

Evidence-Based Response to the MRAC Draft Report on the Inclusion of Audiometrists as Eligible Providers for Limited Audiology MBS Items

This document provides an evidence-based response to selected findings in the MRAC draft report regarding the inclusion of audiometrists as eligible providers for limited audiology Medicare Benefits Schedule (MBS) items.

It is intended to support the Committee in its consideration of the final recommendation by ensuring that conclusions are aligned with current service delivery practice, available evidence, and the objectives of the MBS Continuous Review.

The draft report acknowledges that audiometrists currently perform related services within scope, including under government-funded programs and in regional and rural areas. However, several conclusions rely on assumptions regarding training and professional roles that are not supported by current service delivery practice or available evidence.

1. “Audiometrists primarily conduct hearing tests to determine what hearing aid model might be fitted.”

This statement does not fully reflect current practice. It characterises the role of audiometrists as primarily device-focused and does not acknowledge their involvement in diagnostic assessment, interpretation, referral decisions, rehabilitation planning and counselling within established programs such as the Hearing Services Program (HSP).

The report itself recognises that audiometrists perform services mapped to the MBS items under review within government-funded programs. This indicates that their role extends beyond hearing aid selection and includes broader clinical responsibilities.

Implication:

This interpretation may underrepresent the current contribution of audiometrists to diagnostic service delivery and therefore may not fully reflect their capability within defined scopes of practice.

2. “A person suspected of having hearing loss by an audiometrist would need to be referred to an audiologist to confirm the diagnosis.”

This statement does not reflect typical clinical pathways in hearing care.

In practice, audiometrists conduct diagnostic assessment and determine appropriate management within their scope of practice. Where hearing loss can be managed through rehabilitation, including hearing devices and counselling, this is addressed

directly. Where findings indicate a medical condition or require further investigation, referral is made to a general practitioner for medical management or onward referral to an otolaryngologist.

Referral to an audiologist is not routinely required to “confirm” a diagnosis, nor is it a standard step in the majority of patient pathways.

Implication:

This assumption does not reflect real-world models of care and overstates the role of audiologists in routine diagnostic pathways. While referral to an audiologist is appropriate in defined circumstances, it is not required to confirm a diagnosis in most cases and is not a standard component of care.

3. “Audiometrists alone cannot address equity of access issues.”

This statement is valid in isolation but does not fully reflect the intent of the proposal. The proposal does not position audiometrists as a standalone solution, but rather as part of a broader, complementary workforce model.

In cases where further investigation is required, referral pathways are typically directed to medical practitioners. This applies across both audiometrists and audiologists, and therefore does not represent a distinguishing limitation of audiometrists within the services under consideration.

Available data indicate a mismatch between where services are delivered and where patients live. A higher proportion of patients reside in regional, rural and remote areas compared to the proportion of services delivered in those areas (Figure 3), indicating that access to hearing services remains constrained outside metropolitan locations.

Workforce utilisation data further demonstrate that audiometrists are already contributing meaningfully to service delivery in these areas. While audiologists account for the majority of services overall, the proportion of services delivered by audiometrists increases with remoteness, reaching approximately one-third of services in small rural and remote communities (Figure 4).

This pattern is notable given workforce composition. Audiometrists represent a significantly smaller proportion of the hearing care workforce, with approximately 800 practitioners compared to around 3,500 audiologists. Despite this, their contribution to service delivery increases in non-metropolitan settings, indicating a higher relative presence and utilisation in areas where access is most constrained.

Implication:

Framing the issue as an “either/or” scenario may overlook the role of a distributed, multi-tiered workforce in addressing access challenges. The available data suggest that access constraints persist despite a larger audiologist workforce, and that audiometrists already contribute disproportionately to service delivery in regional and rural areas. Improving access is therefore likely to depend on enabling the existing

workforce to operate effectively across settings, rather than relying on a single workforce group.

4. “People can already access audiometry services through HSP, NDIS, DVA, WorkCover...”

This statement does not reflect the full structure of access to hearing services. Each of these programs is eligibility-based and applies specific criteria, meaning access is limited to defined population groups.

It is also noted that paediatric services, particularly for permanent hearing loss, are primarily delivered through specialised programs such as Hearing Australia. This further illustrates that access pathways are segmented and population-specific, rather than universally available.

As a result, a substantial proportion of the population does not qualify for these programs and must rely on Medicare and private pathways to access clinically necessary hearing services. These programs do not provide universal access and are not substitutes for MBS-supported care.

Broader sector evidence also highlights that access to hearing care is often delayed and underutilised. National consumer research indicates that individuals commonly experience a delay of 4 to 6 years between recognising hearing loss and accessing treatment, with the majority reporting that they should have sought care earlier.

This pattern suggests that existing access pathways are not meeting population needs in a timely or effective manner.

Implication:

The conclusion that unmet need is unclear does not reflect evidence that access to hearing services is both limited by eligibility and delayed in practice. Access to MBS-supported services remains an essential pathway to improving timely and equitable access to care.

5. “The services are not equivalent because training differs.”

Differences in education and training pathways do not, in themselves, determine competency for specific services. The relevant consideration is whether qualified audiometrists are competent to perform the defined MBS items safely and effectively within their scope of practice.

Recent Commonwealth workforce policy developments further support a competency-based approach to service eligibility. The Department has recognised a Limited Scope Audiologist category within the Hearing Services Program whose independent scope of practice aligns substantially with services currently delivered by Audiometrists. While this arrangement relates to the Hearing Services Program rather than the MBS, it demonstrates that Commonwealth policy is capable of recognising practitioners with differing educational pathways where competency, supervision, referral pathways and defined scopes of practice are in place. This

reflects an increasing policy focus on demonstrated capability and authorised scope of practice rather than qualification title alone.

It is acknowledged that audiologists and audiometrists have different training pathways and broader scopes of practice. However, this distinction does not apply uniformly across all services.

For the specific services under consideration including audiometry and tympanometry, service delivery for these specific items is functionally equivalent within defined scopes of practice.

Audiometrists are trained to identify clinical findings that require referral for further diagnostic investigation, medical evaluation, or implantable device consideration, ensuring safe and appropriate care pathways.

While audiologists are trained in a broader range of diagnostic procedures, in practice, the majority of routine hearing services delivered across both professions relate to assessment, monitoring and rehabilitation rather than advanced diagnostics. This reflects real-world service demand and supports the appropriateness of enabling access to these services across the existing workforce.

Service delivery data demonstrate that audiometrists are already performing these services within government-funded programs. Across key Hearing Services Program (HSP) items, audiometrists consistently deliver a substantial proportion of services, typically accounting for approximately 20–23% of claims across assessment, reassessment and client review items (Figure 1).

These services are already being delivered by audiometrists within government-funded programs under established clinical governance frameworks, without evidence of increased risk, adverse outcomes or system failure.

This contribution is consistent across multiple service types, including first assessments, reassessments and ongoing client reviews, indicating that audiometrists are routinely delivering these services as part of standard clinical practice.

Implication:

The available data demonstrate that audiometrists are already delivering these services within established, government-funded programs. In this context, differences in training pathways do not limit the ability to perform these specific services and do not provide a sufficient basis for excluding audiometrists from delivering equivalent MBS items.

6. “Allowing access may disincentivise people from becoming audiologists.”

This statement is speculative and is not supported by evidence presented in the report. Workforce participation and career decisions are influenced by a range of factors, including education access, training pathways, employment opportunities and service demand.

Feedback from stakeholder consultation reflected a range of perspectives on the proposal. Several medical organisations, including Australian College of Rural and Remote Medicine, Australian Medical Association and Royal Australian College of General Practitioners, expressed support or conditional support for expanded access under appropriate clinical governance. Other stakeholders raised concerns, including potential impacts on training pathways and workforce structure.

While these perspectives are important to acknowledge, they reflect differing roles within the current service delivery model rather than evidence of system-level risk. International experience indicates that tiered workforce models can support increased participation in the profession while improving accessibility and patient choice. For example, in the United Kingdom, multiple education and entry pathways into hearing care have contributed to a more distributed and responsive workforce.

Provider eligibility for specific MBS items is typically determined based on patient need, safety and system efficiency. In this context, consideration of workforce structure or training pathway preferences, while relevant to stakeholder views, is not a primary determinant of eligibility.

Implication:

Consideration of potential impacts on professional training pathways is not directly relevant to assessing the safety, efficacy or appropriateness of expanding access to specific services. Decisions regarding provider eligibility are more appropriately guided by evidence of competency, access and patient outcomes.

7. Commercial influence and overdiagnosis of hearing aids

The report raises the potential for commercial influence but also acknowledges that this risk applies to both audiologists and audiometrists. It further recognises that existing MBS requirements, including referral from a medical practitioner, provide a safeguard.

Commercial considerations are a feature of the broader hearing care sector and are not unique to any single professional group. The same regulatory and referral mechanisms apply irrespective of provider type.

Implication:

As this risk is not unique to audiometrists and is already mitigated through existing controls, it does not constitute a differentiating factor in determining provider eligibility

Conclusion

The draft report acknowledges that audiometrists are already delivering services aligned with the MBS items under review within existing government-funded programs and are contributing to service delivery in regional and rural areas.

The available evidence demonstrates that audiometrists are routinely providing these services in practice, contributing disproportionately to service delivery outside metropolitan areas, and operating within established clinical and referral frameworks.

However, several conclusions in the draft report rely on assumptions regarding training and professional roles that are not supported by current service delivery practice or available evidence.

The data presented indicate that access to hearing services remains constrained, particularly for populations outside metropolitan areas and those not eligible for existing programs. At the same time, existing service delivery patterns demonstrate that audiometrists are already a functioning and utilised part of the system addressing these gaps.

The proposal is also consistent with broader Commonwealth workforce reform objectives which seek to optimise the use of existing health workforces, reduce unnecessary barriers to service delivery, and improve access to care in regional, rural and underserved communities. Enabling appropriately qualified and competent Audiometrists to provide limited MBS audiology services represents a practical example of workforce optimisation within an established clinical governance framework.

Ensuring that final recommendations are aligned with both evidence and observed system practice will support the objectives of the MBS Continuous Review in delivering high-quality, accessible and equitable care. Consideration of provider eligibility should be based on demonstrated competency, patient need and system efficiency.

Excluding audiometrists from providing these services under the MBS, despite demonstrated competency, established service delivery and existing system utilisation, risks reinforcing existing access limitations rather than addressing them.

The Australian College of Audiology welcomes the opportunity to contribute to this consultation and would be pleased to provide any further information to support the Committee's deliberations.

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