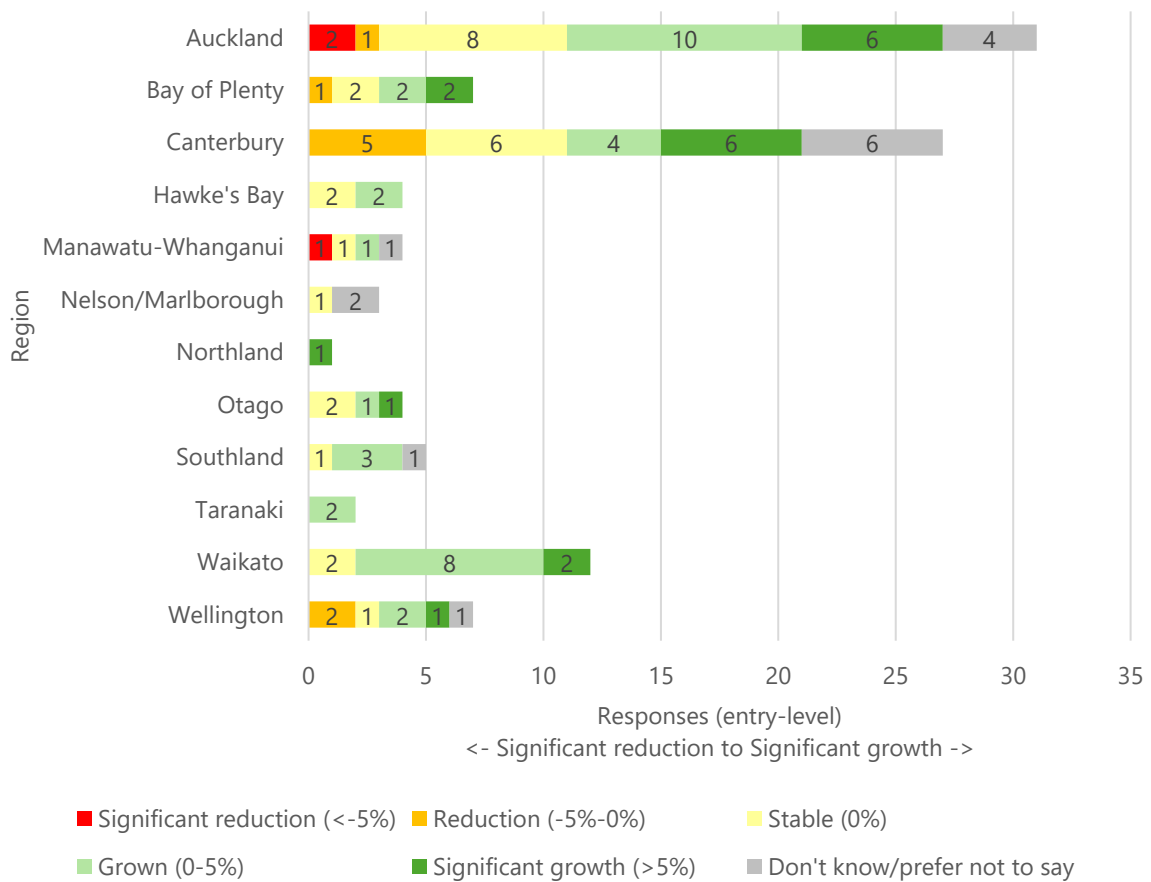
Figure 14: Change in product tier usage for non-ACC funded clients



Regional breakdown

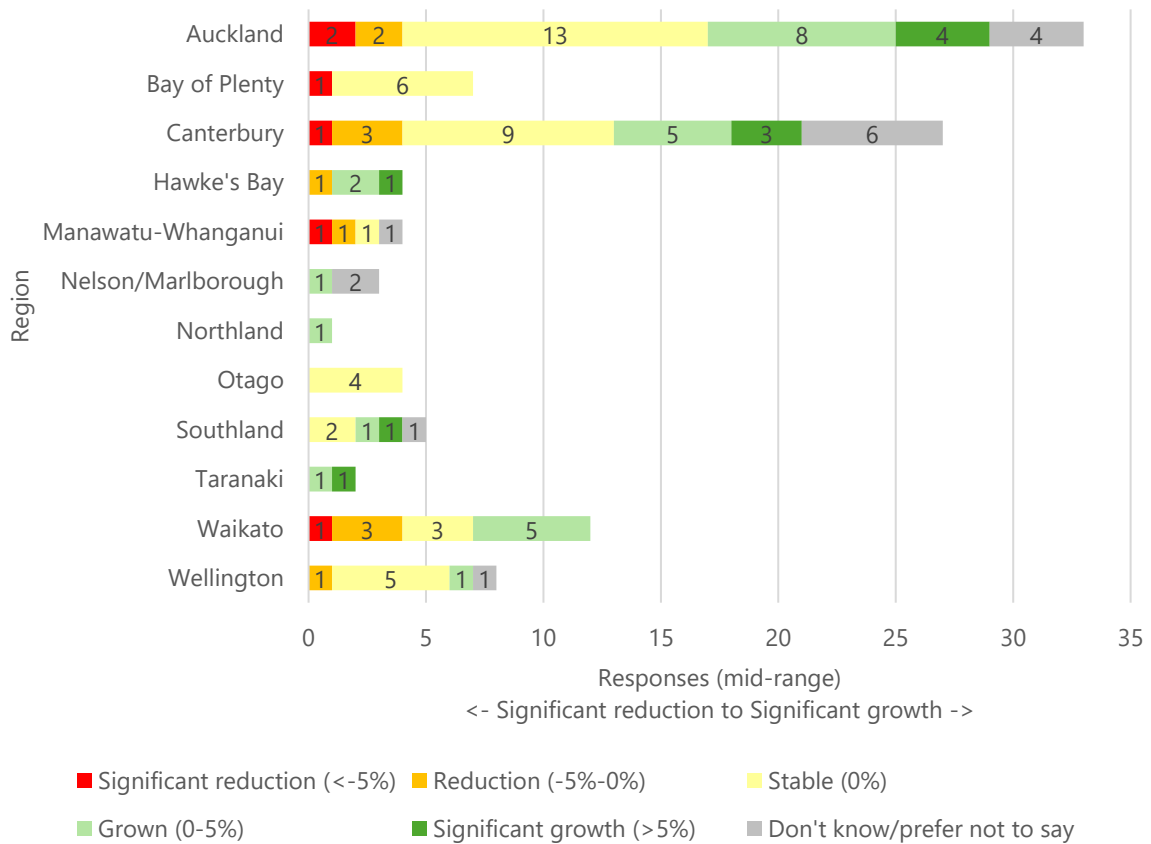
Across regions, entry-level products were reported as having a clear and consistent growth trend. A combined 60 respondents reported either moderate (0–5 per cent) or significant (>5 per cent) growth, compared with 30 reporting stability and only 12 reporting reductions. Growth was most frequently reported by respondents in larger regions such as Auckland, Canterbury, and Waikato, though growth responses were evident across respondents in most regions, indicating a broadly national shift toward increased entry-level use.

Figure 15: Change in entry-level product tier usage for non-ACC funded clients by region



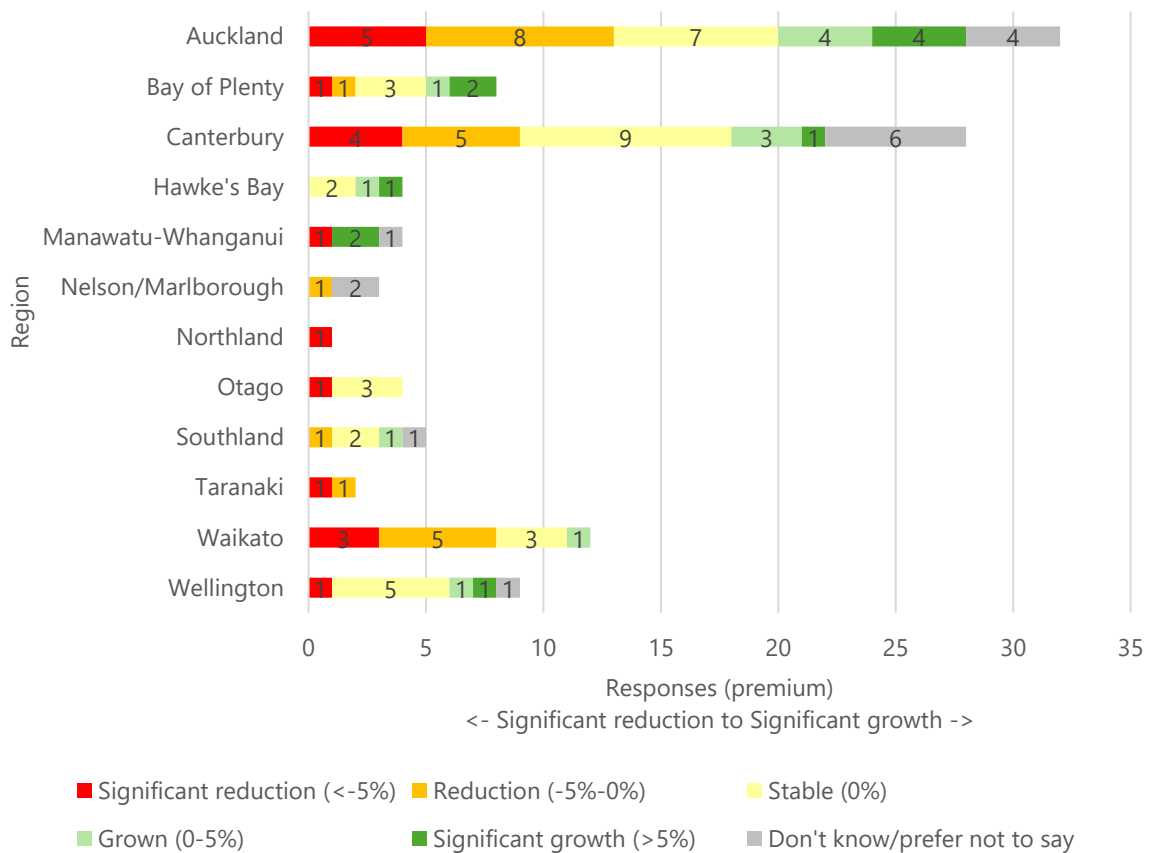
For mid-range products, responses indicated a pattern of overall stability with modest growth. Stability was the most common response (46 respondents) and was widely distributed across respondents' regions, particularly in Auckland and Canterbury. Growth (39 respondents) outweighed reductions (19 respondents), suggesting that while mid-range use is not expanding rapidly, it remains relatively resilient and geographically consistent without strong region-specific divergence.

Figure 16: Change in mid-range product tier usage for non-ACC funded clients by region



In contrast, premium products demonstrated a more pronounced tendency toward decline across respondents' regions as shown in **Error! Reference source not found..** A total of 44 respondents reported reductions (including 19 significant reductions), compared with 25 reporting growth. While stability was still common (36 respondents), declines were most frequently reported in higher-response regions such as Auckland and Canterbury, with respondents from relatively few regions indicating notable growth in premium use.

Figure 17: Change in premium product tier usage for non-ACC funded clients by region



Business type breakdown

Note: Two respondents selected two company types, so are double counted.

The business-type breakdown reinforces a consistent indicated pattern for non-ACC-funded clients: strong growth in entry-level products, relative stability in mid-range products, and a contraction or flattening in premium product use, with these trends reported across respondents from different company sizes and clinic settings rather than being driven by a single organisational model.

Figure 18: Change in entry level product tier usage for non-ACC funded clients by business type

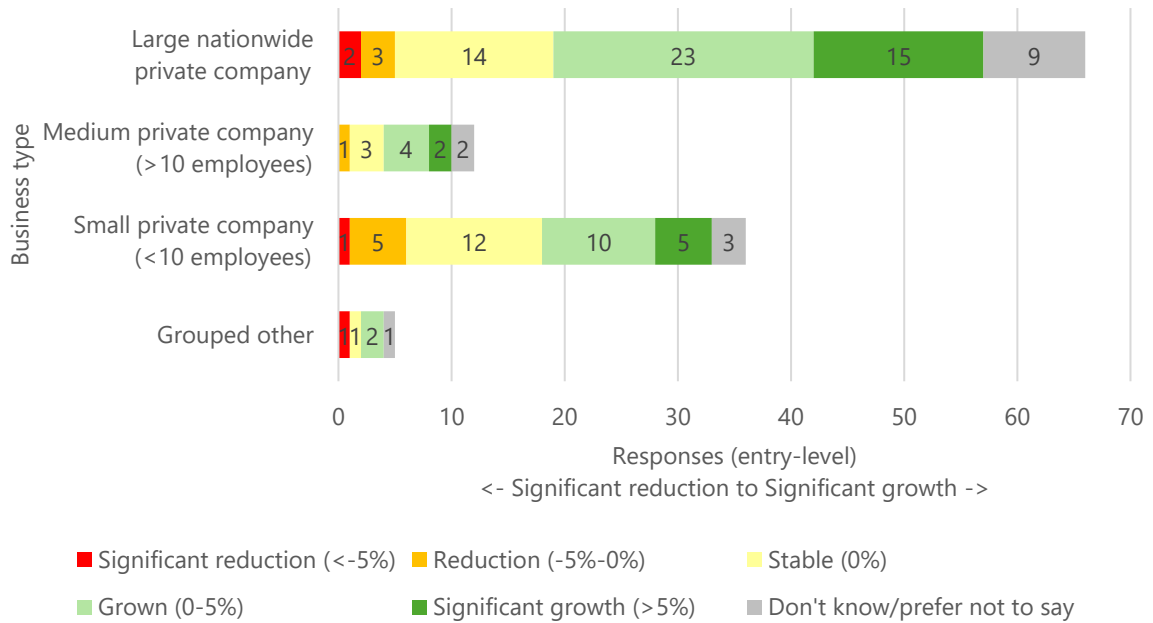


Figure 19: Change in mid-range product tier usage for non-ACC funded clients by business type

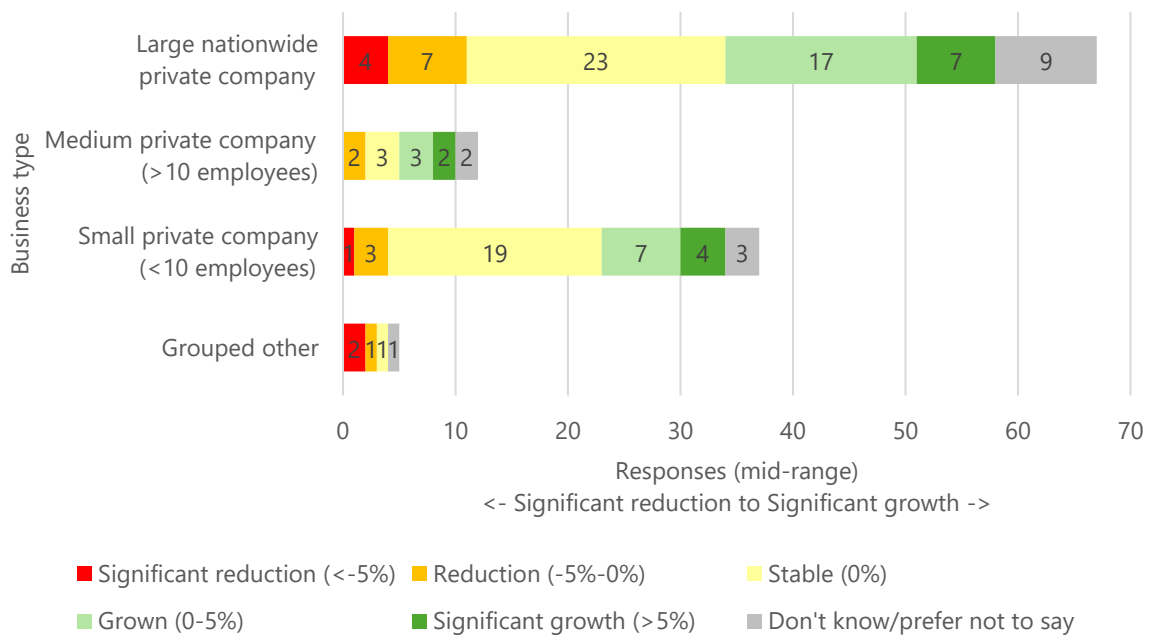
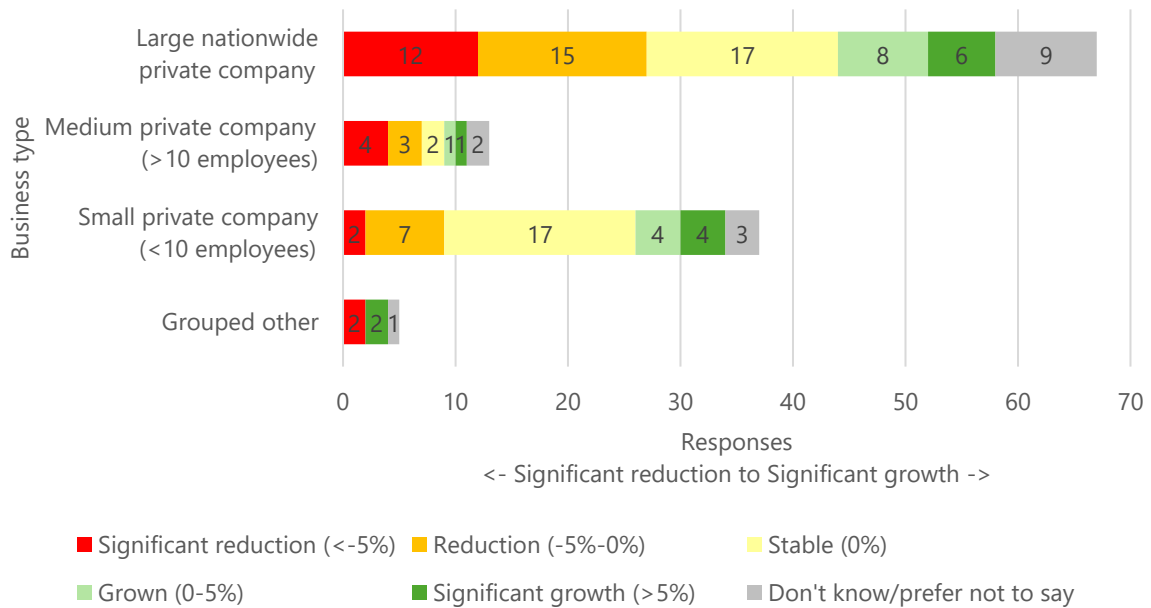


Figure 20: Change in premium product tier usage for non-ACC funded clients by business type



Owner/employee breakdown

Overall, the reporting points to increasing use of entry-level products, relative stability in mid-range products, and a decline in premium product use for non-ACC-funded clients over the past three years. Growth and decline trends were more strongly perceived by respondents that were employees rather than those that were business owners.

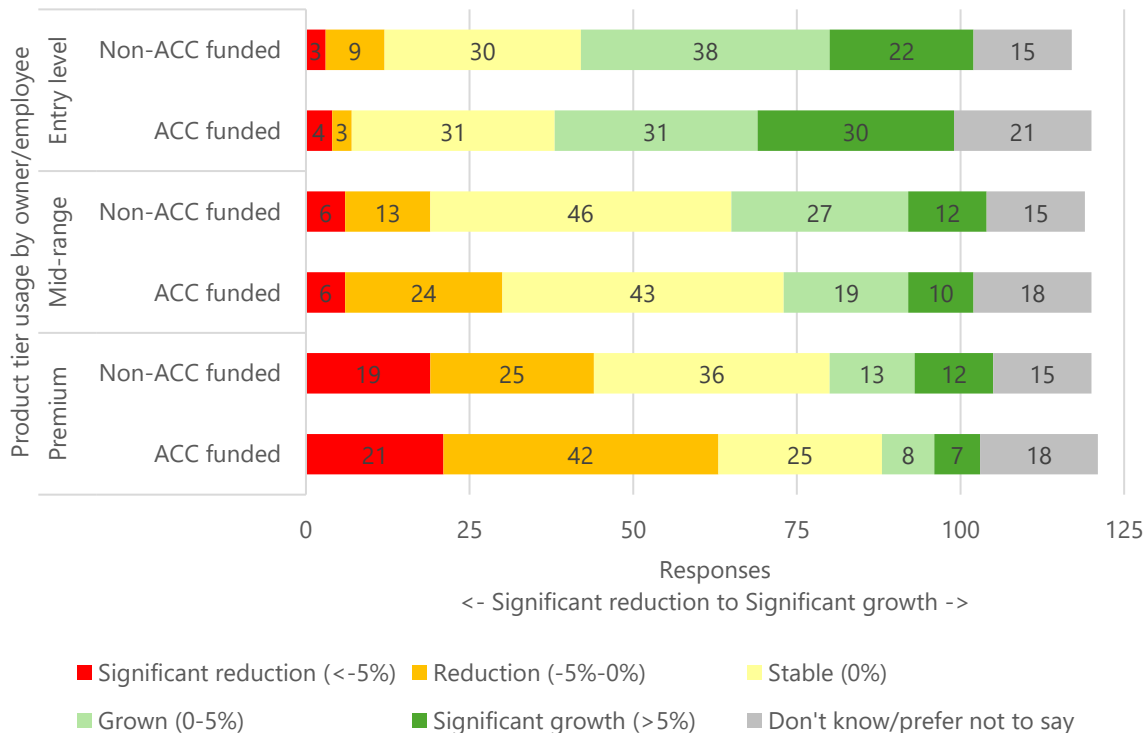
Figure 21: Change in product tier usage for non-ACC covered clients by owner/employee



ACC funded vs non-ACC funded

Whilst broadly product tier usage for both ACC funded and non-ACC funded clients were reported to be similar (growth in entry-level products, stable in mid-range and a slight reduction in premium products), there was reported to be a higher relative reduction in both the premium and mid-range product tiers for ACC-funded clients in comparison to clients not funded by the ACC.

Figure 22: Change in product tier usage for ACC funded clients compared to non-ACC covered clients



3.3 Customer demographics

8. How have customer demographics changed recently (age, referral source, first-time vs. repeat users)?

Total responses to Q8 – 102 responses (+4 N/A responses)

Below we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

More younger clients (30 responses)

"More people in 50-60 age range keen to keep an eye on hearing and possibly do something earlier than previous generations (possibly due to increased marketing, but also seem to see hearing as a health concern and less caught up with stigma)"

"More first time users coming in a[t] a younger age seeking help with hearing loss, tinnitus etc.:"

"we are seeing more clients under 50"

"seeing a lot of younger clients (late 30s, 40s)"

"more younger clients with less hearing loss, having assessments earlier. Re-aid clients are less inclined to replace their aids, citing cost as a major factor."

No change (26 responses)

"No changes noticed over the last 3 years"

"We get a large number of medical referrals - GPs and ENTs, and lots of "work of mouth" referrals. Age of clients is stable. We have a good balance of new versus repeat clients."

"Limited change, the clients in the clinic I service are predominantly older, pakeha clients of a higher socioeconomic status."

"I think the mix of this is similar - obviously we are getting less involvement from GPs given they no longer initiate the ACC45"

More repeat users (15 responses)

"In my demographics, it concentrates more on Pacific Island Nation so I am seeing older age groups around 70's before they manage their hearing losses. In terms of repeat users, Kiwis usually acknowledge their hearing reduction earlier."

"In my clinic I am seeing more repeat users, as we have been open for *[removed to ensure anonymity but slightly over 6 years]* years now and many people replace devices after 6 years. There seem to be more customers being booked in after clicking an ad on social media (referral source). I haven't noticed a significant change in customer age."

Cost conscious (11 responses)

"More low income customers or people not wanting to pay for their hearing aids as much"

"More first time users looking for zero or low cost hearing aid options."

"A lot of people are shopping around"

"Many people in the lower social-economic group are falling through the crack, they can't even get assistance via public sector."

Longer to upgrade (8 responses)

"Repeat users are holding on to their devices longer than the recommended lifespan"

"There are less people replacing hearing aids after 6 years, especially non-ACC funded clients"

"Less repeat users which is affected by purchase power in 2019-2020 due to COVID."

More first-time users (7 responses)

"No change with age over the years, but growth on new users and more referrals from occupational health nurses. Repeat users tend to stay with their current hearing aids and hold off to re-aid"

"Clients are becoming less affected by stigma and are seeking help for hearing disabilities more readily. Many clients are hearing via word of mouth that hearing aids are beneficial."

Fewer first-time users (6 responses)

"Less first time users are buying"

"Less new wearers but more younger wearers coming through."

Fewer ACC approval (5 responses)

"The business I work for seems to be struggling to get first time wearers in and is relying heavily on repeat users. Have seen a large reduction in ACC clients, I would say due to competition in market with other providers offering fully subsidies [sic] aids no matter what band of funding"

"A lot more patients are being declined than they used to for ACC, e.g. especially if they are applying at a later age (e.g. in mid to late 70s or older), the age adjustment for the NAL% almost always excludes them from being given ACC funding. Therefore, a lot I see have been repeat users."

4. Clinician recommendations

4.1 Proportion of clients' clinicians recommend choose different product tiers

9. Recommendations: What proportion of your clients do you recommend choose: entry-level, mid-range and premium devices. Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100.

Total responses to Q9 – 102 responses

102 respondents provided percentage allocations for each device tier (entry-level, mid-range, and premium). Respondents were asked to state a percentage for each product tier totalling 100; responses have been grouped in ranges for analysis.

Table 1: Summary statistics of proportion of clinicians recommending entry-level, mid-range and premium devices

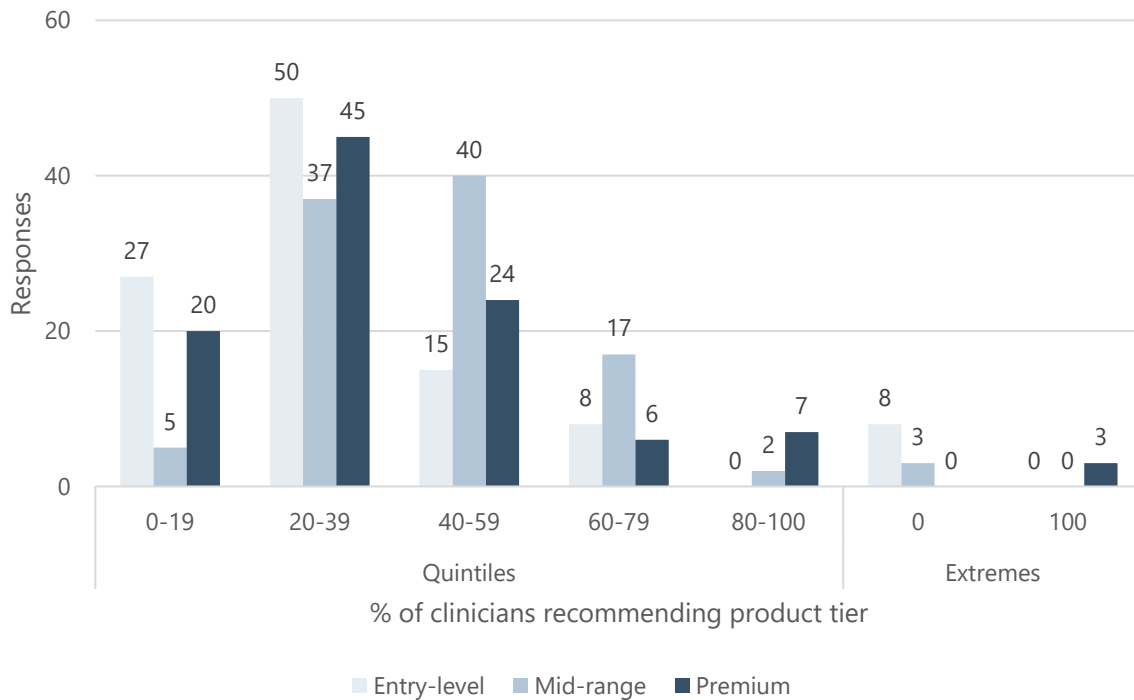
Product tier	Average	Median	Minimum	Maximum
Entry-level	25.4%	20.0%	0%	70%
Mid-range	40.6%	40.0%	0%	80%
Premium	34.0%	30.0%	1%	100%

Entry-level devices were most commonly reported as being recommended for 20–29 per cent of clients (29 respondents), followed by 30–39 per cent (21 respondents) and 10–19 per cent (17 respondents). Fewer respondents recommended entry-level devices for a majority of clients, with only 14 respondents indicating 50 per cent or more, and none reporting recommendations above 80 per cent.

Mid-range devices were typically reported as recommended for a larger share of clients. The most common ranges were 50–59 per cent (24 respondents) and 30–39 per cent (23 respondents), followed by 40–49 per cent (16 respondents). Very low (<10 per cent) or very high (≥80 per cent) recommendations of mid-range devices were uncommonly reported.

Premium devices showed a broader distribution. The most frequently reported recommendation ranges were 30–39 per cent (24 respondents) and 20–29 per cent (21 respondents). Notably, a subset of respondents indicated a strong preference for premium devices, with 7 respondents reporting recommendations of 80 per cent or more, including 3 respondents who recommended premium devices for 100 per cent of clients. It should be noted that there is at least one company that focuses its offering on a premium device only, so it is possible that this could account for those recommending premium devices 100 per cent of the time.

Figure 23: Proportion of clinicians recommending entry-level, mid-range and premium product tiers (%)



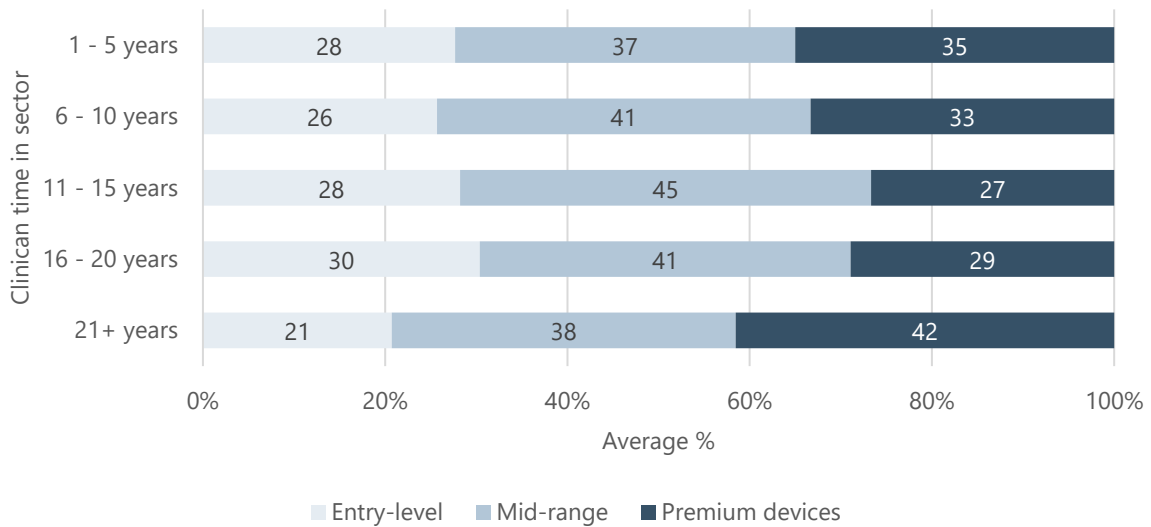
Breakdown by length of time in sector

Note: averages have been used for the chart below.

Results were mostly consistent across length of time in sector:

- For respondents in all cohorts from 1-5 years to 16-20 years, with slight variation, recommendations are mostly reported as being consistent with one another.
- Respondents with 21+ years of experience, compared to the other cohorts, were reported as more likely to recommend a premium device and less likely to recommend an entry-level device.

Figure 24: Proportion of clinicians recommending product tiers by length of time in sector (average %)



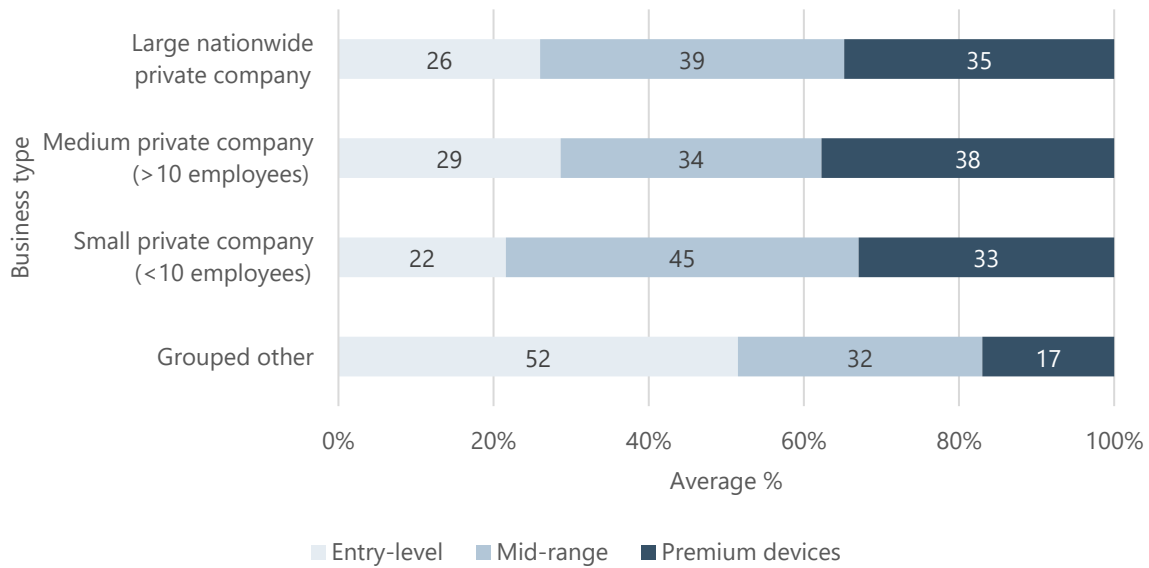
Breakdown by business type

Note: averages have been used for the chart below. Respondent numbers for both Te Whatu Ora – Health NZ and Academia were fewer than 2, so these results have been grouped and should be interpreted with caution.

Results appear more mixed across business types – respondents from:

- large nationwide private companies indicated a balanced profile, with averages of ~39 per cent mid-range, ~35 per cent premium, and ~26 per cent entry-level.
- small private companies (<10 employees) showed the strongest emphasis on mid-range products (~46 per cent), coupled with comparatively lower entry-level recommendations.
- medium-sized private companies demonstrated a slightly higher average proportion of premium recommendations compared with large organisations.

Figure 25: Proportion of clinicians recommending product tiers by business type (average %)



4.2 Influential features in clinician recommendations

10. Recommendations: What are the key features influential in clinician recommendation and why?

Total responses to Q10 – 106 responses

In this section we note that many respondents often raised a combination of factors related to hearing needs, budget and lifestyle factors. As with other open-ended questions, below we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Patient hearing needs (45 responses)

"Clinicians base recommendations on: Clinical Hearing Assessment, Lifestyle and communication needs obtained using validated tools (Such as the Client Orientated Scale of Improvement and Hearing Handicap Inventory), and budget/funding considerations. When assessing lifestyle and communication needs, social, home, occupational and community discussions are included. Both levels of technology, as well as style (body type) of hearing aids are considered against client need and preference [sic]. For clients fitted with their second pair of devices, we consider the technology level of the first pair, and how they fared on this level, recommendations for higher levels of technology may be made at this time if outcomes with [the] initial pair was [sic] inadequate. The approach reflects client-centered rehabilitation, rather than recommending devices purely on price or funding limits. The process for selecting the appropriate hearing aid is strongly guided by New Zealand Audiological Society Best Practice Guidelines"

"Hearing levels, lifestyle needs, management issues (dexterity, etc), expectations, phone requirements, testing outcomes, previous choices, personal preference"

"Evidence of neurological based hearing deficit. The more they require tech that helps processing of speech in challenging situations"

"Degree of hearing loss, duration of unmanaged hearing loss, self-reported and diagnosed degree of tolerance for noise, lifestyle factors and expectations, health of ear canals, dexterity issues, and budget available. All of these play roles in selection of solutions that will ideally allow a patient to use hearing aids daily in as seamless a way as possible."

Affordability (42 responses)

"Client needs first and foremost but then final decision bases on their finances"

"Client budget - it's better to recommend lower tech aids eg. if they have a Community Services Card, as they need to feel confident that even lower tech hearing aids will still give them good benefit"

"Client lifestyle and budget. I carefully counsell [sic] them re. expectations. Not everyone needs premium devices, and certainly not everyone can afford them. At the same time, it's hard as a clinician when someone would definitely benefit from higher tech and we can't make it work for them."

"Premium level devices provide the closest we can get to a "normal" listening experience in all sound scenes with current technology. I firmly believe that all clients, irrespective of their needs would benefit from this. However, if their needs are simpler, there are many lower cost products which will be easier on their budget and provide a great outcome for them."

Background noise reduction and hearing clarity (38 responses)

"Due to the shape/ configuration of hearing loss from noise damage, they struggle mostly in the presence of background noise rather than in quiet. Often they need high level tech to defeat the noise to meet their needs"

"Noise cancelling based on how often people are in bgn"

"Background noise reduction and microphone directionality. A lot of clients still socialise and find it difficult especially with their sharply sloping hearing loss that they often have with noise induced hearing loss in background noise. We know that social isolation puts clients at a higher risk of dementia, therefore having hearing aids that have the best possible background noise reduction/management and microphone directionality to help in these situations is important. Additionally, the higher the technology, the more automatic/better at adjusting the HAids are depending on different situations they're in. Having a higher level technology helps clients to listen more with ease without having to worry/stress about changing settings in the HAids."

"Everyone reports difficulty hearing in back ground noise. Very few people are solely in quiet 1:1 environments as shown by data logging in hearing devices. Cost/budget also an influence on recommendations"

Lifestyle factors (35 responses)

"Lifestyle and listening needs. Hearing loss and physical considerations. Budget"

"People are living longer and are remaining socially active for longer. In complex hearing situations, higher technology levels are more capable and effective."

"Mid range or premium [*sic*] devices have significantly improved noise reduction strategies compared to entry level devices. Whilst my clients are retired, their lives are not 'quiet.' They still go to cafes, have large family gatherings, attend meetings, volunteer, happy hour at rest homes. They are in just as much noise as younger people. I want my clients to have the best experience possible with their hearing aids and to be able to hear in ALL situations, not just quiet."

Technology features, such as recharging and Bluetooth (19 responses)

"I often recommend upgrading slightly for rechargeable technology. Other than that, the only reason to upgrade is background noise management (big reason)"

"Budget. Lifestyle needs. (not sure if this means hearing aid features- if so rechargeability; adaptive directional microphones; 10 channel+ devices)"

"Ease-of-use (e.g. rechargeable) is a must, and generally available in all technology levels. Noise management features are ideal for social clients, and generally become available in higher technology levels."

"Rechargeability [*sic*], Directional mics and directional modes, AI De-noising/DNN"

Physically limited patients (6 responses)

"Patient GOALS Expectations in background noise/complex challenging listening settings Physical limitations ie arthritic hands - rechargeable devices much more user friendly"

"Budget, cosi goals and needs of clients as well as other factors like personal preference, dexterity issue, etc"

Reliability (3 responses)

"Sound quality, noise reduction and reliability of brand (regarding repairs and follow-up frequency/requirement and the manufacturers' response)."

11. Recommendations: How significant are the following to clinician recommendations?

Total responses to Q11 – 111 responses

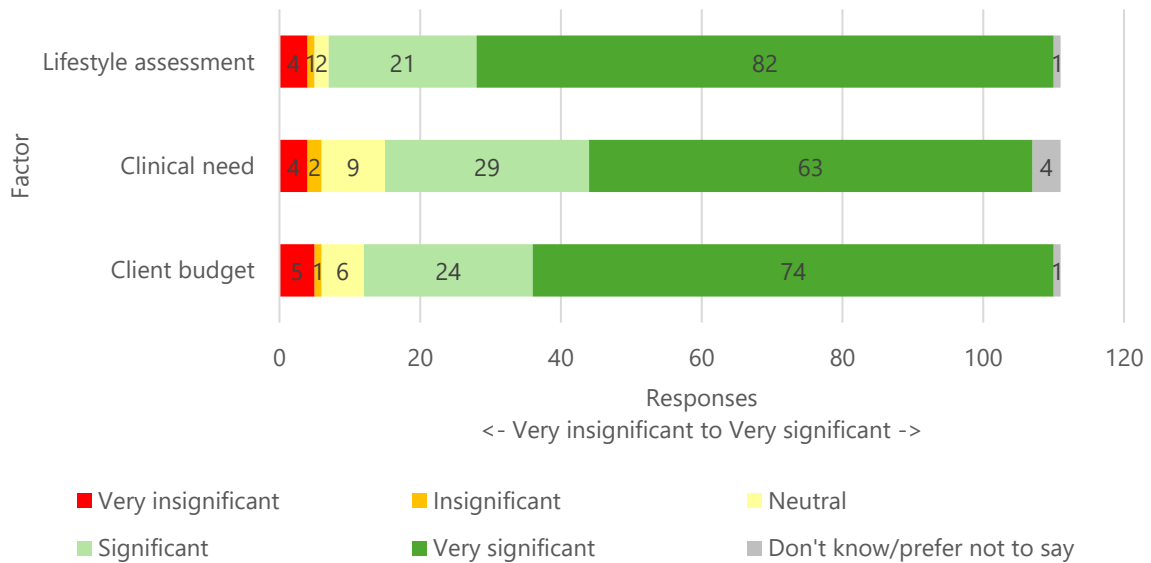
All three factors were considered significant overall.

Lifestyle assessment was rated as the most influential factor, with the large majority of respondents indicating it was very significant (82 respondents) or significant (21 respondents). Only a small number rated lifestyle assessment as neutral or insignificant, and 1 respondent preferred not to say.

Client budget was also considered highly important, with 74 respondents rating it as very significant and a further 24 respondents as significant. Very few respondents viewed client budget as insignificant, although 5 respondents rated it as very insignificant, and 1 respondent preferred not to say.

Clinical need was similarly rated as a key determinant of recommendations, with 63 respondents indicating it was very significant and 29 respondents rating it as significant. Neutral or lower ratings were uncommon, and 4 respondents selected "don't know/prefer not to say."

Figure 26: Significance of factors influencing clinician recommendations



Business type breakdown

For reporting purposes, Te Whatu Ora – Health New Zealand, academia, and other sectors were combined into a single “Other” category.

Across all business types, lifestyle assessment and clinical need were consistently rated as highly influential, with the majority of respondents selecting very significant or significant for each factor.

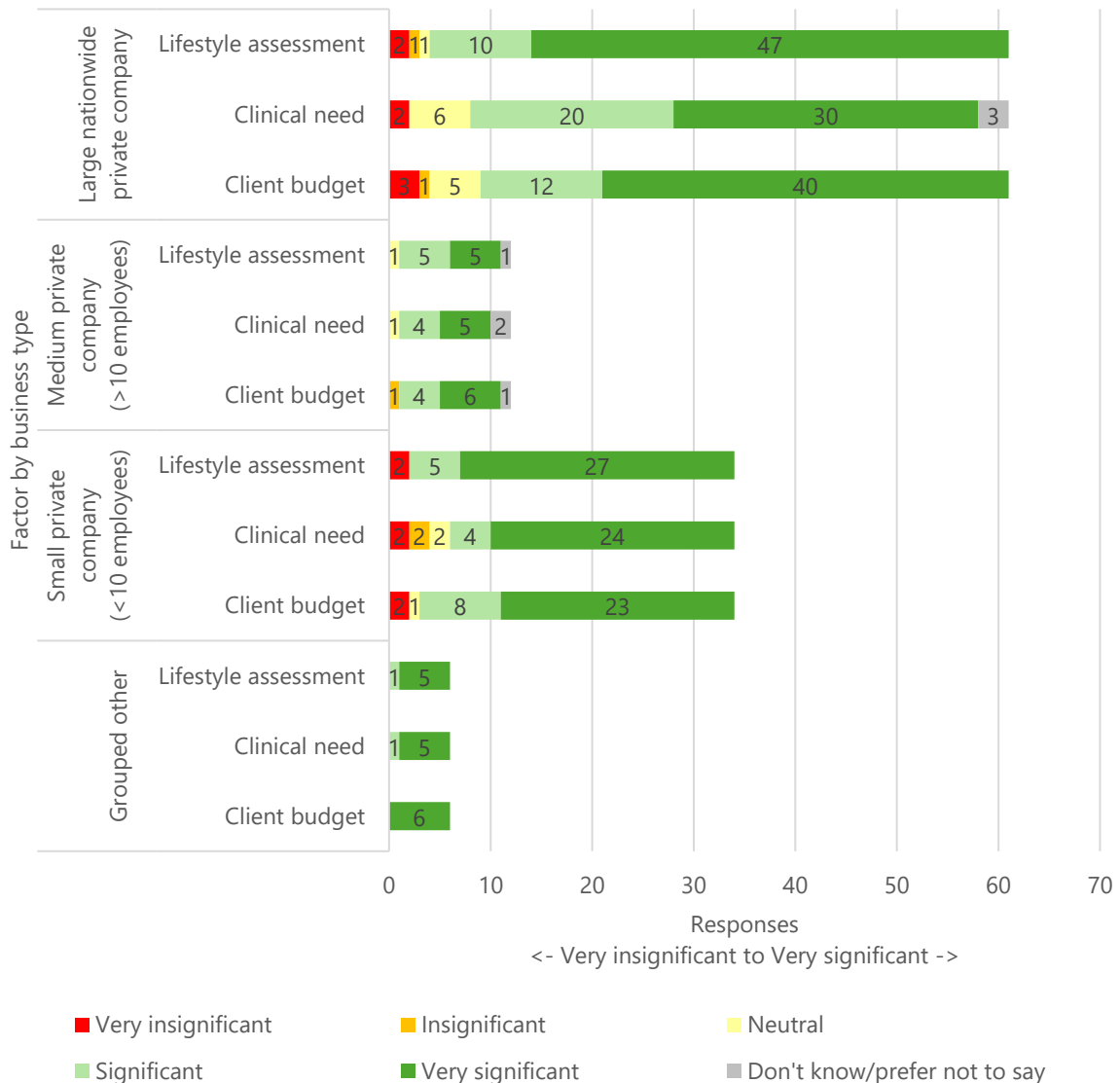
Among respondents working in large nationwide private companies, lifestyle assessment was the most influential factor. A substantial majority rated it as very significant (47 respondents), with only a small number indicating neutral or lower importance. Client budget was also strongly influential, with 40 respondents rating it as very significant, although this factor showed slightly more variability than lifestyle assessment. Clinical need remained highly important, with most respondents rating it as very significant or significant, though a small number selected neutral or lower ratings.

Respondents from medium-sized private companies demonstrated a similar pattern, though with more evenly distributed responses between very significant and significant. All three factors—client budget, clinical need, and lifestyle assessment—were typically rated as important, with only isolated neutral or insignificant responses. Lifestyle assessment and clinical need were equally weighted, indicating a balanced approach in recommendation decision-making.

Respondents from small private companies, lifestyle assessment again emerged as the most consistently valued factor, with a large majority rating it as very significant. Clinical need was also rated very highly, though this group showed slightly more dispersion, including a small number of neutral or insignificant ratings. Client budget remained important but demonstrated greater variability than the other two factors.

Within the Grouped other category, all three factors were predominantly rated as very significant or significant. However, given the small number of respondents in this group, these results should be interpreted with caution.

Figure 27: Significance of factors influencing clinician recommendations by business type



Breakdown by length of time in sector

Across all levels of clinician experience, all three of client budget, clinical need and lifestyle assessment were rated by a large majority of clinicians at least a significant factor in their recommendations to clients.

When looking at factors rated as significant or very significant, lifestyle factors was most or equal-most highly rated factor across all experience levels (only client budget was rated as significant in the 6-10 years of experience level). However, ratings for client budget and clinical need was fairly similar to that of lifestyle factors.

Of the few respondents who rated any factor as insignificant or very insignificant, they were relatively even across the three different factors. No respondent in the 16-20 years of experience rated any of the factors as being insignificant or very insignificant.

Figure 28: Significance of factors influencing clinician recommendations by length of time in the sector



5. Client preference and needs

12. Choices: What proportion of your clients choose: entry-level, mid-range and premium devices. Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100.

Total responses to Q12 – 100 responses

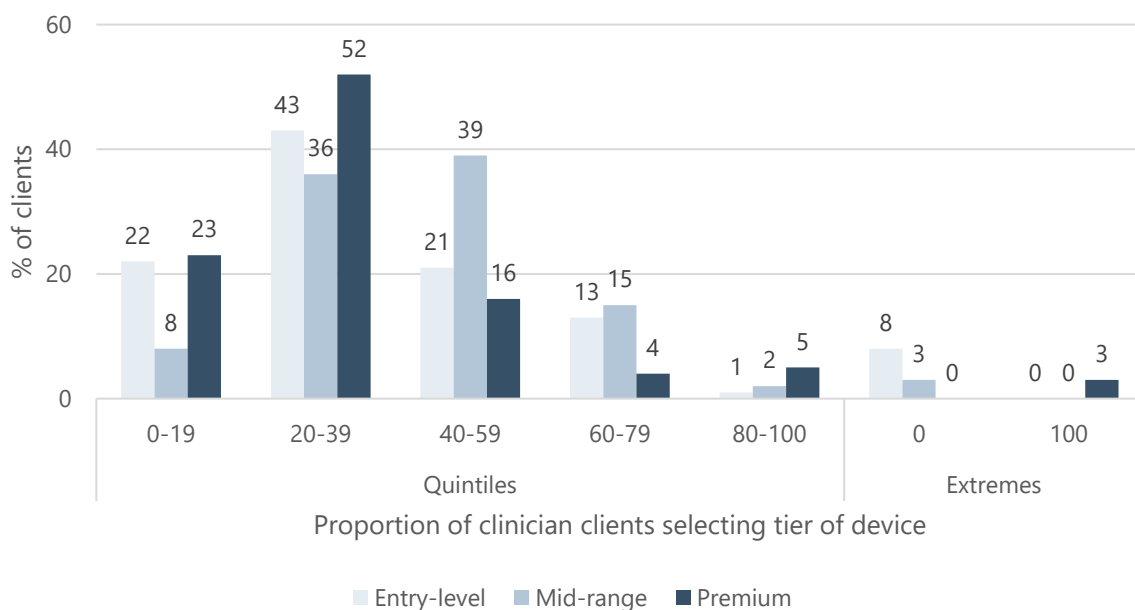
39 per cent of clients were reported as opting for mid-range devices, making it the most selected price level. Entry-level devices were the next most popular, reported to be selected by over 31 per cent of clients. Premium devices were the least popular, with less than 30 per cent of clients reported as opting for devices at the higher end.

Table 2: Summary statistics of proportion of clients choosing entry-level, mid-range and premium devices

Product tier	Average	Median	Minimum	Maximum
Entry-level	31.5%	30.0%	0%	90%
Mid-range	38.7%	40.0%	0%	80%
Premium	29.8%	22.5%	1%	100%

8 per cent of respondents were reported to not offer entry-level devices, whilst 3 per cent reported only offered premium devices. Clients of respondents in smaller businesses and those with more than 21+ years' experience generally report a greater portion of clients choosing premium, or above entry level devices.

Figure 29: Proportion of clients who choose entry-level, mid-range and premium devices (%)

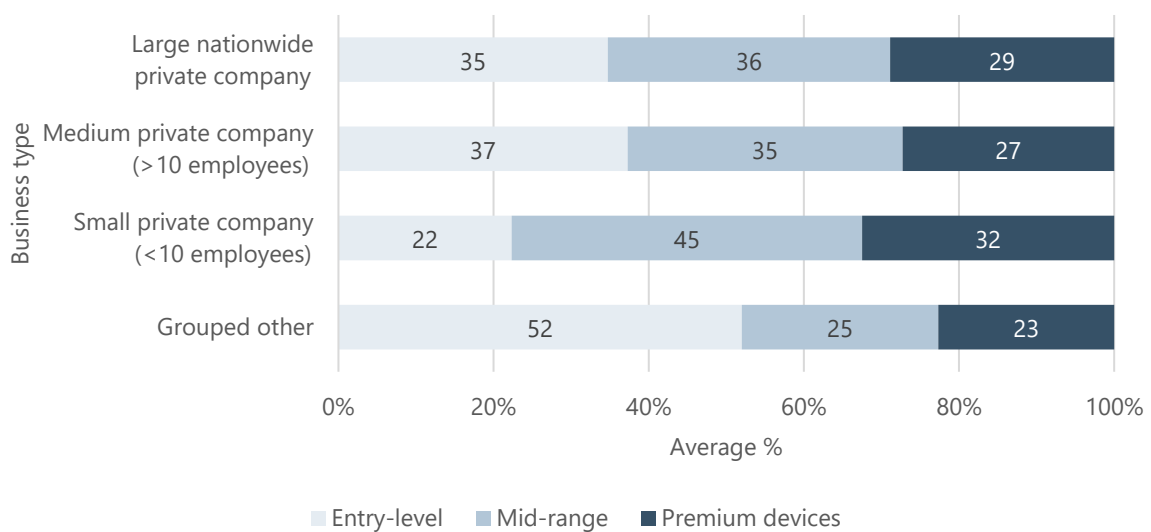


Breakdown by business type

Respondents from large and median-sized private companies were reported as tending to offer all three product tiers in similar proportions, with entry-level and mid-range devices reported as being chosen by about the same proportion of clients, whilst their clients were reported as opting for premium devices at a slightly lower rate.

Respondents from smaller private companies reported fewer clients opting for entry-level devices, choosing instead mid-range devices and premium devices at a higher rate than reported for clients at larger companies.

Figure 30: Proportion of clients choosing product tiers by business type (average %)

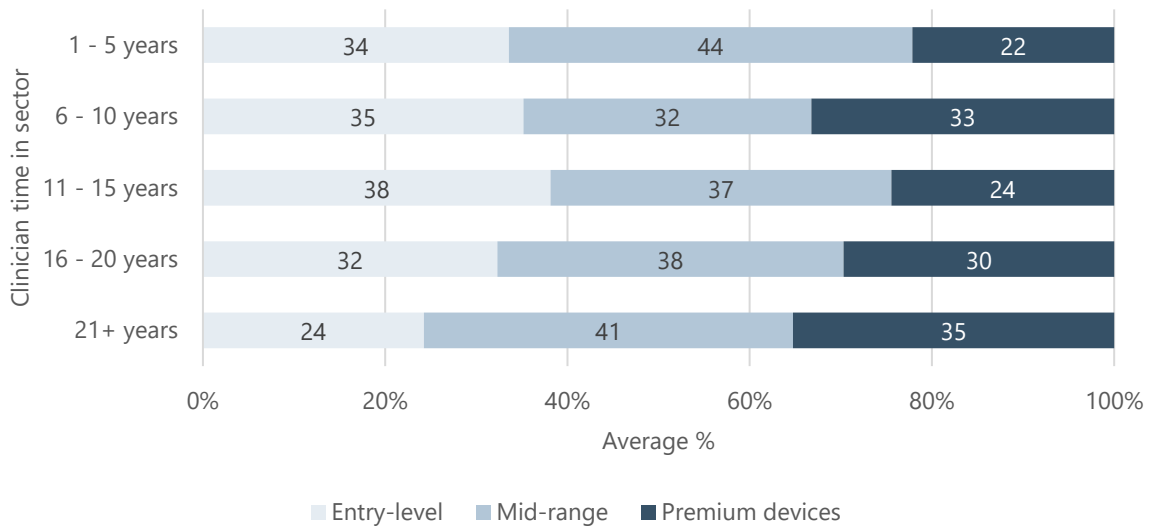


Breakdown by length of time in sector

The proportion of clients reported as choosing different product tiers was largely consistent across different bands of respondents' years of experience for all categories.

Clients of respondents with 21+ years of experience, however, were reported as less likely to choose an entry-level device. They were also indicated as slightly more likely to choose a premium device.

Figure 31: Proportion of clients choosing product tiers by clinician time in sector (average %)



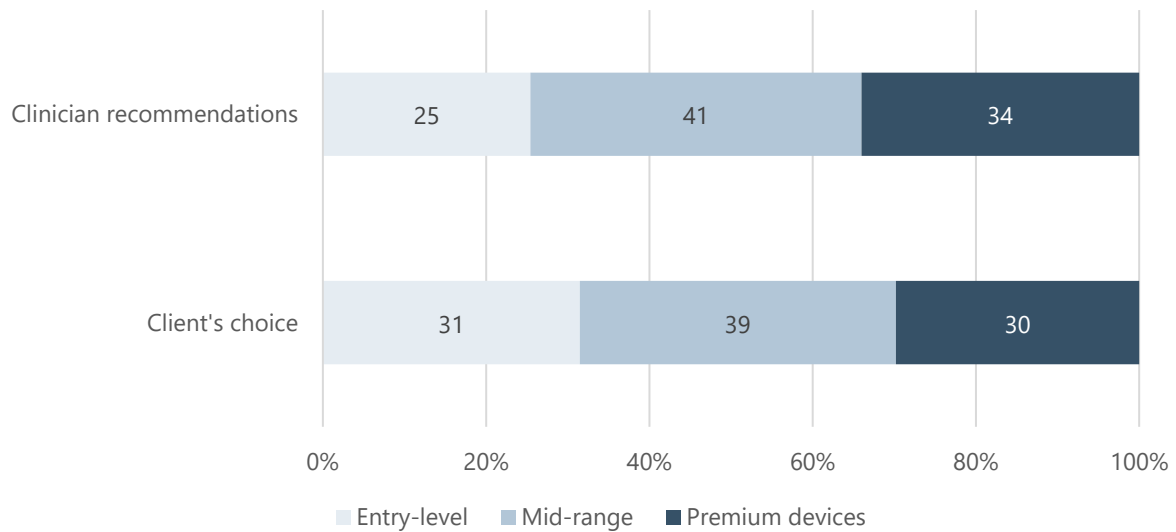
Clinician recommendations of devices vs what clients choose

There is a sense from respondents of some degree of clients opting for lower product tiers than what was recommended to them by their clinicians.

Respondents indicated that:

- clinicians were more likely to recommend a premium device (34 per cent on average) than clients opting for premium devices (30 per cent).
- clinicians also recommended mid-range devices at a higher rate (41 per cent) than clients (39 per cent).
- entry-level devices were only recommended 25 per cent on average but opted for by clients 31 per cent of the time.

Figure 32: Proportion of product tiers recommended by clinicians compared to what product tier clients chose (average %)



13. Features: Which particular features of hearing aids are sought by clients the most and why?

Total responses to Q13 – 107 responses

The features that were reported as most sought by clients were noise reduction, Bluetooth and streaming capabilities and rechargeability. Participants discussed the needs behind these feature requirements such as socialising in loud environments, workspaces or wind noise reduction.

As with other open-ended questions, below we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Noise reduction (77 responses)

"Definitely background noise suppression which often ACC clients need or people with noise induced hearing loss need"

"Noise reduction and speech in noise processing. Because they are missing out in group and background noise settings and it is impacting their connection with others and confidence and they are self isolating because of this"

"Background noise management, microphone directionality and automaticity of the hearing aids, to help hear the best in more challenging situations they find it hard to hear in with background noise e.g. socialising in cafes/restaurants and in family or friend gatherings."

"AI and noise reduction features"

"Ability to hear better in noise eg open floor work spaces, meetings, hearing in social situations."

"Noise reduction feature to help hear better in noise - this is still number one problem for most clients. Wind noise reduction as a lot of our clients still work or are active outside - to be able to reduce wind, Sudden sounds adjustments - being able to reduce loud sudden sounds to make things more comfortable. Bluetooth capabilities and rechargeable options."

Bluetooth and streaming capabilities (57 responses)

"Features that are able provide meaningful [sic] access to speech in background noise, over distance and in poor acoustics is often needed, due to the nature of noise induced hearing loss, which typically manifests as poor speech clarity in complex listening environments. Most noticeably is AI or directional microphone features for enhancing speech clarity in background noise. Bluetooth streaming capability, and rechargeability has also gained usefulness over the past 5-7 years"

"Blue tooth streaming. Find my hearing aid. App connectivity. Good hearing in noise! So important."

"direct phone call streaming automatic programs sudden sound stabilizer wind noise reduction noise reduction system"

Rechargeability (53 responses)

"Rechargeable - convenience, battery life if streaming Bluetooth - streaming Noise management - hearing in noise is challenging"

"Rechargeability- ease of use for older populations Help with hearing in background noise- better noise reduction/automation/ and sound quality impact this outcome. Bluetooth phone connectivity. Aesthetically non-offensive"

Discreet design (17 responses)

"Rechargeability, for daily ease of use. Open fitting, as these sound and feel more natural Reliable Bluetooth connectivity, for streaming calls and media from their phone Discretion: very few people want to advertise they have hearing aids Easy to use: many clients have eyesight and dexterity limitations, so the aids need to [be] easy to handle on a daily basis. Reliability: their aids are used every day and they become very reliant on them. They do not want to be without them for long if they stop working."

"Depends on the demographic. Advertising drives conversations around 'invisible' hearing aids. This is super annoying - not only is it promoting unnecessary [sic] stigma around hearing loss, tiny devices are not suitable for almost every patient I've ever seen. Elderly need easy to manage devices."

Ease of use (12 responses)

"Ease of use, automatic functions, phone connectivity, discrete solutions"

AI features (11 responses)

"AI and noise reduction features"

Sound quality (8 responses)

"Ability to hear clearly in all the different listening situations that they are in; sound quality; easy to use; sometimes connectivity and rechargeability."

Durability/reliability (5 responses)

"Rechargeability for ease of use. Water resistance for durability. Artificial Intelligence for perceived functionality."

"Reliability - as sending for repair repeatedly is not ideal for a client who relies on their aids. Good warranty supports this, but even then some brands are requiring 2+ offsite repairs each year whereas others I work with might only [sic] go offsite once over a 6 year period. Classic bluetooth compatibility or MFI depending on if the client is a heavy phone user - and no instrument offers both classic bluetooth and MFI, so important to determine this need. Useability - comfort, easy to use. Discreet (usually preferred) Personalised to their lifestyle and needs - e.g. upgradeable or features they can use for their lifestyle in the app."

14. Meeting needs: In relation to clients' current and expected future needs, do you feel you are predominantly providing hearing aids that: 'do not meet these needs', 'meet these needs', or 'exceed these needs'

Total responses to Q14 – 108 responses

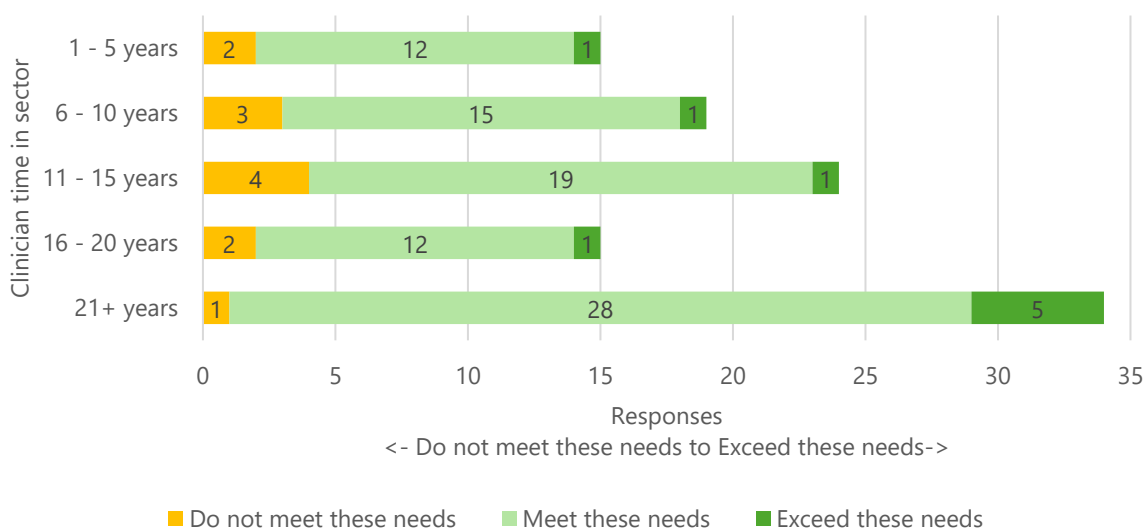
Across participants, 86 out of 108 responses found that they were able to provide hearing aids that met their clients' current and expected future needs. This was a relatively even spread across different time in sector ranges. A low proportion (9) of participants found that hearing aids exceeded clients' current and future needs.

By time in sector

Most clinicians across all levels of experience reported assessing that their clients current and future needs were being met.

Clinicians with 21+ years of experience were less likely to answer their clients' needs were not being met and that their needs were being exceeded.

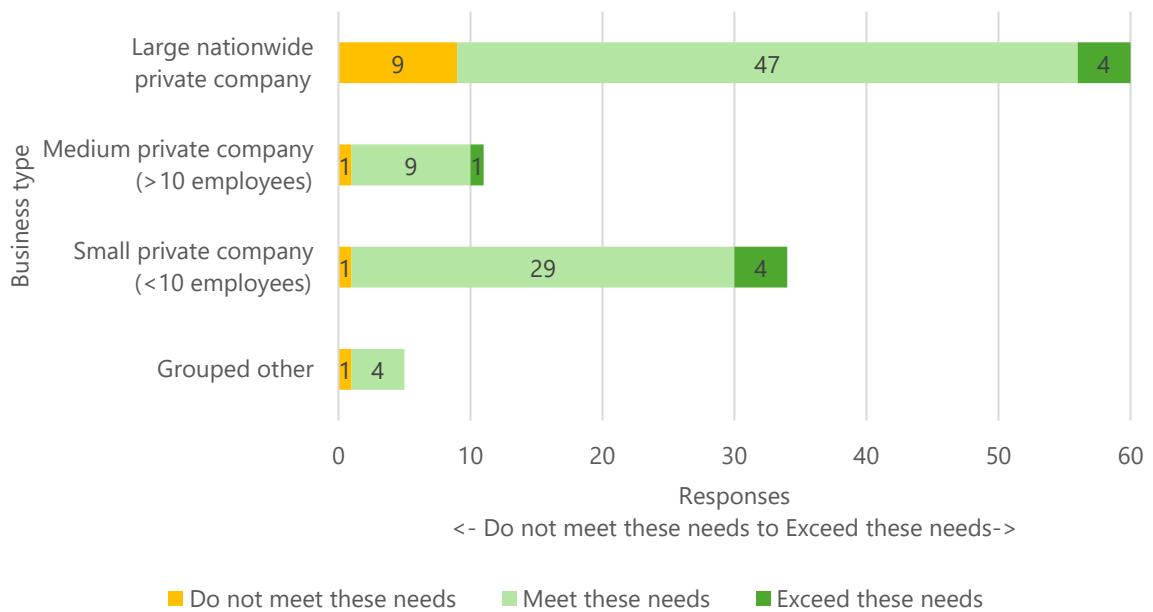
Figure 33: Clinician assessment of whether hearing aids meet clients' current and future needs by time in the sector



By company type

Of the 12 respondents who assessed their clients' needs were not being met, 9 worked at a large nationwide private company.

Figure 34: Clinician assessment of whether hearing aids meet clients' current and future needs by business type



Note: two respondents selected multiple business sizes, leading to double counting in the figure above.

6. Revenue, time and cost

6.1 Source of funding

15. Funding source: If your client were not able to receive ACC funding, would your recommendations, the basis for them, or your sense of whether clients' needs are predominantly met differ? If so, how?

Total responses to Q15 – 106 responses (+1 N/A response)

83 per cent of respondents said that there would be no change to recommendations if their clients were not able to receive ACC funding. Reasons for this included recommendations being made on the basis of clinical assessment or ACC funding not having a significant financial impact on clients. Twenty-five per cent of participants would work with clients to find more affordable options, with one participant mentioning that they may seek cheaper hearing aid brands to achieve the same goals.

As with other open-ended questions, below we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

No change to recommendations (88 responses)

"No. Hearing aid recommendations are made on the basis of clinical assessment, not on the basis of available funding. Once a recommendation is made, it is placed against available funding and private pay options discussed. A client is then able to make an informed decision, based on all information provided to them. It would be unethical to base clinical recommendations on available funding alone."

"My recommendation would stay the same."

"No. I don't find that ACC funding changes the financial load on clients by much."

"No. ACC funding is their business, not mine. I would actually prefer for all their funding to be done through the patient, ACC fund them, and then they come to us without our knowledge of where they get their funding from. It is an administrative nightmare dealing with ACC that takes up a massive amount of time. If ACC made things more efficient for clinicians, they would save millions!"

Work with clients to find more affordable options (27 responses)

"The need doesn't change but clearly the budget has. What can we achieve within the budget constraint"

"No, the clinical recommendation is based on the patient needs and not their funding. Of course their budget comes in to play and it is up to them to decide from my recommendations based on what they tell me are their needs, what best suits their budget."

"Yes, often people are limited by their budgets"

"ACC candidacy is a huge factor. It often decides whether the client can get entry vs midrange tech. Most individuals will benefit from higher tech but are limited by affordability"

"May seek cheaper hearing aid brand/model to achieve the same goals"

Note that clients may opt for lower technology options (9 responses)

"The clients' needs and the device recommendation do not change whether they have ACC funding. However in reality the devices they are fitted with will be lower-cost/lower-technology as many clients struggle to afford advanced hearing aids. Without ACC funding clients are less likely to be able to afford mid-range technology and will instead be fitted with basic technology, which may not be appropriate for their hearing needs."

Note that clients needs may not be met (7 responses)

"No but typically, clients would choose aids that were cheaper and insufficient for their needs"

"I find that ACC clients are often unwilling to top up any money at all, meaning that they end up with slightly lower technology than the most common non-ACC client. This means that client's needs are often not met as well as they could be."

Suggest alternative funding options (3 responses)

"DSS subsidy; or if client has financial issues and on WINZ then I would do a quote for them to take to WINZ and this would include the subsidy"

"Some clients will only proceed with hearing aids because ACC is funding them: they would not be prepared to spend their own money on the aids. If ACC funding were not available, I would recommend the Enable Subsidy, seeking assistance from WINZ, or the client paying privately for their devices."

Note that clients may not proceed (2 responses)

"Yes, when ACC is declined, most people who would have tried the low level technology decide not to go ahead.. Some do as they may approach WINZ to help fund the technology."

6.2 Hearing assessments

Time (minutes)

16. Hearing assessments time: Across all staff, how much time would typically be spent per client for an ACC funded hearing assessment on the following?

Total responses to Q16 – 103 responses

The median time indicated to be spent per client on ACC-funded hearing assessments across all activities was 90 minutes. This included a median time of 15 minutes on administrative tasks per client. Respondents that were business owners reported spending more time (140 minutes) compared to those that were employees (99 minutes).

Table 3: Typical time spent per client on ACC-funded hearing assessment activities (minutes)

Assessment activity	Minimum	Lower quartile	Average	Median	Upper quartile
Initial client needs discussion	8	15	27	25	35
Technical hearing assessment	15	25	34	25	50
Administrative tasks (e.g. completing ACC forms)	8	15	23	15	25
Recommendations and hearing aid selection (where relevant)	8	15	27	25	35
Sum of categories	38	70	111	90	145

Table 4: Typical time spent per client on ACC-funded hearing assessment activities by employee/owner (minutes)

Assessment activity	An employee	A business owner
Initial client needs discussion	24	34
Technical hearing assessment	31	42
Administrative tasks (e.g. completing ACC forms)	21	29
Recommendations and hearing aid selection (where relevant)	24	35
Sum of categories	99	140

Cost

17. Hearing assessments cost: Given the time above as well as the skills and equipment needed for each, what portion of the cost of an ACC funded hearing assessment would be due to the following? Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100.

Total responses to Q17 – 84 responses

On average, 38 per cent of ACC-funded hearing assessment costs were reported to be attributable to the technical hearing assessment. Fifteen per cent of costs were reported to be attributable to administrative tasks.

Table 5: Proportion of ACC-funded hearing assessment costs attributable to assessment activities, by employee/owner (%)

Assessment activity	Average	Median	An employee	A business owner
Initial client needs discussion	20%	21%	20%	19%
Technical hearing assessment	36%	38%	34%	41%
Administrative tasks (e.g. completing ACC forms)	15%	15%	16%	12%
Recommendations and hearing aid selection (where relevant)	23%	21%	23%	21%

Assessment activity	Average	Median	An employee	A business owner
Other (please specify activities in box below)	7%	5%	6%	7%

18. Please specify what other activities are identified in Q17 above.

Total responses to Q18 – 18 responses (+6 N/A responses)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Ear impressions (7 responses)

"Ear impressions, written quotes for hearing aids."

ACC admin and paperwork (4 responses)

"Submitting the ACC45 which is done outside the original appt when client has brought back the completed ACC724"

"Calling ACC to confirm funding if re-aiding, calling ACC to check on progression of claim"

"Filling out forms takes way too long"

"Admin staff spend a lot of time following up with ACC. ACC staff do not appear to understand ACC NIHL process and often get confused."

Counselling (4 responses)

"Hearing aid demonstration between hearing aid brands to assess how clients will respond to certain hearing aids. Counselling and setting realistic expectations. Taking impressions of ears for moulded earpieces. Explaining the next steps"

Researching and getting advice for products (2 responses)

"Item research eg FM systems/remote mics etc"

"seeking advice for various manufacturer's/ Getting product update"

Checking phone compatibility (1 response)

"Discussions regarding mobile phone compatibility [sic] and demos, budget considerations (many ask at this point) time spent loading info to portal by admin staff"

6.3 Hearing aid fitting

Time

19. Hearing aid fitting time: Across all staff, how much time would typically be spent per client for an ACC funded hearing aid fitting on the following?

Total responses to Q19 – 101 responses

There was a wide distribution of results: the average reported time taken to provide an ACC-funded assessment was 87 minutes across the different categories.

Table 6: Summary statistics of time typically spent on tasks on during the ACC-funded hearing aid fitting process (minutes)

Task	Minimum	Lower quartile	Average	Median	Upper quartile	Maximum
Client needs discussion	8	15	25	25	35	70
Hearing aid fitting and testing	15	35	44	50	50	70
Administrative tasks (e.g. completing ACC forms)	8	8	19	15	25	70
Sum of results²	30	58	87	90	110	210

Respondents that were business owners assessed, on average, that about 22 more minutes were required for an ACC-funded fitting than respondents that were employees. Interestingly, the main difference did not arise in a different assessment of the administration time required but in the client facing time, which may suggest that the population of clinics where an employee responded could be different to the population of clinics which a business owners responded to. One possibility is that responding business owners have more discretion to spend additional time with clients, whereas the time may be more set for employees.

Table 7: Breakdown of time spent on tasks by employee/employer during the ACC-funded hearing aid fitting process (minutes)

Task	Average employee response	Average business owner response
Client needs discussion	23	29
Hearing aid fitting and testing	40	52
Administrative tasks (e.g. completing ACC forms)	18	21
Sum of results	81	103

Cost

20. Hearing aid fitting cost: Given the time above as well as the skills and equipment needed for each, what portion of the cost of an ACC funded hearing aid fitting would be due to the

² Note that the sum of results is the above rows added up, rather than referenced to the total time taken. For example, the minimum response for one category may come from one response and the minimum for another category from a different response.

following? Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100

Total responses to Q20 – 82 responses

There is relatively little variation across the answers to this question, with both respondents that were employees and business owners identifying that around 65 per cent of the costs involved are with the hearing aid fitting and testing. Interestingly this percentage is higher than the implied average taken from the previous question (50 per cent) which suggests that the costs of the equipment involved in the fitting and testing are relevant to assessing the answer.

Table 8: Breakdown of costs of an ACC funded heading aid fitting

Cost item	Average	Median	An employee	A business owner
Client needs discussion	21%	22%	21%	21%
Hearing aid fitting and testing	64%	67%	63%	66%
Administrative tasks (e.g. completing ACC forms)	15%	11%	16%	13%

21. Please specify what other activities are identified in Q20 above.

Total responses to Q21 – 25 responses (+8 N/A responses)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Device management training (9 responses)

"Fitting management, that is to teach my client how to use and maintain the hearing aids and the accessories"

"Often elderly clients will need more time going through hearing aid management such as care, cleaning insertion and removal leading to more time. These can change client to client"

Follow-up appointments (8 responses)

"follow up post fitting but still during the hearing aid fitting process (before finalisation of device)"

"follow ups - some ACC clients do not use their hearing aids right away or long enough during the day to know if they are benefitting or not. Some of them do not attend their follow ups as well. I think there should be some compensation on these appts and ACC should reiterate this to their clients so they take the hearing aid trial seriously"

Needs counselling (5 responses)

"Counseling [sic] re complex auditory conditions."

Phone connection (3 responses)

"Management and care of device, connecting to phone etc"

Troubleshooting (2 responses)

"clients could have issues that require ongoing email, text or phone call to help them with trouble shooting the devices"

Aural rehabilitation exercises (1 response)

"Going over use and management of devices (approx. 10-15 mins); counselling on realistic expectations and guiding the client through their hearing aid journey (approx. 10-15 mins); setting up phone connectivity/controls and going through the app (approx. 5-10 mins); going through any aural rehabilitation exercises (approx. 5-10 minutes)"

Hearing aid model selection (1 response)

"Sometimes, client tries a few models before deciding the level of technology."

ACC claims (1 response)

"Calling ACC to follow up when claim has been submitted."

Cost of the hearing aid itself (1 response)

"Cost of the aid"

6.4 Revenue and cost components/drivers

22. Clients: What proportion of your clients have an element of ACC funding? - business type, owner/employee.

Total responses to Q22 – 76 responses

On average, respondents reported that 28 per cent of their clients had an element of ACC funding.

Table 9: Percentage of clients that have an element of ACC funding, by owner / employee

	Average	Median	Employee	Business owner
Overall	28%	25%	30%	23%

The average percentage of clients with an element of ACC funding was reported to be higher for clients of respondents from large nationwide private companies.

Table 10: Average percentage of clients that have an element of ACC funding, by entity type

	Large nationwide private company	Medium private company (> 10 employees)	Small private company (< 10 employees)
Average proportion of clients that have an element of ACC funding	33%	24%	23%
Number of responses	42	9	22

Note that where two or fewer responses were received, we have not reported averages for these entity types.

23. Revenue by purchaser: What is the rough break-down of portion of your clinic's revenue by key funder/purchaser? Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100.

Total responses to Q23 – 56 responses

On average the greatest portion of revenue is reported as coming from MSD/DSS, followed by ACC and other and private insurance being the smallest. Of other, Veteran's Affairs and private funding were the most commonly stated.

Table 11: Breakdown of revenue to clinics by key funder/purchaser

Key funder/purchaser	Average	Median	An employee	A business owner
ACC	23%	26%	26%	19%
MSD/DSS	42%	54%	40%	46%
Private insurance	10%	10%	11%	7%
Other (please specify funders/purchasers in box below)	25%	10%	23%	28%
Number of responses	55	55	37	18

On average, respondents from large nationwide private companies reported higher portions of their revenue coming from ACC compared to those from smaller companies, which reported higher portions coming from other sources. Respondents from medium sized private companies also reported lower portions of revenue coming from MSD/DSS than respondents from smaller or larger sized private entities.

Table 12: Average percentage of clinics' revenue by key funder/purchaser by entity type

	Large nationwide private company	Medium private company (> 10 employees)	Small private company (< 10 employees)
ACC	32%	26%	20%
MSD/DSS	51%	44%	52%
Private insurance	12%	10%	11%
Other (please specify funders/purchasers in box below)	16%	39%	30%
Number of responses	31	8	15

Note that where two or fewer responses were received, we have not reported averages for these entity types.

24. Please specify any other funders/purchasers identified in Q23 above.

Total responses to Q24 – 32 responses (+6 N/A or unable to answer responses)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Veterans' Affairs (VA/VANZ) (18 responses)

"Veterans Affairs 2-3 times a year"

"VA, HAFS are uncommon in my clinic, so have entered that as 1. BUT in other clinics i've worked in, the demographic is quite different, and there's a lot more."

"VA - about 5 %, included in MSD in figures above"

Privately or self-funded (11 responses)

"Private funded aids = 80% (it is not clear above if you are referencing MSD/DSS as the subsidy or funding so have assumed you mean full Enable funding) that will make a significant difference to your calculations!"

"private pay amount for 40% of market"

"2% Veterans' Affairs, 71% private funding from clients (some of this could be cash settlements from insurance claims)"

Other subsidies including Enable and HAFS (4 responses)

"DSS, Enable"

"HAFS Fully funded. VA."

Work and Income (WINZ), Iwi and community grants (1 response)

"Work and Income, Iwi funds, local philanthropic [sic] grants targetted [sic] for health or hearing"

Other responses (2 responses)

"non NZ residents"

"VANZ, Employers"

25. Time by service: Across all staff, how much time would typically be spent per client visit on the following services where ACC-funded?

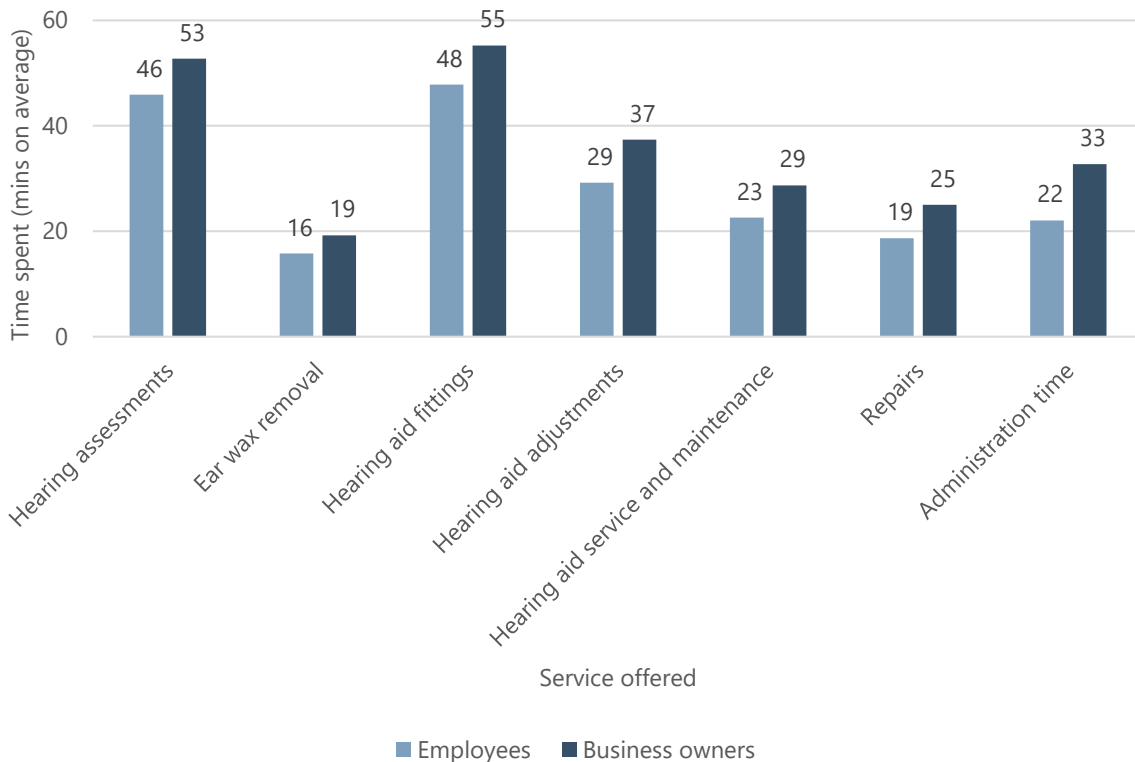
Total responses to Q25 – 75 responses

Hearing aid fittings were consistently reported as demanding the most time of staff, followed by hearing assessments. In each case respondents that were business owners assessed that more time was required than those that were employees (but we offer the same caveat as before that there are possibly distinct survey populations – the majority of clinics where the business owner responded had fewer than ten employees).

Table 13: Time spent (minutes) per client visit on ACC funded services

Service	Average (mins)	Median (mins)
Hearing assessments	48	50
Ear wax removal	17	15
Hearing aid fittings	51	50
Hearing aid adjustments	32	25
Hearing aid service and maintenance	24	25
Repairs	20	15
Administration time	25	25

Figure 35: Time spent (minutes) per client visit on ACC funded services by business type (on average)



26. Revenue by source: What is the rough break-down of the portion of your clinic's revenue?
Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100.

Total responses to Q26 – 47 responses

Hearing aid fittings were reported as making up the largest proportion of respondent clinic's revenue. Ear wax removal, hearing aid adjustments, hearing aid servicing and maintenance and repairs were reported to make up around the same proportion of revenue.

Table 14: Breakdown of clinic revenue by service offered

Service	Average	Median	An employee	A business owner
Hearing assessments	15%	11%	15%	15%
Ear wax removal	8%	6%	7%	9%
Hearing aid fittings	56%	66%	57%	53%
Hearing aid adjustments	7%	6%	7%	8%
Hearing aid servicing and maintenance	6%	6%	5%	6%
Repairs	5%	6%	5%	4%

Service	Average	Median	An employee	A business owner
Other	3.6%	1%	3%	4%

27. Please specify any other revenue identified in Q26 above.
Total responses to Q27 – 6 responses (+8 N/A or unable to answer responses)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon.

Specialist audiology services (4 responses)

"Specialist audiology services like tinnitus and hyperacusis."

"People seeking 2nd opinions"

"Medical tests"

Accessories (2 responses)

"consumables like batteries etc."

Not applicable or unable to answer (8 responses)

"We don't have revenue, we are a hospital service."

28. Revenue by source: What portion of ACC-funded clients would have hearing assessments only and not proceed with further treatment at your clinic within the next 6-months?
Total responses to Q28 – 58 responses

On average around 18 per cent of ACC funded clients were reported as having hearing assessments only with no further treatment in the next six months, with a higher average of 31 per cent for respondents that were business owners.

Table 15: Proportion of ACC funded clients that have hearing assessments only with no further treatment within six months

	Average	Median	Employee	Business owner
Overall	18%	13%	18%	31%

29. Costs: What portion of your clinic's overall costs do the following represent? Please enter a percentage in numerical form in each text box below but do not include the percent sign (%). Note that the total of all responses need to add up to 100.

Total responses to Q29 – 30 responses

On average workforce was reported as the most significant cost to clinics, followed by goods sold or premises, then equipment. Responses were fairly consistent across business owners and employees with employees indicating a relatively large portion of costs relating to goods sold and reduced portion relation to workforce. This could partly reflect the higher portion of business owners in smaller businesses.

Table 16: Breakdown of clinic overall costs

Cost item	Average	Median	An employee	A business owner
Workforce	33%	33%	37%	29%
Premises	13%	11%	15%	12%
Licenses	5%	6%	6%	4%
Equipment	10%	11%	9%	11%
Goods sold	18%	22%	12%	23%
Administration	6%	6%	5%	7%
Marketing	7%	6%	7%	7%
Franchise fees	3%	0%	3%	4%
Training	4%	6%	5%	4%
Number of responses	74	74	54	20

30. Please specify any other costs identified in Q29 above.

Total responses to Q30 – 1 Response (+ 12 N/A or unable to answer responses)

Travel & utility costs (1 response)

"Travel to other clinics and courier and power costs are constantly increasing"

7. Outlook

31. Outlook: What trends are you seeing and future dynamics do you see impacting future sales and the audiology market in future?

Total responses to Q31 – 60 responses (+3 N/A responses)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Over-the-counter (OTC) and online sales to customers (15 responses)

"Possibly more OTC amongst younger generation"

"I could see the advent of hearables, OTC options, and low cost direct-to-ear options pulling some portion away from conventional hearing aids. However I do believe there will always be a need for verification of amplification by a hearing care professional."

Increased competition, particularly from larger chains (14 responses)

"Insurance companies having preferred suppliers seems incompatible with their customers right to choose their provider and not be penalised because they choose a smaller company that may not be able to access discounts offered to preferred suppliers. Retail owned by manufacturers. Online purchases."

"Parallel importing of hearing aids by large organisations. Differences in price lists from manufacturers - clearly the large chains can purchase hearing aids cheaper than we can, due to their buying power."

"Overseas providers entering the market and undercutting/by-passing traditional nz-based manufacturer-supplied hearing aid pricing. e.g. frequently, insurance replacement quotes from providers allied with the insurance industry undercut the WHOLESALE price of hearing aids available to independent clinics. Aggressive target- and bonus- driven sales practices by larger clinics, which may limit or negatively influence choice for the patient. Audiology becoming a sales-driven professional rather than a patient-centred clinical profession."

"Things are getting more and more into retail. Providers are seemingly going stronger on "free" hearing aids whether it be with ACC or no. Black Friday sales was a real shock. The bigger companies are seemingly upping their cold calling of people to draw in more business - some people have received multiple calls within the same week from different providers. I worry with the economy going the way it is, some people will put off getting the help they need for fear of what it all costs."

Economic uncertainty (13 responses)

"Hard economic times lead to people spending less. Technology replacing audiologists/hearing aids."

"cost is a major factor for almost all clients. There is more competition, and more options for consumers. this means there is less brand loyalty and more shopping around. I think companies are

also trying to make their sales quicker and in higher volumes, which means clients have less time spent on them. This can speed up their journeys, but also means they might have less support."

AI and technology advancements (9 responses)

"Went to a product launch this week and finally saw how AI could effect my job. Clients will be able to make their own adjustments with the use of their phone and AI"

"AI use in hearing aids improving their performance in noise will increase uptake"

Concerns about commercialisation of the sector (9 responses)

"Poorer quality of audiological services being provided due to commercialisation of hearing aid fittings."

"subscription plans teleaudiology flagship clinics only selling one brand"

"My worry is clients being treated to 'cookie box' audiology with limited choices and reduced funding."

"Some clinics focus on high volumes models where minimal time is spent assessing and fitting given 'cheap' prices. I feel this devalues the profession and usually delivers much less user satisfaction - which can put people off hearing aids. I think spending more time and focusing on personalised solutions ensures better outcomes, and most people are willing to pay for products and services that deliver better outcomes. It is hard to help clients who have used their ACC (or other) funding on 'free' devices from elsewhere and are unhappy with performance. While I think having fully funded solutions is great (and we offer this), clients need to understand the limitations. Conversely, having the flashest hearing aids that a person is unable to manage when they need a simple device can be just as difficult to manage - so a proper and complete needs assessment is essential. Some brands are being seen more as 'disposable' devices with a limited lifespan"

Comments on ACC coverage (7 responses)

"I think that there will be less approval under ACC funding as clients in their 50s and 60s were already told about use of hearing protection in the early 1990's. So less chance of losing hearing due to work. In the future, it would be more mechanics and engineers that may lose their hearing due to to listen to equipment"

"Our whole hearing health system is horribly inefficient and built for private, offshore manufacturers who hide their retail arms in vertical integration, ie all the chains of clinics are (pretty much) owned by manufacturers of hearing aids. Commercial interests are outweighing public health needs or government budget. We urgently need MORE investment in adult, public audiology. Some former DHBs have this service, and some don't. This means that people who qualify for free hearing aids under Enable often can't afford to pay a \$1380 fitting fee to private chains. If the government paid the salaries of a couple more audiologists in the public sector in each region you could save a tonne of money in people applying for disability benefits, Work and Income grants etc etc just to access hearing care, which the overseas chains profit from. In terms of ACC, funding is heavily skewed towards traditionally 'male' professions and there is a big gender disparity in funding applied for and awarded. The envionmental [sic] data in the model is pretty shonky."

Subscription/rental models (6 responses)

"Rent to purchase, more affordable pay weekly options. More hearables entering the market, possible disruption to hearing aid sales as people look at more entry options"

"Hearing aid cost is still a major factor. Gatekeeping good hearing aid and accessibility technology behind a massive financial wall is almost akin to a disability tax. In the future, audiology will have to look subscription models to improve access."

Choice (6 responses)

"Keeping choice for clients. Not one size fits all. Manufacturers has [sic] specific sound recommendations, Clients like choice. Clients are doing more research prior to visiting."

Client awareness of hearing difficulties (2 responses)

"more client awareness of listening difficulties with normal pure tone audiograms"

8. View on services

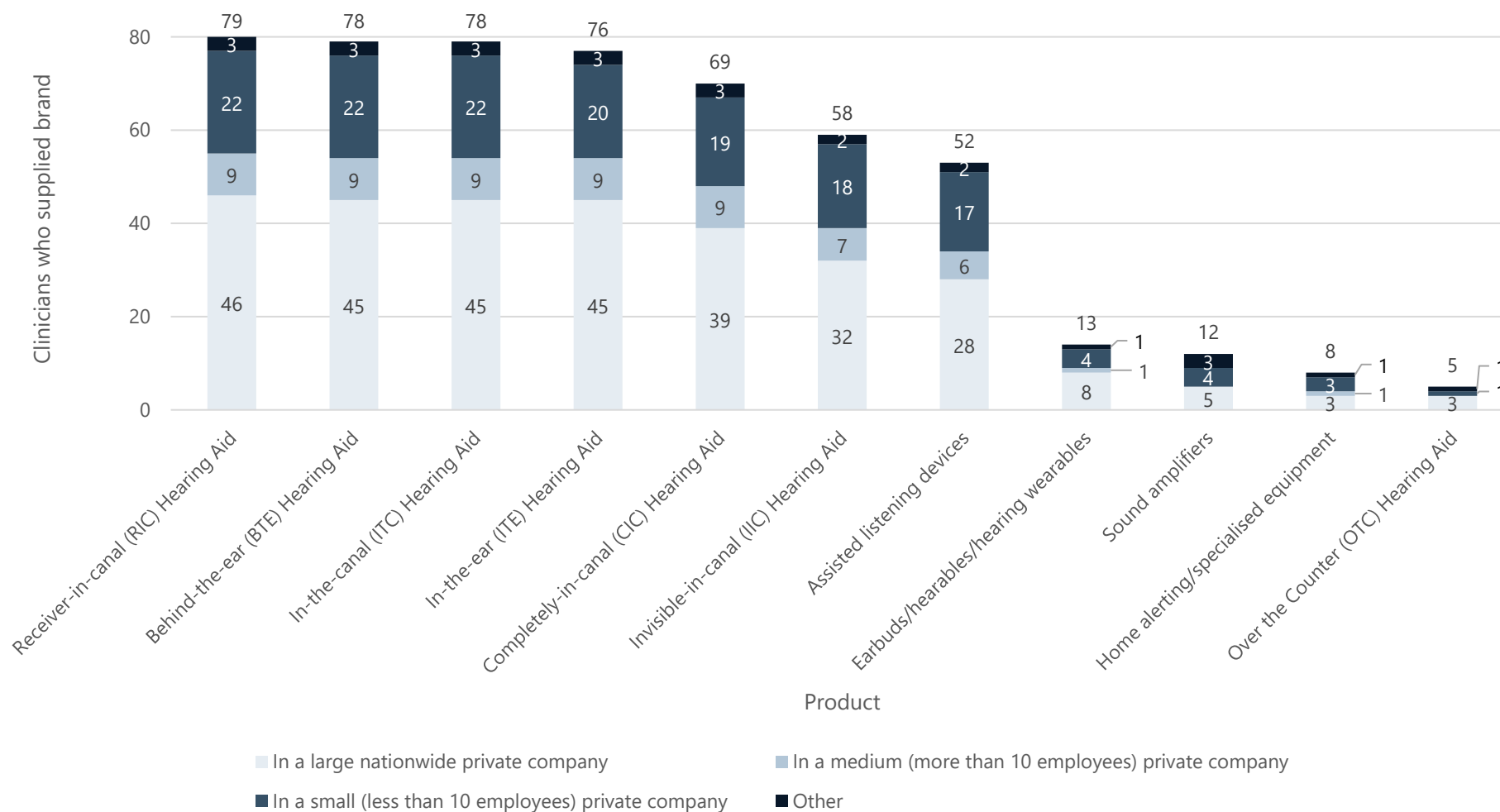
32. In relation to hearing aids/hearing support, what span of products types do you supply (please tick all that apply)?

In relation to hearing aids, what span of manufacturers do you typically supply (please tick all that apply)?

Total responses to Q32 – 79 responses

Respondents reported most common supply and fairly even spread of RIC, BTE, ITC, and ITE with only small reductions for CIC then IIC and then assisted listening devices. A smaller portion supplied other products.

Figure 36: Products provided by clinics by business type



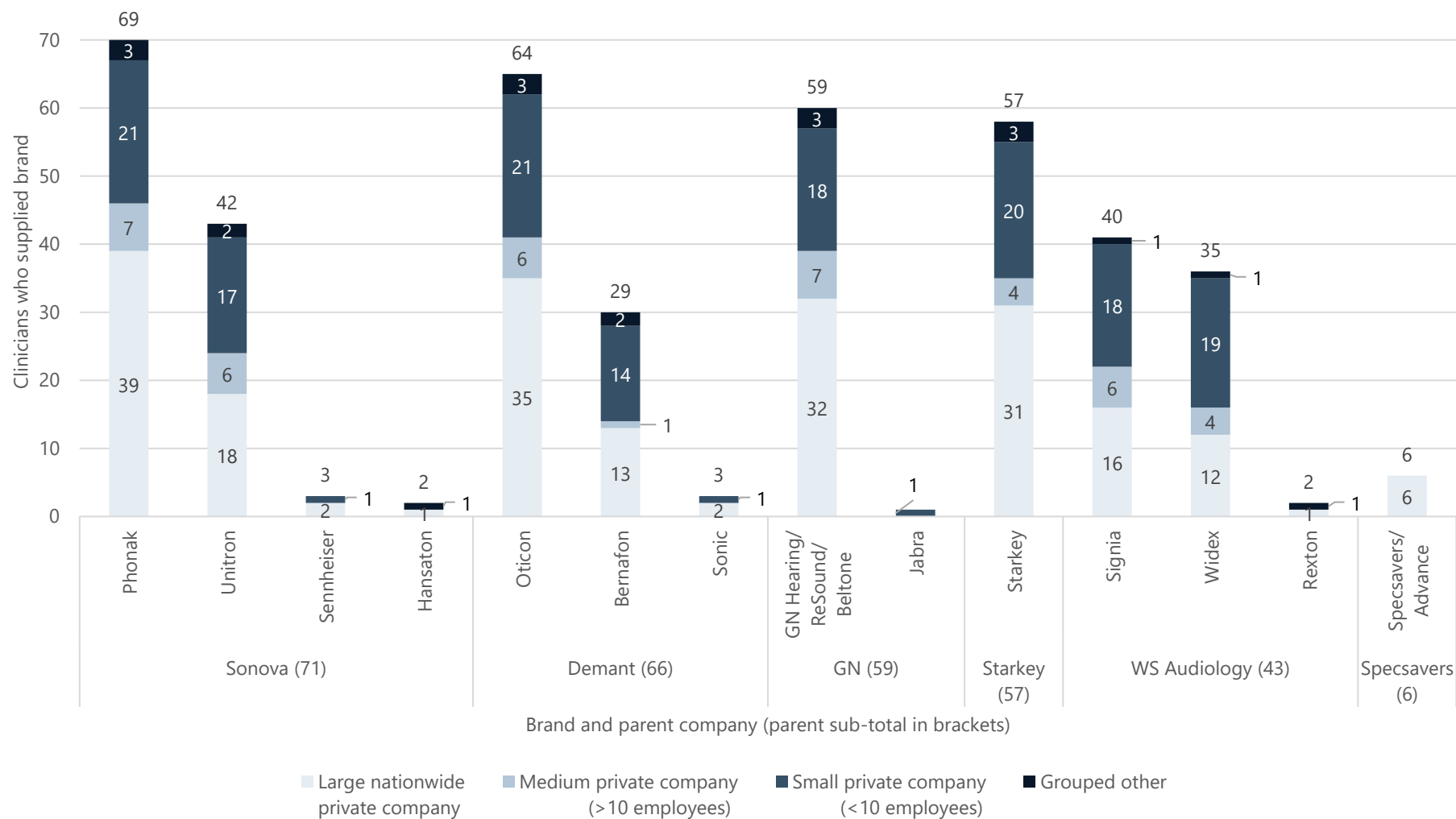
Note: due to some respondents reporting multiple business types, they may appear twice in a category. They are not counted twice in the total value.

33. In relation to hearing aids, what span of manufacturers do you typically supply (please tick all that apply)?

Total responses to Q33 – 78 responses

The greatest portion of respondents reported supplying Phonak, followed by Oticon, GN Hearing, and Starkey. The next tier (also with similar supply rates from smaller businesses) were Unitron, Signia, Widex and Bernafon, with lower portions reporting supply of other brands. Products supplied were brands owned by/associated with Sonnova (4 brands), Dermant (3 brands), WS Audiology (3 brands), GN (4 brands) or Starkey with a smaller portion supplying Specsavers/Advance.

Figure 37: Manufacturers provided by clinics by business type



Note: due to some respondents reporting multiple business types, they may appear twice in a category. They are not counted twice in the total value.

34. What range needs to be offered across the New Zealand market to meet ACC client needs (e.g. type, manufacturer, level of technology, size or speaker size)?

Total responses to Q34 – 62 responses (+1 N/A response)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Full range of styles and technology (43 responses)

"Everything - all styles, manufacturers, and technology levels"

"BTE, RICS, all types of custom aids and rechargeable options. all makes, all levels of tech should be offered to suit needs."

"ACC clients should [sic] have access to all types of hearing aids - what hearing aid is appropriate [sic] to a client depends on their hearing levels, ear health, canal shape - one type does not fit all. The same with technology - in fact, I think we should be providing more mid and high tier tech rather than less - entry level tech is appropriate for very few peoples lifestyles. Manufacturer choice should also be available - not every manufacturer has a full range of appropriate products (eg bluetooth connectivity is very important to some clients, and many brands do not have universal connectivity with all mobile brands. Another example - if a client needs a BTE, some manufacturers have very large and bulky options, whereas others have more discreet and smaller options which are rechargeable). Speaker size - all need to be available for different levels of loss and canal sizes."

At least several manufacturers (8 responses)

"5 brands at least to ensure a fair trial can be offered to the client 10 channels, bluetooth compatible"

"Phonak, Oticon and Widex - the three biggest brands"

"I would say the major 6 manufactueres [sic] should be offered, all hearing aid style types to meet different client needs and there should be a wide access of technology levels to meet different client needs and budget. Also a [sic] the entire variety of receiver size to meet different hearing loss needs"

Current selection is fine as is (4 responses)

"Good range of technology/styles/brands already offered. The clinics need to ensure that all of these are considered for the patient."

Other (7 responses)

"We really, really, really need to stop over-prescribing RICs. These are favoured by chains as they offer a quick turn around, but aren't suitable for anyone with very waxy ears or management concerns eg. poor eyesight or dexterity - the bulk of ACC clients I have seen."

"I don't see there being a great difference in performance between the brands at a given technology level. The introduction of AI may give one brand a boost compared to its competitors but it won't be long before others catch up. The main problem is ACC funding doesn't appear to be catching up with

the cost of hearing aids (at least if we refer to the price increases we are seeing with providers). Being forced to opt for lower technology because it's the only one fully funded by ACC is the main issue. Especially if that person feels they need a loan to secure a better pair."

"Mid range to premium"

"Ric and bte, basic to mid tech, medium"

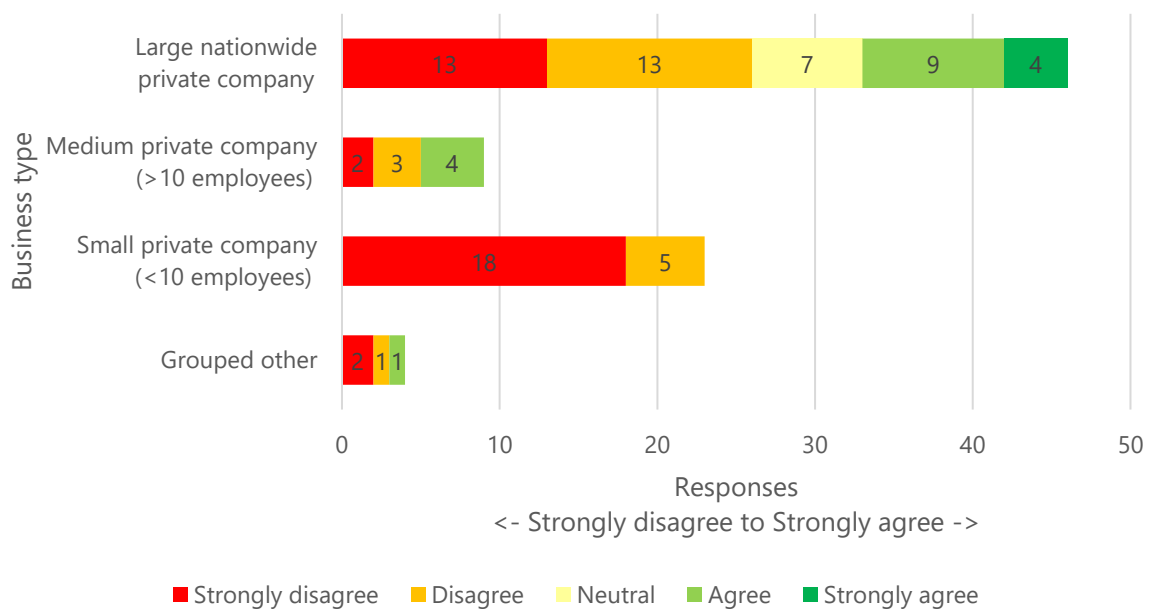
"Receiver in the ear due to the pattern of hearing loss, manufacturer based on clients sensitivity to sound(Eg: if someone is very sensitive then we can give them Oticon for more rounded sound quality and if someone prefers high frequency sharpness for music appreciation we can offer GN resound etc.) Current levels of technology which ACC are offering are meeting most of our ACC clients needs. Wire length Mostly 1 or 2."

35. To what extent do you agree that if the speaker size is sufficient, for a particular type of hearing aid (e.g. BTE), one brand's device can be fit to cover most clients' needs?

Total responses to Q35 – 80 responses

The majority of respondents disagreed with this statement with a higher proportion of respondents from smaller private companies strongly disagreed compared to those from medium or large nationwide companies.

Figure 38: Clinician assessment whether hearing aid speaker size is sufficient by business size



Note: two respondents selected multiple business sizes, leading to double counting in the figure above

36. What works well about ACC-funded audiology service arrangements and why?

Total responses to Q36 – 72 responses (+1 unsure response)

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Funding allows for high levels of service and technology, including repairs and accessories (24 responses)

"Funding is provided albeit quite low funding for majority- band 1. Repairs and ongoing care are covered"

"When funding is approved, ACC provides a great amount of service for the patient (hearing aids, consumables, batteries, repairs)"

"That all funding covers at least an entry level device. That the clients are given a specific amount but are able to pay the difference if they want something that is not covered by the funding."

"ACC funded clients receive quality hearing aids that are suitable for their individual lifestyle and needs as well as good follow up care from our clinic. ACC cover for repairs helps many."

Faster, streamlined claims, including through the new online portal (23 responses)

"Works sufficiently, some clients get frustrating with the capped funding. Clinicians making claim directly has helped reduce the time their claim takes."

"The removal of in person ENT appointments has significantly sped up the process for those waiting for funding."

"The online application process is straight forward and easy to use."

"Since you sped up the decision time, it's worked much better. The online portal makes the process easier too"

Gives clients more funding certainty that they will receive funding (21 responses)

"Decision time has vastly improved. I also believe the shift to a trust-based system has resulted in more approvals for client's whose work history justifies an approval, where in the past there were legitimate claims being declined."

"there is continuity in care as funding is available every 6 years or earlier if there's a big change in client condition"

"People are funded for life"

"It covers the person not just at the initial stages of assessment and fitting but later on when devices break down and need repair. People really appreciate this."

It gives clients choice over which provider and device they choose (14 responses)

"Clients get the choice to top up their funding - it allows freedom to choose while providing the base support meaning no person with a hearing loss will go without and those who are able to afford better hearing aids and who are entitled to ACC funding are able to get better hearing aids. The streamlined process whereby audiologists are able to submit ACC45 claims (rather than GPs) have made things much easier for the clinics and less confusing for clients. Certainty of the entitlements that clients have once their ACC funding has been approved. The eBusiness gateway makes it easy to see what ACC has paid for and if not, why."

"They are able to choose different providers after getting an approval"

"I think the system is good - clients receive funding and it is their choice on which provider, what product etc. to go with."

"Makes better aids more affordable (clients typically pay more to upgrade when possible)"

Makes people consider hearing aids where they may otherwise not have done so (3 responses)

"People who may not have considered hearing aids do so because an avenue is provided"

Other (5 responses)

"Gradual process NIHL claims seem to work well if the claimants are farmers or builders, where the exposure is from a 'traditional' source. Claims seem to be covered if the audiogram matches the text book NIHL dip at 4k."

"It's better than the Ministry of Health subsidies only, but patients still have to compromise on a lot if they're to stay within ACC funding limits."

"Nal calculator - immediate feedback on eligibility and easy to explain to client"

37. What are the opportunities for improvement in the ACC-funded audiology service arrangements?**Total responses to Q37 – 67 responses (+1 unsure response)**

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Funding, including caps and bands, are inadequate (27 responses)

"Some clients get frustrating with the capped funding. As clients get older they are more likely to get band 1 which makes it hard for them to get the most appropriate technology. This was a big change in 2011. \$3000-5000 is not enough toward hearing aids. Help more clients to get the funding they need towards their hearing aids. We're doing more paperwork but not getting covered for this."

"Higher levels of funding - lower band levels means clients c[a]n only access entry level devices fully funded, yet this does not suit their lifestyle. Clients dropping down bands over time also seems unfair - they still have the same amount of noise induced loss."

"The initial funding (assessment/fitting) is good, however, the funding for follow up during the next 6 years is less than adequate (review appointments etc.). Clients who are declined even though their work history and audiogram would suggest otherwise."

The administrative burden is too high (18 responses)

"The new hub is cumbersome, not user-friendly, and has a LOT of duplication compared to the old system. If ACC has approved a client for Band 2, why do I have to re-enter the values on the ACC 611? You already know what they've been approved for."

"Streamline it. Make it more equitable, especially by sex (men vs women)."

"ACC misses email submissions. A portal to submit ACC612, ACC611 would be better"

Eligibility criteria and assessment outcomes are unclear (16 responses)

"More clarity on the process and eligibility criteria for trauma-related cases of hearing loss, tinnitus, hyperacusis and auditory processing disorder."

"better explanation to clients of reasons for decline of funding when noise exposure has been experienced[,] better explanation of what is approved- clients cannot understand the approval letter with funding amounts"

Provide wider service levels to address complex needs and tinnitus (15 responses)

"i feel that even with a very mild loss with and obvious noise history and obvious loss, these should still be considered due to impact that even a mild loss will have on people. Also tinnitus should be an absolute factor and deciding the level of funding as these clients have more complex needs and the damage is having more of an impact on these clients."

"ACC is only funding a very narrow band of those with potential work and injury related hearing losses eg those with TBI, tinnitus and hyperacusis often have a very long, protracted claim process for little funding outcomes or simply give up in the process"

Don't discriminate against older clients (6 responses)

"Older people who have a clear NIHL pattern are deemed ineligible for funding due to high age deductions"

"Continue allowing provider choice. Increase funding sufficiently to allow for fitting of hearing aids with sufficient technology to allow hearing in background noise, if required. Do not move to a one-size-fits all model (see above). Work with ALL manufacturers to select a (truly) mid-level hearing aid in their range with a special ACC price. Use robust, evidence-based science to underpin eligibility decisions. Continue funding for older patients when appropriate, especially if their hearing has been stable over many decades - please do not cut them off just because of their age; the underlying injury may still be a large factor. Put more funding/effort into education re NIHL before it becomes a problem. Also more funding into regulatory enforcement – it's unbelievable the number of road works

and building sites I pass with young people not wearing hearing protection while engaged in noisy work."

On dealing with manufacturers (4 responses)

"Do not use vertically integrated providers who are owned by hearing aid manufacturers or own a hearing aid manufacturing company as they push their own products onto people even when the patient says it doesn't suit them."

"Buy HA's direct from manufacturers and fund like Enable where it's meeting the lifestyle of the person. Still let the person have the option to top up."

More choice is needed (3 responses)

"More options, better deals"

Satisfied with the current ACC-funded audiology service arrangements (2 responses)

"For all intents and purposes, I believe ACC are doing a good job of funding those who it's appropriate for."

Other (6 responses)

"I think ACC could consider adding restrictions on what percentage of mark up an audiology provider can place on a set of hearing devices. (ie no more than 15% plus GST?)"

"Given some providers can supply hearing aids with little to no top-up for the same ACC customer whereas another provider may charge [sic] a couple of thousand or more, surely there should be some auditing in place to monitor margins. I cannot believe the largest provider in the country has to be so much more expensive than the second or even third largest. Surely this would help ensure ACC recipients are getting value for money."

"To save funds work into the model when the client was last fit with aids (e.g. if they upgrade privately or through insurance replacement) - so if they got aids 2 years ago, this pushes the next 612 out until 6 years after fitting. This could free up funds to help cover things like charger repairs perhaps. Currently the client signs to say the aids are no longer meeting their needs on the [sic] 612 re-aid, but in some models (e.g. subscriptions with upgrades 3 yearly) I would think the aids should be meeting the person's needs still! If not, maybe it wasn't the right device for them. I know in some cases, despite a full and comprehensive needs assessment, client lifestyle or needs can change, but this would be more of an exception."

"I would like to see ACC mandate that providers need to provide follow up care after hearing aid fitting. Too often at some places after the fitting people are not called for annual review and so the devices that Acc have provided funding for are not working properly. Is there opportunity for transparency regarding what providers actually pay for aids versus what they charge acc? Addressing that could level things up a bit."

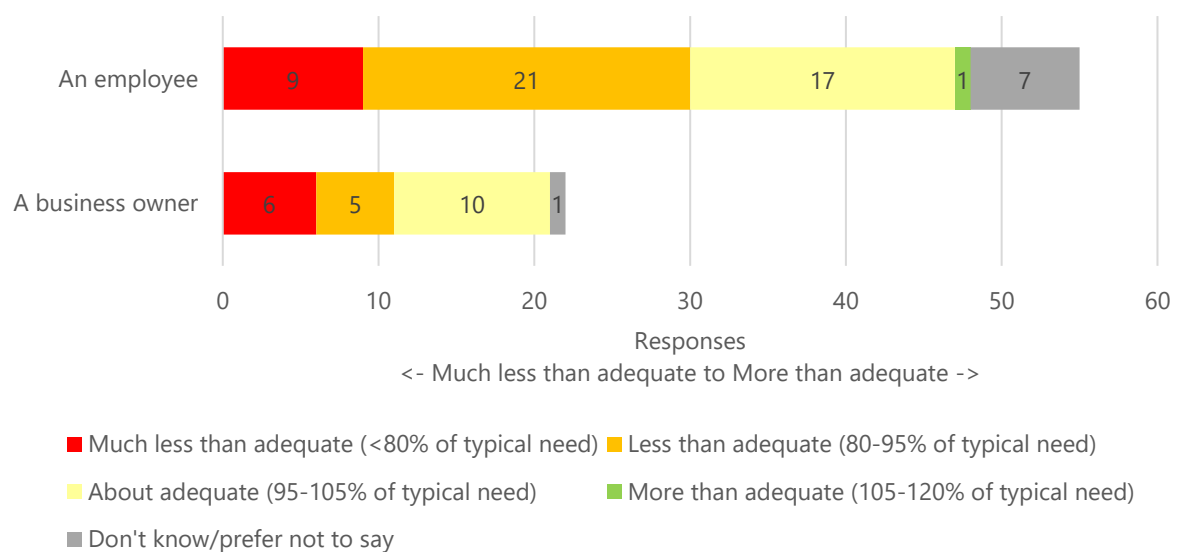
38. How adequate is the current ACC funding in terms of covering the cost of the services provided?

Total responses to Q38 – 77 responses

More than half of respondents indicated that ACC funding was less than sufficient to cover costs, while many thought it was about adequate and only a small portion of those that were employees in medium size businesses indicated it was more than adequate.

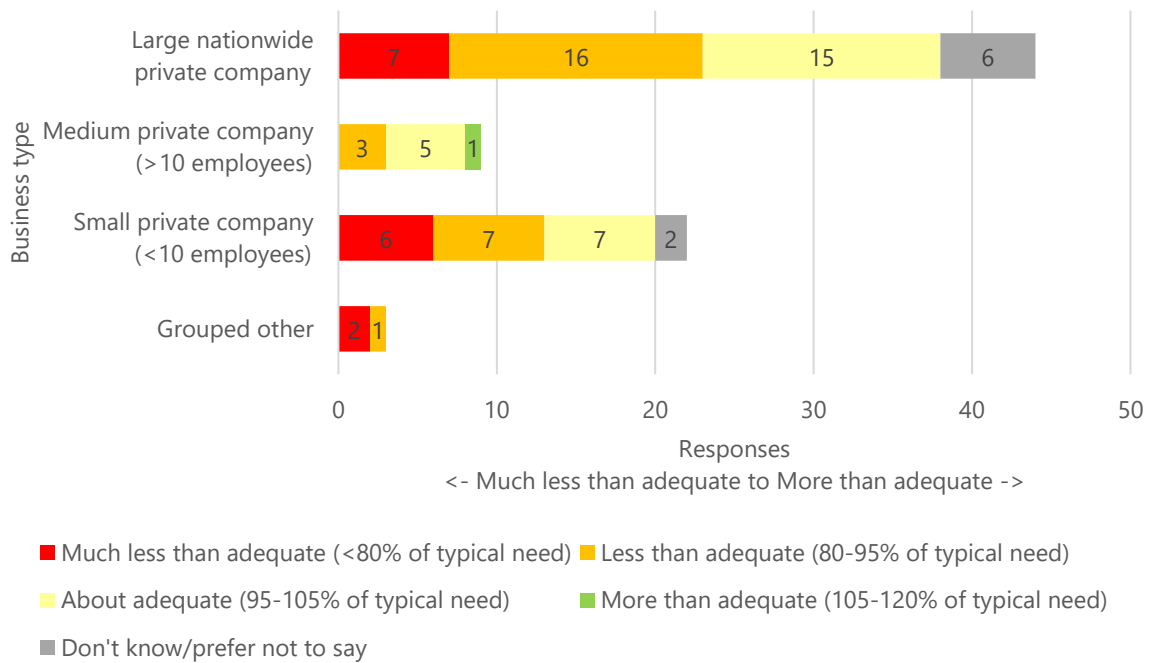
By employee/business owner

Figure 39: Clinician assessment of whether ACC funding is currently sufficient in covering cost by employee/business owner



By company type

Figure 40: Clinician assessment of whether ACC funding is currently sufficient in covering cost by business type



Note: one respondent selected two company types, so is double counted

39. Please explain the reason for your response above.**Total responses to Q39 – 55 responses (+5 unsure OR N/A responses)**

For open-ended questions such as this one, we identify the key themes that were raised, noting that responses have been counted against each theme touched upon (i.e. they may be counted against more than one theme) and are presented in full so they can be read in context (including where they touch on different themes).

Current funding is inadequate (27 responses)

"Grossly underfunded higher technology levels"

"Most of the elderly and patients with poor hearing get minimal funding i.e. bottom tier so unless they are able to top up themselves often end up with inadequate hearing aids. The NAL tables that discriminate regarding age are unfair"

"Just about every clients needs to top up to get the aids they wish to obtain"

"The amount provided to purchase the hearing aids (i.e. the amount apart from the fitting fee) is not enough to even purchase a pair of entry level hearing aids. Typically for an entry level pair of hearing aids, the client with band 1 funding is having to contribute around \$1000 co-payment. If the price of hearing aids (through bulk buying) is lower, the cost to the individual is less."

"40% of clients make a personal contribution"

Current funding is satisfactory (15 responses)

"With our subscription model, ACC funding covers our costs very well."

"I think the current funding provided, when the person has been through a fair claim process, is actually fair."

"Fundings for most services are ok like hearing test, hearing aid discussion, HL21 and HL20"

"The issue is not ACC's coverings. they Provide good levels of funding! The issue is the last of regulations based on how much a pair of hearing aids can be marked up by a manufacturer or audiology provider. I also think that ACC's funding should be reflected in models that are fully funded (for instance, band 1 could be entry, Band 2 could be mid-level, band 3/4 could be high end)"

Other clarifying comments on response to Q37 (8 responses)

"This is hard to answer. At my old employer it was wholly inadequate. I could only offer an Entry level device or mid-tier with Band 3 funding. Whereas now at my new employer it is top tier regardless of coverage. For where I am now, it is adequate. But it was genuinely disheartening at my old employer watching the fully funded tech levels drop, and higher models becoming more expensive with specials to attract top-ups to the top models."

"It needs to be simplified to free up more funds for those that truly need it. Eg set choice of aids (only need two company's products); set funding (one level of funding for everyone); easy portal for ordering aids, less paperwork."

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