POLICY PROPOSAL FOR NATIONAL CONSULTATION

A National Audiology Education and Workforce Pathway for Australia

A staged, competency-based model from community hearing and Audiometry pathways to Hearing Rehabilitation Audiology and Specialist Practice

Prepared by	Australian College of Audiology Inc HAASA (ACAud)
Prepared for	National consultation with education, workforce, First Nations, consumer, professional and government stakeholders
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Status	Policy proposal for national consultation with First Nations participation and leadership; not a final accreditation, scope or regulatory standard
Purpose	To propose an attainable education and certification architecture capable of strengthening workforce supply, First Nations participation, regional access and public protection
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"The future of hearing care works best when the workforce works together."

Contents

Important status note
This paper proposes an architecture for national consultation. It does not settle final protected titles, task-level scopes, placement requirements, accreditation or certification ownership, or regulatory category names. Those matters require national competency and risk mapping, direct First Nations participation in matters affecting First Nations students, workforces and communities, workforce evidence, consumer input and formal consultation.

Executive summary

Australia has an opportunity to align audiology education with the way hearing care is actually delivered. Under the current mainstream pathway, an applicant completes a qualifying undergraduate degree that is not required to be in audiology or hearing health before entering a two-year accredited Masters-level audiology program.[5][6] After completing their studies, graduates undertake a one-year clinical internship for professional certification. Australia therefore does not currently have a nationally articulated undergraduate-to-postgraduate audiology pathway: the Masters program carries both foundational professional education and preparation across a broad scope of practice. At the same time, a substantial share of service demand is concentrated in community hearing assessment, hearing rehabilitation, device management, counselling and ongoing hearing care.

ACAud does not propose lowering standards. It proposes placing the right standard at the right level of practice. A single postgraduate entry model attempts to prepare every graduate for the full breadth of audiology before the graduate has chosen, entered or maintained a specialty. In practice, many Masters-qualified clinicians work predominantly in hearing rehabilitation. Advanced competencies that are not used regularly may not remain current, while the education pathway remains lengthy, expensive and difficult to access for many regional, remote, mature-age and First Nations students.

The proposed alternative is a connected, competency-based pathway that recognises Audiometry and Audiology as distinct professions with separate education, competency and scope requirements, while also recognising the contribution of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners who hold relevant ear and hearing health competencies. It creates genuine progression between four education levels:

- **HLT47425 Certificate IV in Audiometry (AQF Level 4):** a supported hearing assessment qualification for screening and audiometric testing, referral, care coordination and hearing health support. Practice occurs within defined supervision and consultation arrangements, which may be direct, indirect or remote in regional and remote settings. The qualification does not authorise independent prescribing or dispensing of hearing aids.[4][17]
- **HLT57425 Diploma of Audiometry (AQF Level 5):** the recognised qualification for Audiometrists practising within a defined audiometry and hearing rehabilitation scope, including hearing-device prescription and dispensing where certification requirements are met.[4]
- **Bachelor of Audiology (AQF Level 7):** the foundational professional qualification for hearing rehabilitation audiology and the broad community-based work required across much of Australia.
- **Masters-level specialist education (AQF Level 9),** potentially supported by stackable AQF Level 8 Graduate Certificates and Graduate Diplomas: advanced formation in defined specialty areas, followed by a specialty internship and annual renewal and maintenance of specialist certification.

Under this model, the Certificate IV and Diploma provide two distinct VET entry and progression points within Audiometry, the Bachelor is not a reduced Masters, and the Masters is not the universal entry gate to the profession. The Bachelor is a purpose-built professional degree containing the science, clinical reasoning, assessment, rehabilitation, communication, ethics, cultural safety and integrated clinical training required for safe hearing rehabilitation practice. Masters and postgraduate education then become true specialist formation.

Core proposition

Build an accessible workforce ladder from Certificate IV and Diploma through Bachelor-level professional formation; reserve Masters/postgraduate education for advanced and specialist practice; and maintain specialist authority through recency, clinical exposure and annual renewal and maintenance of specialist certification rather than qualification title alone.

ACAud's current working estimate is that approximately 85% of workforce need is concentrated in hearing rehabilitation and community service delivery. That estimate should be independently tested through a national workforce and service-mix study and should not be treated as a settled national statistic. The scale of the Australian Government Hearing Services Program nevertheless demonstrates the importance of rehabilitation services: Departmental figures show that 834,048 Australians received program support across 3,510 service sites in 2024–25.[7]

The proposal is designed to support public protection and workforce growth simultaneously. It includes national competency standards, accredited programs, integrated clinical assessment, defined scopes, public clinician verification, specialist certifications, recency requirements, continuing professional development, complaints and conduct mechanisms, and fair transition arrangements for existing Audiometrists and Audiologists.

For Aboriginal and Torres Strait Islander students and communities, the pathway should support meaningful First Nations participation in shaping education and workforce arrangements that affect them, while remaining within applicable national education, accreditation and regulatory requirements. It should recognise existing Aboriginal and Torres Strait Islander Health Worker and Health Practitioner pathways, including relevant ear health and audiometry competencies, and enable supported articulation through Certificate IV and Diploma Audiometry, Bachelor and specialist education where individuals choose to progress. It should include earn and learn entry, paid placements, regional and community based delivery, local supervision, recognition of prior learning, culturally responsive learning and employment environments, and progression into research, governance and leadership. Universities, governments and professional bodies should work directly with First Nations people, communities and organisations to support equitable participation and locally appropriate delivery.[8][13][14]

ACAud therefore proposes a time-limited, milestone-based period of education and workforce reform before final regulatory architecture is settled. The period should not be indefinite. It should be tied to a national taskforce, workforce mapping, agreed competency frameworks, accreditation standards, transition plans and transparent public reporting.

Proposed national actions
1. Use the four-level pathway as a basis for national consultation rather than treating the current postgraduate-first model as fixed.
2. Establish a time-limited, milestone-based education and workforce reform program, with six-month public reporting, an 18-month progress and accountability review and a consolidated pathway implementation and evidence report at five years.
3. Establish an independently chaired reform taskforce with direct First Nations participation in matters affecting First Nations students, workforces and communities, meaningful consumer representation and balanced sector expertise.

1. Purpose and status of this proposal

This paper responds to the need for a more coherent and attainable solution for hearing-health education and workforce development. It provides a concrete alternative to treating the present postgraduate-first education architecture as fixed and proposes a staged pathway that can be tested through national consultation, competency mapping and workforce evidence.

The proposal does not seek to predetermine or avoid any future regulatory outcome; it seeks to ensure that future decisions are informed by a properly developed education, competency and workforce pathway.

The proposal builds on ACAud's earlier work advocating for connected Audiometry-to-Audiology progression, clearly differentiated scopes and competency at the point of qualification and practice. It now incorporates the current HLT47425 Certificate IV in Audiometry as a formal first level in the audiometry pathway.[1][2]

1.1 What this paper seeks to achieve

- provide Australia with a sustainable education pathway matched to population and service need;
- create a clear professional foundation in undergraduate education;
- allow Masters-level education to become genuine specialist formation;
- recognise the existing Certificate IV- and Diploma-qualified Audiometry workforce within a connected national education and workforce pathway;
- create attainable and supported pathways with meaningful First Nations participation in their design and delivery, including regional, rural, remote and mature-age entry and progression;
- reduce unnecessary educational barriers without reducing competency standards;
- support transparent scopes, specialist certifications and public protection; and provide a defined, reviewable reform program with transparent milestones rather than an open-ended reform process.

1.2 What this paper does not propose

- It does not collapse Audiometry and Audiology into one interchangeable profession.
- It does not remove the need for advanced education in paediatrics, vestibular practice, cochlear implants, complex diagnostics or other specialist areas.
- It does not assume that a qualification title alone establishes current clinical competence.

- It does not require existing Certificate IV- or Diploma-qualified Audiometry practitioners to complete a Bachelor degree in order to retain an existing recognised scope for which they are currently qualified, certified and competent.
- It does not diminish the status of current Masters-qualified Audiologists or remove existing competencies that are current and demonstrable.
- It does not predetermine how annual renewal and maintenance requirements for specialist certification would be established or administered by ACAud and Audiology Australia, including whether a nationally aligned approach should be developed.

2. Why the current architecture requires reform

2.1 The current pathway is postgraduate-first

Under the present mainstream Australian pathway, applicants enter an accredited two-year Masters-level audiology program after completing a qualifying undergraduate degree.[5][6] The prior Bachelor degree is not required to be in audiology or hearing health and does not form part of an articulated audiology sequence. After completing their studies, graduates complete a one-year clinical internship to obtain professional certification. Audiology Australia currently lists seven accredited postgraduate programs.[6]

This model can produce highly educated graduates, but it also makes Masters education the minimum gateway for all audiology work, regardless of whether the graduate will ultimately practise mainly in adult hearing rehabilitation or in a highly specialised setting. It delays entry to the workforce, increases cost and assumes that broad specialist preparation should occur before the practitioner's long-term practice area is known.

2.2 The qualification is broad, but practice is often concentrated

Masters programs necessarily expose students to a wide range of audiology domains. After graduation, however, many clinicians enter community and rehabilitation-focused roles. Skills in specialist domains may not be routinely used. The issue is therefore not that the clinician "loses" a qualification. The issue is that authority to practise safely should reflect current competence, recency, supervision and clinical exposure, not only what was studied at university.

A model that front-loads advanced content but does not create formal post-qualification specialty pathways can produce two unsatisfactory outcomes:

- the system pays the access and workforce cost of universal Masters entry; while
- specialist workforce capacity still depends on employer exposure, local supervision and informal opportunities after graduation.

2.3 The service system is heavily dependent on rehabilitation

The Australian Government Hearing Services Program funds assessment, rehabilitation and devices through a national provider network. Departmental figures show that 834,048 Australians received program support through 3,510 service sites in 2024–25. These figures do not describe the entire hearing workforce or establish the exact proportion of work undertaken in rehabilitation, but they demonstrate the scale and geographic importance of community hearing services.[7]

ACAud's working estimate that approximately 85% of workforce need sits in hearing rehabilitation should be tested through independent workforce mapping. The proposed model

remains sound even if the final percentage differs: Australia requires a large, accessible and competent rehabilitation workforce, alongside smaller but essential specialist workforces.

2.4 Existing education pathways do not form a coherent ladder

Australia already has two nationally endorsed VET qualifications in Audiometry. The current HLT47425 Certificate IV in Audiometry (AQF Level 4) is a supported practice qualification for workers who assist with hearing assessment through hearing screening and audiometric testing. The qualification description expressly includes hearing screeners, allied health assistants, nurses and Aboriginal and Torres Strait Islander health workers. The qualification requires supervision by a Diploma qualified Audiometrist, Audiologist or other medical practitioner, but this should not be interpreted as requiring an on site supervisor. HLTAHA048, a core unit in the qualification, recognises direct, indirect and remote supervision in rural and remote settings. This enables a practitioner to work locally while maintaining access to an appropriately qualified clinician for consultation, case discussion and escalation. Certificate IV practitioners do not prescribe or dispense hearing aids, and the qualification does not confer an autonomous clinical scope. The HLT57425 Diploma of Audiometry (AQF Level 5) prepares Audiometrists for comprehensive hearing assessment and hearing rehabilitation, including prescription and dispensing of hearing aids and other listening devices. The two qualifications form an endorsed progression pathway, with Certificate IV units able to provide credit into the Diploma.[4][17]

The AQF positions the Certificate IV as preparation for specialised skilled work and further learning, the Diploma as preparation for advanced skilled or paraprofessional work and further learning, the Bachelor as preparation for professional work and further learning, and the Masters as preparation for advanced professional practice or scholarship.[3]

The issue is not the absence of qualification levels or undergraduate innovation. It is the absence of a nationally agreed competency, scope and articulation framework connecting them. Certificate IV graduates should have a transparent pathway into the Diploma; Diploma-qualified Audiometrists should be able to progress through transparent credit and bridging to the proposed Bachelor of Audiology without repeating equivalent learning; and Bachelor-qualified Audiologists should be able to enter a specialty Masters without re-learning the same foundational content. Charles Darwin University also offers an AQF Level 7 Bachelor of Audiometry designed for Diploma-qualified Audiometrists, delivered online and including work-integrated learning. It should remain an important existing articulation pathway within the ladder.[11]

Separate but connected First Nations primary health care qualifications also carry relevant ear and hearing health capability. HLT40121 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care and HLT40221 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice include ear-health learning options; HLT40221 also includes current audiometry units such as HLTAUD007, HLTAUD008 and HLTAUD009. HLT50121 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice contains an ear and hearing health elective group including HLTAHCS014 and HLTAUD007-HLTAUD010. These roles are distinct from Audiometry and Audiology and should be explicitly recognised within the hearing workforce where the relevant competencies are held.[13][14]

2.5 Access barriers are workforce barriers

A postgraduate-only entry point is least attainable for students who cannot relocate twice, carry multiple years of university cost, undertake lengthy unpaid placements or defer income until after postgraduate study. These barriers are magnified for regional and remote students, people with family and caring responsibilities, mature-age workers and First Nations students.

An education model cannot claim to solve workforce shortages if its structure excludes many of the people and communities Australia needs in the workforce.

2.6 Education reform should precede decisions that may entrench the current model

Australia's education and workforce architecture must be capable of supporting training capacity, supervision, regional placements, First Nations participation and specialist workforce supply. These outcomes cannot be achieved through regulatory settings alone. If system settings are built around the current postgraduate-only architecture before education reform is considered, Australia risks embedding unnecessary barriers and preserving the mismatch between qualification, actual work and maintained competence.

Policy test
The question is whether Australia's hearing health workforce is supported by an education and competency architecture that is coherent, attainable, responsive to workforce need and capable of maintaining appropriate standards of public protection. The priority should be to establish that architecture on its merits, supported by evidence, clearly defined competencies and genuine pathways for progression.

3. Principles for a national pathway

Principle	Application
Consumer safety first	Every level must have defined competencies, limits, referral requirements, supervision expectations and conduct obligations.
Competence over title alone	Qualification establishes educational attainment; current authority to practise must also reflect assessed competence, recency and clinical exposure.
Distinct professions, connected pathways	Audiometry and Audiology retain distinct qualification and scope foundations, with clear articulation rather than artificial barriers.
No educational dead ends	Every qualification should support employment and provide a recognised pathway to further learning.
Proportionate education	The length and level of education should be matched to the complexity and risk of the work.
Specialty is earned and maintained	Specialist authority should follow specialty education, supervised practice and ongoing certification.
First Nations partnership and leadership	First Nations priorities, experience and local context should inform the design, delivery and evaluation of pathways affecting First Nations students, workforces and communities.
Regional viability	Programs must be capable of distributed delivery, local placements and supported remote supervision.
Transition fairness	No existing practitioner should lose an established scope without evidence of risk and a fair, supported transition process.
Data and review	Workforce assumptions, outcomes and safety indicators must be measured and the model adjusted where evidence requires it.

4. The proposed four-level education model

The proposed pathway uses the existing AQF architecture but assigns each level a clear workforce purpose. It is not a hierarchy of professional worth. It is a structure of increasing breadth, autonomy, complexity and specialisation, with distinct exit points that support safe employment and further learning.

Stage	Qualification	Professional recognition	Primary workforce purpose	Progression
Level 1	HLT47425 Certificate IV in Audiometry AQF Level 4	Supported audiometry practice (proposed pathway descriptor, subject to consultation)	Hearing screening and audiometric testing within defined supervision arrangements; recognition of potential hearing impairment and ear disorders; referral, care coordination, hearing device management support and hearing health education. In regional and remote settings, supervision may be indirect or remote. No independent prescribing or dispensing.	Employment in supported hearing health roles plus structured credit into the Diploma.
Level 2	HLT57425 Diploma of Audiometry AQF Level 5	Rehabilitation Audiometrist (proposed designation, subject to consultation)	Defined independent audiometry and hearing rehabilitation services, including comprehensive assessment, hearing devices, communication support, counselling, education, monitoring and referral within certified scope.	Employment plus structured credit into Bachelor pathways, including recognition of the existing Bachelor of Audiometry.
Level 3	Bachelor of Audiology AQF Level 7	Audiologist - Hearing Rehabilitation (proposed designation, subject to consultation)	Foundational professional audiology for adult/community hearing assessment and rehabilitation, device verification, counselling, communication support, clinical reasoning, referral and population hearing health within defined scope.	Direct entry from school or articulation from Audiometry pathways; progression into Masters/postgraduate specialties.
Level 4	Masters degree - AQF Level 9, potentially supported by stackable AQF Level 8 Graduate Certificates and Graduate Diplomas	Audiologist with specialist certification(s)	Advanced and complex practice in defined specialty domains, following specialty education and supervised clinical formation.	Multiple specialist certifications, research, education, leadership and advanced practice.

4.1 A Common Competency Spine

All four levels should be aligned to one national competency framework. The framework should identify what is common across the hearing workforce and what changes in depth, autonomy, complexity and risk at each level. Work should begin with the current ACAud Professional Competency Standards for Audiologists and Audiometrists, together with the competencies contained within the Certificate IV and Diploma of Audiometry. Other relevant professional competency frameworks should also inform the national mapping process. The task is to map existing competencies transparently across the proposed pathway, identify gaps and overlaps, and determine through national consultation the competency expectations that should apply at each level[4][12][18]

- ethical and person-centred practice;
- communication and counselling;
- cultural safety and culturally responsive care;

- scientific and clinical foundations;
- assessment and interpretation;
- rehabilitation and technology;
- clinical reasoning, referral and escalation;
- documentation, privacy and information governance;
- evidence-informed practice and quality improvement;
- interprofessional and team-based care; and
- professional accountability, continuing development and recency.

4.2 Multiple entry and exit points

Students should be able to enter directly into the Certificate IV, Diploma or Bachelor where admission requirements are met, and should be able to progress from Certificate IV to Diploma and from Audiometry qualifications into Bachelor pathways with transparent credit. Bachelor graduates should be employable in a defined professional scope and may later return for modular specialty study. A person should not have to decide at the beginning of their education whether they will eventually practise in paediatrics, vestibular care, cochlear implants or another specialty.

4.3 International feasibility

Undergraduate audiology education is not without precedent. The University of Southampton offers a three-year BSc Audiology with clinical and professional preparation, while Aston University offers a three-year BSc Healthcare Science (Audiology) with integrated clinical learning, a degree-apprenticeship option and a direct-access final-year route. These examples should not be copied without Australian consultation, but they demonstrate that bachelor-level professional audiology education, integrated clinical formation and articulated or earn-and-learn pathways are feasible.[9][10]

4.4 Connecting First Nations health pathways with the national hearing health pathway

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners should not be treated as an additional rung beneath Audiometry or Audiology. They are established and distinct workforce roles within primary and community health care, and Aboriginal and Torres Strait Islander Health Practice is a registered health profession under the National Law. Current national qualifications include relevant ear and hearing health and audiometry competencies. Where individuals hold these competencies, they should be recognised within their existing qualification, registration where applicable, employment scope and clinical governance arrangements.[13][14][15]

The national pathway should create formal mechanisms for competency recognition, credit and RPL into HLT47425 and HLT57425 where an individual chooses to progress, and from there into Bachelor and specialist education. Design and implementation should occur with Aboriginal and Torres Strait Islander communities, community-controlled organisations and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP), without displacing the existing identity or authority of that workforce.[16]

5. The Bachelor of Audiology as the foundational professional qualification

Australia already has an undergraduate hearing health pathway through the Bachelor of Audiometry offered by Charles Darwin University. That program provides an important AQF Level 7 pathway for Diploma qualified Audiometrists and demonstrates the feasibility of flexible, employment linked undergraduate education in hearing health.[11]

The proposed Bachelor of Audiology should build on this existing education architecture and the established Certificate IV to Diploma Audiometry pathway, rather than unnecessarily duplicating learning or creating new barriers to progression. National consultation should consider how the existing Bachelor of Audiometry, Diploma qualifications and demonstrated clinical competencies could articulate into the Bachelor of Audiology through appropriate credit, recognition of prior learning and bridging arrangements.

This could include alternative articulation models for experienced Diploma qualified Audiometrists, including appropriately designed Undergraduate Certificate or other bridging pathways where the required Bachelor level learning outcomes can be demonstrated. The objective should be to provide more than one attainable route to the Bachelor of Audiology while maintaining the agreed competency and accreditation requirements.

The Bachelor of Audiology should be designed as a complete, purpose built professional program, not as a shortened version of the current Masters. It should integrate audiological science, clinical assessment, hearing rehabilitation, communication support, hearing device management, counselling, culturally responsive practice, ethics, referral pathways, interprofessional practice and clinical governance throughout the degree.

Existing Certificate IV, Diploma and Bachelor of Audiometry qualifications should be appropriately recognised within the articulation framework, with transition arrangements for current students and graduates and no unnecessary repetition of learning or competencies already demonstrated.

5.1 Proposed graduate outcome

At graduation, a Bachelor-qualified practitioner should be able to assess, plan, deliver, verify, review and document hearing rehabilitation services safely for the defined population and complexity covered by the accreditation standard. The graduate should recognise red flags, know when the presentation exceeds scope, and refer or collaborate appropriately.

5.2 Proposed curriculum domains

Domain	Required educational outcome
Foundational sciences	Anatomy and physiology of hearing; acoustics; psychoacoustics; lifespan development; communication science; relevant pathology and pharmacology foundations.
Clinical assessment	Case history, otoscopy and ear-health screening within scope; behavioural audiometry; speech testing; middle-ear assessment; interpretation; risk recognition and referral.
Hearing rehabilitation	Needs assessment; shared decision-making; hearing device selection and fitting; verification; outcome measurement; communication strategies; counselling; family-centred support; assistive technology; ongoing care.
Technology and data	Hearing device systems; digital and connected care; teleaudiology; cybersecurity, privacy and clinical data quality; emerging technology and AI literacy.
Public and population health	Prevention, screening, occupational and community hearing health, service navigation, health literacy and access inequity.

Domain	Required educational outcome
Cultural safety	First Nations cultural safety and anti-racism; culturally and linguistically responsive care; disability inclusion; trauma-aware and respectful communication.
Professional practice	Ethics, consent, boundaries, documentation, evidence appraisal, quality improvement, teamwork, referral, supervision and professional accountability.
Integrated clinical education	Progressive simulation, placements and workplace-based assessment across metropolitan, regional, rural, remote and community contexts where possible.

5.3 Clinical competency at completion

The degree must include sufficient integrated clinical experience for graduates to demonstrate the agreed minimum competencies. The national accreditation process should determine the required placement quality, case mix, supervision and assessment arrangements, rather than relying on a single placement-hours number as a proxy for competence.

Graduation and professional certification should require multiple forms of evidence, including observed clinical practice, structured clinical examinations, case-based reasoning, written assessment, communication assessment and supervisor sign-off. Where a transition-to-practice period is retained, it should be paid, competency-based, time-limited and integrated with employment rather than an additional unfunded educational barrier.

5.4 Scope boundary

The Bachelor scope should be broad enough to meet Australia's hearing rehabilitation need, but it should not imply unsupervised authority in every advanced domain. Complex paediatric diagnosis, advanced vestibular testing, cochlear implant programming, electrophysiology, complex hospital diagnostics and other high-risk or low-volume work should require a relevant specialist certification.

5.5 Why this is not a lowering of standards

A Bachelor degree sits at AQF Level 7 and is expressly intended to prepare graduates for professional work. Standards are determined by the competency outcomes, clinical formation, assessment and governance attached to the degree. Requiring a Masters title for work that can be safely and completely prepared at Bachelor level is not automatically safer; it may simply make the workforce smaller and less accessible.[3]

6. Masters education as true specialist formation

Under the proposed model, Masters education is not removed. It is strengthened by giving it a clearer purpose: advanced and specialist practice. The Masters should build on a common Bachelor foundation and take the practitioner to greater depth, complexity, autonomy and clinical responsibility in a defined field.

6.1 Potential specialty pathways

- Paediatric audiology and family-centred childhood hearing care;
- Cochlear implants and implantable hearing technologies;
- Vestibular assessment and rehabilitation;
- Advanced diagnostic audiology, electrophysiology and complex medical pathways;

- Auditory processing and complex listening assessment;
- Tinnitus, hyperacusis and complex sound-tolerance care;
- Complex adult and hospital-based audiology;
- First Nations ear and hearing health advanced practice, developed with First Nations people and organisations and aligned with applicable education and professional standards;
- Public health, population hearing, education, research and clinical leadership pathways where advanced practice standards are appropriate.

6.2 Stackable postgraduate design

Specialty education should be flexible. Graduate Certificates and Graduate Diplomas may stack into a Masters where the AQF and accreditation standards permit. This allows practitioners to build capability while working and reduces the need to leave regional communities for long uninterrupted periods.

A specialty program should include advanced theory, simulation, supervised practice, workplace-based assessment and a defined specialty internship or residency. Completion of academic units alone should not activate independent specialist authority.

6.3 Specialty internship or residency

The internship should occur in the specialty after the practitioner has chosen that field. It should have a defined case mix, minimum supervision capability, transparent assessment points and an alternative pathway where local case volume is insufficient. Distributed supervision, cross-site rotations and tele-supervision may support regional participation, but must not substitute for direct observation where the competency requires it.

6.4 Preventing scope attrition

The proposed model separates a practitioner's base professional qualification and recognised scope from any additional specialist certification. A Masters-qualified Audiologist who moves from a specialist role into hearing rehabilitation retains recognition as an Audiologist and retains their existing recognised scope, subject to ordinary recency, conduct and competency requirements.

Specialist certification in a particular advanced area remains active only while the practitioner meets the relevant recency and maintenance requirements for that specialty. This approach preserves the standing of the practitioner's original qualification and professional recognition while ensuring that current specialist certification reflects maintained competence in the relevant specialty.

6.5 AuD out of scope

The Doctor of Audiology (AuD), as utilised in some international jurisdictions, has not been specifically considered within this framework. The purpose of this framework is to strengthen and align Australia's existing education and workforce pathways, which are currently based on recognised audiology master's level qualifications and associated accreditation processes. While doctoral-level qualifications may form part of future discussions regarding advanced practice, research capability or professional specialisation, consideration of an AuD qualification is outside the scope of the current workforce pathway work and would require separate consultation involving universities, accreditation bodies, regulators and the profession.

7. Annual renewal and maintenance of specialist certification

After completing the specialty education and internship, the practitioner should be eligible for specialist certification in the relevant field. Existing public clinician lookup mechanisms should enable verification of the practitioner's professional category and each current specialist certification.

7.1 Proposed annual requirements

Requirement	Proposed evidence
Professional standing	Current registration or recognised professional certification; professional indemnity insurance; fit-and-proper declarations; compliance with conduct and notification requirements.
Continuing development	A defined portion of annual CPD directly relevant to each specialist certification.
Recency of practice	Evidence of recent clinical exposure or an approved simulation, supervised practice or re-entry pathway where case volume is low.
Clinical governance	Participation in audit, peer review, case review, supervision or quality-improvement activities appropriate to the specialty.
Competency concerns	Targeted reassessment where complaints, prolonged absence, restricted practice or other evidence raises a competency concern.
Public transparency	Current specialist certification status able to be verified through the existing public clinician lookup mechanism.

7.2 Certification should be proportionate

Annual renewal and maintenance of specialist certification should not require every specialist to repeat a full examination each year. A risk-based model should use declarations, CPD, recency, audit and portfolio evidence, with examination or observed reassessment when evidence indicates it is necessary. The objective is maintained competence, not administrative burden.

7.3 Multiple specialist certifications

A practitioner may hold more than one specialist certification, but each must be maintained separately. For example, an Audiologist may maintain active specialist certifications in cochlear implants and paediatric audiology while allowing vestibular specialist certification to become inactive. Re-entry requirements should be clear and fair.

Public protection benefit
Consumers, employers and referrers would be able to distinguish the practitioner's base qualification from the specialist areas in which current competence has been certified.

8. First Nations, regional and accessible pathways

The proposed pathway will improve access only if Aboriginal and Torres Strait Islander peoples have meaningful involvement in shaping the education and workforce arrangements that affect their communities. The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan seeks representation across all health disciplines, roles and levels, sufficient student participation and completion, culturally

safe workplaces and clear career pathways. The audiology model should explicitly contribute to those objectives.[8]

8.1 First Nations partnership and leadership

Education and workforce pathways should be developed in partnership with Aboriginal and Torres Strait Islander peoples, communities and organisations, with First Nations priorities, experience and local context informing their design, delivery and evaluation. Education providers remain responsible for meeting applicable national qualification, accreditation and regulatory requirements, while governments and professional bodies should support accessible delivery, articulation, workforce development and culturally responsive student support.

Aboriginal Community Controlled Health Organisations and First Nations ear and hearing services should be engaged as education, workforce and delivery partners, not simply as placement sites.

8.2 Recognising Aboriginal and Torres Strait Islander Health Workers and Health Practitioners in hearing care

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners are an established and essential part of primary and community health care. Current national training products provide specific routes to ear and hearing health capability. HLT40221 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice includes ear-health and audiometry electives, and HLT50121 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice includes an ear and hearing health elective group. HLT40121 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care also includes ear-health capability.[13][14]

The pathway should recognise the contribution of these workers and practitioners without relabelling them as Audiometrists or Audiologists. Aboriginal and Torres Strait Islander Health Practitioners are already a registered health profession with protected titles under the National Law. Hearing-health activities should therefore sit within the practitioner's demonstrated competencies, registration and local clinical-governance arrangements, with clear referral and escalation pathways.[15]

For those who choose to progress further in hearing health, relevant units and demonstrated competencies should support transparent credit and RPL into the Certificate IV or Diploma of Audiometry and onward progression to Bachelor and specialist pathways. This work should be developed with NAATSIHWP and Aboriginal Community Controlled Health Organisations, with direct First Nations participation in decisions affecting pathway design and delivery.[16]

8.3 A pathway, not a ceiling

Core design principle
Certificate IV and Diploma entry should provide valid workforce outcomes and genuine opportunities for further progression. First Nations students should be supported to enter, remain within, or progress through nationally recognised education and workforce pathways according to their goals, with First Nations input shaping culturally responsive delivery, support, community engagement and progression opportunities

8.4 Practical access mechanisms

Mechanism	Required design features
Entry and preparation	Foundation and bridging programs; alternative admission evidence; recognition of community health, language and cultural knowledge; academic skills support before and during study.
Earn-and-learn	Paid traineeships, cadetships and employment-linked study so students are not required to choose between income and qualification.
Articulation and RPL	National credit from relevant First Nations health qualifications, Certificate IV and Diploma Audiometry and other health qualifications; transparent RPL; no unnecessary repetition of equivalent learning.
Regional delivery	Hub-and-spoke university/RTO partnerships; block intensives; supported online learning; local simulation; travelling educators; regional cohort models.
Paid clinical education	Paid or adequately supported placements, travel and accommodation; local placements wherever competency and supervision standards can be met.
Supervision capacity	Funded supervisor development; recognition of supervision workload; regional supervision networks; culturally safe mentors and peer support.
Cultural safety	Cultural safety supported through culturally responsive teaching, placements and workplaces; anti-racism responsibilities; mechanisms for safe reporting and response; evaluation informed by First Nations students and communities.
Progression and leadership	Supported pathways to Masters specialties, research, education, governance and leadership not only entry-level service roles.
Data sovereignty and evaluation	First Nations governance of data about participation, completion, placement experience, workforce retention and community outcomes.

8.5 Regional and remote workforce retention

Training people in or near the communities where they are likely to work should be a central workforce strategy. Regional cohorts, local placements and employment-linked education can strengthen retention and reduce the dependence on short-term outreach. The model should include regional specialty rotations so advanced practice does not remain concentrated only in metropolitan centres.

8.6 Financial attainability

The reform package should address tuition, placement, travel, accommodation and loss-of-income barriers. Scholarships alone will not solve access if the underlying program requires repeated relocation or long unpaid clinical blocks. Governments, employers and education providers should develop paid placement and cadetship models as core workforce infrastructure.

9. Public protection, accreditation and clinical governance

A staged education pathway is credible only if its public-protection architecture is explicit. The following elements should be designed nationally before new titles or scopes are implemented.

9.1 National competency standards

One framework should map knowledge, skills, judgement, autonomy and limits across the Certificate IV, Diploma, Bachelor and each specialist certification. It should clearly distinguish qualification recognition, clinical competence, authorised scope, registration where applicable and professional certification.

9.2 Program accreditation

Certificate IV, Diploma and university programs should be accredited or quality-assured against transparent standards appropriate to their sector, covering curriculum, staff capability, clinical education, assessment, cultural safety, student support, governance, complaints, data and continuous improvement. Accreditation and quality assurance should assess whether graduates can meet the relevant competency standard, not whether a program reproduces an existing institutional model.

9.3 Independent assessment and certification

Professional certification should include independent or externally moderated assessment at key transition points. The assessment model may combine university evidence with national examinations, structured clinical assessment or portfolio review. Governance should separate curriculum delivery from final certification decisions sufficiently to manage conflicts and maintain public confidence.

9.4 Defined scope and referral

Each professional category and specialist certification should have a published scope statement, referral thresholds and prohibited or conditional activities. Scope should be written in a way that supports team-based care and escalation rather than implying that one profession must perform every element of a consumer's pathway.

9.5 Public verification and complaints oversight

Australia already has consumer-facing mechanisms through which members of the public can verify the certification status of clinicians. Both ACAud and Audiology Australia provide publicly accessible clinician lookup functions, supporting transparency about professional recognition and certification.

These existing mechanisms provide a foundation that could be adapted as the education and workforce pathway develops, so that consumers can readily understand:

- practitioner's recognised professional category;
- their current certification status;
- any active specialist certification relevant to their practice;
- the scope associated with each professional category or specialist certification; and
- how to access the relevant complaints and professional conduct process.

Professional conduct and complaints for practitioners certified through ACAud and Audiology Australia are supported through the Hearing Professional Conduct and Complaints Body (HPCCB). The HPCCB is an independent body established by ACAud and Audiology Australia, providing an established mechanism for the management of conduct and complaints matters.

9.6 Ongoing assurance

All levels should be subject to professional conduct requirements, complaints and notification processes, CPD, recency, audit and re-entry mechanisms. Public protection is strengthened when standards follow the practitioner throughout the career rather than being concentrated only at graduation.

10. Professional recognition within the proposed pathway

The proposed education and workforce pathway requires clear recognition of the competencies, scope and level of practice associated with each stage. The purpose is not to prescribe future regulatory arrangements, but to establish a coherent structure in which education, competency, professional recognition and progression are aligned.

Existing professional certification, public clinician verification, complaints and conduct mechanisms provide an established foundation for this work. As the pathway develops, recognition arrangements should clearly distinguish between supported Certificate IV Audiometry practice, independent rehabilitation practice, foundational audiology practice and specialist practice.

Any future regulatory arrangements could take account of this architecture, but the development of the education and workforce pathway should not depend on a particular regulatory outcome.

10.1 Indicative professional recognition across the four-level pathway

Recognition element	Purpose
Supported audiometry practice	Certificate IV in Audiometry (HLT47425) pathway supporting hearing screening and audiometric testing within the competencies of the qualification and defined supervision and consultation arrangements, including remote supervision where relevant. Professional recognition and terminology should not imply independent prescribing or dispensing.
Rehabilitation Audiometrist	Diploma of Audiometry (HLT57425) pathway supporting comprehensive hearing assessment and hearing rehabilitation within an established certified scope, including hearing device prescription, fitting and management, communication support, counselling, education, monitoring, ongoing care, referral and escalation. Provides a recognised professional outcome in its own right, with clear opportunities for further articulation into Bachelor pathways.
Audiologist - Hearing Rehabilitation	Bachelor level professional audiology pathway supporting broader foundational audiology practice in hearing rehabilitation and community hearing care, with greater depth in audiological science, clinical reasoning, assessment and interpretation, rehabilitation planning, interprofessional practice, referral and management within a defined professional scope. Proposed designation remains subject to consultation.
Audiologist - Specialist certification	Masters/postgraduate pathway supporting advanced and complex practice in defined specialty areas following postgraduate education, supervised clinical formation and appropriate maintenance of specialist competence

10.2 Proportionate education, competency and assurance requirements

Education, clinical training, assessment, supervision, recency and maintenance requirements should be matched to the competencies, complexity and risk of the relevant work. Higher-risk and complex specialist functions require more advanced education, clinical exposure and ongoing assurance. Requirements for foundational and rehabilitation practice should remain rigorous but should not exceed what is necessary to establish and maintain safe practice within the relevant defined scope.

This principle is intended to ensure that education, competency and assurance requirements are proportionate to the work being undertaken while maintaining appropriate standards of public protection.

10.3 A time-limited pathway development, implementation and evaluation period

ACAud proposes a defined, time-limited program for the development, implementation and evaluation of the education, competency and transition architecture proposed in this paper. The program should be supported by published milestones, six-month progress reporting, a formal 18-month progress and accountability review, and an initial five-year pathway development, implementation and evaluation horizon.

The 18-month review should assess progress against agreed outputs, identify barriers, confirm responsibilities and establish the next program of work. It should examine whether the proposed pathway remains credible, attainable and responsive to workforce and community need, and whether further evidence or refinement is required.

The five-year review should assess implementation progress, education and articulation outcomes, workforce participation and distribution, First Nations participation, regional and remote access, consumer and safety indicators, and the effectiveness of the pathway in supporting a sustainable hearing health workforce. Findings should inform the next stage of education and workforce development and any broader system decisions.

11. Transition arrangements for the existing workforce

Reform must not destabilise the workforce Australia already relies on. Transition arrangements should recognise current competence, protect consumers and provide optional progression without forcing unnecessary requalification.

11.1 Existing Certificate IV and Diploma Audiometry workforce

- retain their existing recognised title or role, certified scope and employment rights appropriate to their qualification and certification, subject to ordinary renewal, recency, conduct and competency requirements;
- are not required to complete a higher qualification merely to continue an existing recognised scope for which they remain qualified, certified and competent;
- receive transparent credit and RPL from Certificate IV to Diploma and from Diploma or equivalent Audiometry learning toward Bachelor pathways where they choose to progress;
- Bachelor of Audiometry graduates retain recognition within the Audiometry profession and receive additional transparent credit and RPL toward the proposed Bachelor of Audiology;

- have access to supported bridging in sciences, clinical reasoning, research literacy and any additional clinical domains; and
- may complete progression through part-time, employment-linked and regional delivery models.

11.2 Existing Masters-qualified Audiologists

- retain recognition as Audiologists, their current general scope and existing employment rights during transition, subject to ordinary recency, conduct and competency requirements;
- are not required to requalify for their current general scope and are not downgraded by the creation of a Bachelor pathway;
- may receive specialist certifications through a generous, time-limited portfolio, recency and competency-mapping process where current evidence supports the specialty;
- are not assumed to hold every specialist certification solely because their original degree included introductory exposure; and
- retain every current, demonstrable competency, with fair re-entry and supervised pathways available for specialties that are not currently practised.

11.3 Current students and interns

Students and interns already enrolled in approved pathways should be able to complete under the standards that applied at entry, with an option to transition where this is advantageous and does not delay completion. No cohort should be stranded between old and new arrangements.

11.4 Overseas-qualified practitioners

Overseas qualifications should be mapped separately from clinical competence. An overseas qualification may be comparable to a Certificate IV, Diploma, Bachelor or Masters level, but professional scope should be determined through documentary verification, competency assessment, supervised practice and the relevant certification requirements. Qualification recognition must not be treated as automatic full-scope equivalence.

11.5 Aboriginal and Torres Strait Islander Health Workers and Health Practitioners

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners are distinct professions and workforce roles with their own qualifications, professional identity, scope and governance arrangements. Their contribution to ear and hearing health should be recognised where relevant competencies are held, without absorbing these professions into Audiometry or Audiology.

Where an individual chooses to pursue further study in Audiometry or Audiology, relevant prior learning and demonstrated competencies should support appropriate credit and recognition of prior learning. Progression should remain optional and should not diminish or replace the practitioner’s existing professional role.

11.6 Educators, employers and supervisors

Universities and RTOs may need to review curricula, articulation arrangements and course delivery as the pathway develops, consistent with applicable education, accreditation and regulatory requirements. Employers will have an important role in supporting supervision, clinical placements, workforce transition and service continuity. Government can support implementation through national policy coordination, regulatory clarity, workforce investment and the removal of unnecessary barriers. Public funding should prioritise areas where there is a clear public benefit, including equitable First Nations participation, regional and remote workforce access, independent workforce data, clinical training capacity and essential national

infrastructure. Reform should be phased so that education providers, employers and the existing workforce can adapt without disrupting current service delivery.

12. Implementation and accountability milestones

A credible national education and workforce reform proposal requires a disciplined implementation program. ACAud proposes the following staged process.

Timing	Workstream	Required output
0–3 months	National consultation and taskforce establishment	Agree scope, governance, direct First Nations participation in matters affecting First Nations students, workforces and communities, meaningful consumer participation, funding responsibility, milestones, conflict management and public reporting.
3–9 months	Evidence and design	National workforce/service-mix mapping; current scope mapping; graduate destination data; education cost and access analysis; draft common competency spine.
6–12 months	Qualification and scope standards	Map the current Certificate IV in Audiometry, Diploma of Audiometry and Bachelor of Audiometry qualifications against the proposed four-level pathway; develop competency and scope standards for the proposed Bachelor of Audiology and specialist pathways; establish articulation and RPL arrangements, proposed professional designations, public verification arrangements and transition principles.
9–18 months	Accreditation and certification architecture	Program accreditation standards; clinical education requirements; independent assessment model; specialty internship and annual renewal and maintenance framework for specialist certification.
12–24 months	Pilot partnerships	Select university, RTO, employer, First Nations and regional partners; strengthen and formalise articulation between the Certificate IV, Diploma and existing Bachelor of Audiometry pathways; develop and pilot articulation into the proposed Bachelor of Audiology; and establish specialist clinical training and residency networks.

Timing	Workstream	Required output
18 months	Progress and accountability review	Publish progress against agreed milestones, identify barriers, confirm responsibilities and establish the next work program. The review should assess the credibility and progress of the reform program without requiring final regulatory architecture to be settled before the proposed pathways have been implemented and meaningfully evaluated.
24–48 months	Program accreditation and first enrolments	Approve pilots, implement transition arrangements, begin data collection and independent evaluation.
48–60 months	Five-year implementation and evidence review	Assess pathway development and implementation, accreditation and enrolment outcomes, First Nations participation, regional access and retention, transition impacts, consumer and safety indicators, and graduate outcomes where available. Publish a consolidated report and recommendations for the next stage of implementation and evaluation.
60–72 months	Continued graduate and workforce evaluation	Evaluate the competence and employment distribution of the first graduating cohorts as they become available, together with workforce, consumer, regional and specialist-capacity outcomes.

12.1 National Audiology Education and Workforce Reform Taskforce

The reform program should be supported by a small, independently chaired National Audiology Education and Workforce Reform Taskforce. Its terms of reference should provide for meaningful consumer participation, direct Aboriginal and Torres Strait Islander participation in matters affecting First Nations students, workforces and communities, transparent conflict of interest arrangements and balanced sector representation.

Membership should include appropriate representation from:

- Aboriginal and Torres Strait Islander workforce, community and education interests;
- consumers and people with lived experience of hearing loss;
- Audiometry and Audiology professional bodies and practitioners;
- VET and higher education providers;
- public, private and community hearing service providers and employers;
- regional, rural and remote hearing health services;
- government, education, AQF, articulation, workforce and policy expertise; and
- research, students, interns and early career practitioners.

The taskforce should be able to draw on additional organisations and specialist expertise through targeted working groups and consultation as required. Where appropriate,

implementation could also connect with existing or evolving national hearing health sector collaborative arrangements.

12.2 Evidence program

The taskforce should commission data capable of testing the assumptions in this paper, including:

- workforce numbers by qualification, scope, setting and location;
- the proportion of work performed in rehabilitation and each specialty area;
- service demand and projected shortages;
- graduate employment destinations and specialty retention;
- placement and supervisor capacity;
- education costs, attrition and barriers to entry;
- First Nations enrolment, completion, placement experience and workforce retention;
- consumer safety, complaints and referral data by service type; and
- the impact of alternative regulatory and education scenarios.

13. Risks and safeguards

Risk	Safeguard
Perception that standards are being lowered	Publish competency and scope standards before titles are implemented; use independent assessment, program accreditation and established professional conduct and complaints oversight through the HPCCB.
Confusion between Certificate IV, Diploma and Audiologist roles	Use distinct pathway descriptors and plain language scope statements; make supervision, consultation and autonomous clinical scope boundaries explicit; enable verification of current certification and specialist certifications through existing clinician lookup mechanisms.
Fragmentation between qualification levels	Use one competency spine, clear national articulation and aligned education, competency and certification requirements across Certificate IV, Diploma and higher education pathways.
Bachelor programs graduate without sufficient clinical competence	Require integrated clinical education, externally moderated assessment and evidence of graduate competence, with a paid transition period where necessary.
Specialist workforce shortages continue	Fund specialty placements and residencies, recognise current specialists fairly and create cross-site regional training networks.
First Nations participation is not meaningfully embedded, or pathways create unintended barriers	Recognise existing Health Worker and Health Practitioner pathways, support direct First Nations participation in pathway design and delivery, fund equitable access and progression, track outcomes, and maintain optional progression through Audiometry, Audiology, specialist education, research and leadership.

Risk	Safeguard
Annual renewal and maintenance of specialist certification becomes burdensome	Use a proportionate, digital and risk-based model; reserve re-examination for identified need.
Existing practitioners are disadvantaged	Preserve existing recognised scope, map demonstrated competence and provide supported, optional bridging and re-entry.
Pathway reform loses momentum or accountability	Use published milestones, six-month reporting, an 18-month progress and accountability review and a consolidated five-year implementation and evidence report.
Employer interests dominate scope design	Ensure independent chairing, consumer representation, conflict declarations, transparent evidence and published consultation outcomes.

14. Recommendations

1. Use a national, staged four-level Audiometry-Audiology education and workforce pathway as the basis for consultation rather than treating the current postgraduate-first model as fixed.
2. Recognise HLT47425 Certificate IV in Audiometry as the first level of the Audiometry pathway, with defined supervision and consultation arrangements that may be delivered remotely where appropriate, and with no independent prescribing or dispensing.
3. Recognise HLT57425 Diploma of Audiometry as the rehabilitation-focused Audiometry level, with transparent progression from Certificate IV and into Bachelor pathways.
4. Establish an independently chaired National Audiology Education and Workforce Reform Taskforce with direct Aboriginal and Torres Strait Islander participation in matters affecting First Nations students, workforces and communities and meaningful consumer representation.
5. Explicitly recognise Aboriginal and Torres Strait Islander Health Workers and Health Practitioners who hold relevant ear-health and audiometry competencies as part of the hearing-health workforce, without collapsing those professions into Audiometry or Audiology, and develop optional credit and RPL pathways in partnership with NAATSIHWP and community-controlled organisations.
6. Commission independent workforce and service-mix mapping, including validation of the proportion of demand in hearing rehabilitation, the contribution of community and First Nations hearing-health roles, and the specialist workforce required by region.
7. Develop one national competency spine that distinguishes Certificate IV supported Audiometry, Diploma level rehabilitation Audiometry, Bachelor level Hearing Rehabilitation Audiology and Masters or postgraduate specialist practice, building from current competency standards and training package requirements.
8. Develop accreditation standards for a purpose-built Bachelor of Audiology, with integrated clinical education, externally moderated assessment and demonstrated competency at completion.

9. Create nationally consistent Certificate IV-to-Diploma and Diploma-to-Bachelor articulation, credit and recognition of prior learning arrangements, with no loss of existing recognised scope and appropriate recognition of the Charles Darwin University Bachelor of Audiometry.
10. Develop Masters and postgraduate specialty pathways, specialty internships or residencies, and proportionate annual renewal and maintenance requirements for specialist certification.
11. Support and fund equitable First Nations participation in education and workforce pathways, including earn and learn entry, paid placements, regional and community based delivery and optional progression through all qualification and career levels. Education providers, governments and professional bodies should work directly with First Nations people, communities and organisations to shape culturally responsive delivery and support within applicable education, accreditation and regulatory requirements.
12. Strengthen and align existing public clinician verification mechanisms so consumers can verify a practitioner's professional category, current certification status, active specialist certifications and the scope associated with their certification, with clear access to established HPCCB complaints and professional conduct processes.
13. Publish transition arrangements that preserve the existing recognition and current scope of Certificate IV and Diploma Audiometry practitioners and Masters-qualified Audiologists, while providing fair pathways for Bachelor of Audiometry graduates, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, overseas-qualified practitioners, students and interns.
14. Publish progress every six months, complete a formal progress and accountability review at 18 months and provide a consolidated pathway implementation and evidence report at five years.

Conclusion

Australia does not have to choose between workforce access and professional standards. It can design an education system that achieves both.

The Certificate IV in Audiometry should provide a respected supported entry point into hearing assessment and referral, with defined supervision and consultation arrangements that can operate remotely where appropriate. The Diploma of Audiometry should remain the rehabilitation focused qualification for the Audiometry profession. The Bachelor of Audiology should become the foundational professional qualification for hearing rehabilitation and community practice. Masters and postgraduate education should become the pathway into genuine specialist formation. Specialist authority should then be maintained through supervised clinical experience, recency and annual renewal and maintenance of specialist certification.

This structure is more attainable, more transparent and more closely aligned with how hearing care is delivered. It creates a pathway that can begin in local communities, recognise Aboriginal and Torres Strait Islander Health Workers and Health Practitioners with relevant ear and hearing competencies, support First Nations participation, retain regional workers, use the existing Audiometry workforce, prepare a larger rehabilitation workforce and still protect advanced practice through rigorous specialist standards.

A time-limited period for education and workforce reform is justified only if it is used to complete this work. The sector should now move from debating titles in isolation to designing the education, competency and workforce architecture Australia needs for the next generation.

Final proposition
Create accessible entry and progression from Certificate IV through Diploma and Bachelor. Specialise deliberately at Masters/postgraduate level. Certify what practitioners currently do. Recognise the contribution of First Nations health workforces. Create pathways that Australians can realistically enter, complete and sustain.

Appendix A – Indicative scope and competency matrix

Domain	Certificate IV, supported Audiometry	Diploma - Rehabilitation Audiometrist	Bachelor - Hearing Rehabilitation Audiologist	Masters/postgraduate - Specialist-certified Audiologist
Professional foundation	Person centred communication, consent, privacy, documentation, cultural safety, infection control and referral within defined support and consultation arrangements.	Person centred communication, consent, ethics, privacy, documentation, evidence informed practice, counselling, referral and professional accountability within Audiometry scope.	Broader professional foundation integrating audiological science, evidence informed practice, clinical reasoning, interprofessional practice, service planning and professional accountability within Audiology scope	Advanced judgement, leadership and complex decision-making in the endorsed specialty.
Assessment	Hearing screening and audiometric testing within required supervision arrangements; identify potential impairment or ear disorder and escalate appropriately.	Comprehensive hearing assessment and interpretation within certified Audiometry scope; identify red flags, determine rehabilitation needs and refer or escalate where required.	Broader adult and community hearing assessment and interpretation within Bachelor scope, integrating audiological, functional, communication and rehabilitation information to inform clinical decision making and referral.	Advanced, complex or specialty-specific diagnostics and interpretation.
Rehabilitation	Support care coordination, hearing-device management and hearing-health education; no independent prescription or dispensing.	Comprehensive hearing rehabilitation within certified Audiometrist scope, including needs assessment, hearing device prescription and fitting, verification, communication support, counselling, outcome measurement, monitoring and ongoing care.	Hearing rehabilitation within Bachelor scope with greater depth of clinical reasoning, integration of broader assessment findings, rehabilitation planning, technology management, counselling, outcome evaluation and management of more varied presentations within scope.	Complex specialty intervention, advanced technology or specialist rehabilitation.
Population and access	Community, occupational and screening support within qualification, supervision and workplace scope.	Community and occupational hearing services, hearing health education, prevention, screening, teleaudiology and service delivery within qualification and certified scope.	Population and community hearing health, prevention, screening pathways, teleaudiology, service coordination and interprofessional approaches to hearing health access.	Specialist public health, program design, advanced service leadership or research.

Domain	Certificate IV, supported Audiometry	Diploma - Rehabilitation Audiometrist	Bachelor - Hearing Rehabilitation Audiologist	Masters/postgraduate - Specialist-certified Audiologist
Paediatrics	Screening support only where trained, authorised and supervised; recognise red flags and refer.	Screening, support and referral only where specifically certified.	Defined foundational knowledge, family communication, screening and referral; no advanced independent specialist practice without specialist certification.	Specialist paediatric assessment, intervention and family-centred care under specialist certification.
Vestibular / implants / complex diagnostics	Outside independent scope; recognise concerns and refer/escalate.	Outside independent scope unless separately qualified and certified.	Foundational recognition, referral and team participation.	Independent practice only within the relevant active specialist certification.
Supervision	May work locally, including in regional or remote settings, with direct, indirect or remote supervision as appropriate. Must have access to an appropriately qualified Audiometrist, Audiologist or medical practitioner for consultation, case discussion and escalation in accordance with the qualification and workplace arrangements.	Receives and provides supervision only as authorised by certification.	May supervise within demonstrated scope after supervisor preparation and experience requirements.	May supervise specialty practice when endorsed and approved.
Maintenance	Employer/sector competency, CPD and conduct requirements appropriate to role; progression available into Diploma.	Annual professional certification, CPD, conduct and recency within scope.	Annual base certification or registration, CPD, conduct and recency.	Annual maintenance of each specialist certification, including specialty recency and governance evidence.

Note: This matrix is indicative only. Detailed task-level scopes must be developed through competency mapping, risk assessment, consultation and legal review.

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners with relevant ear and hearing competencies sit alongside this four-level pathway rather than beneath it. Their activities remain governed by their own qualification, registration where applicable, employment scope and clinical-governance arrangements, with optional credit and RPL into Audiometry and Audiology pathways where desired.

Appendix B – Indicative annual renewal and maintenance cycle for specialist certification

Step	Requirement
1. Annual declaration	Professional standing, insurance, conduct matters, health or practice conditions and specialist certification(s) sought.
2. CPD evidence	Specialty-relevant learning completed and reflected upon.
3. Recency evidence	Case activity, clinical hours or approved alternative evidence appropriate to the specialty.
4. Governance evidence	Peer review, audit, supervision, case conference or quality-improvement participation.
5. Risk screening	Complaints, absence, low case volume or other indicators considered against a published risk framework.
6. Renewal outcome	Renewed, not renewed or referred for targeted reassessment in accordance with the relevant certification framework.
7. Public clinician verification	Current specialist certification able to be verified through the existing public clinician lookup mechanism.

Appendix C – Questions requiring national consultation

1. How should the established Certificate IV and Diploma of Audiometry qualifications be described within the proposed national pathway, what professional designation should apply to the proposed Bachelor of Audiology, and how should differences in supervision, autonomy and scope between the levels be clearly communicated?
2. How should the established qualification outcomes and competencies of the Certificate IV and Diploma of Audiometry be mapped against the proposed Bachelor of Audiology and specialist certification levels, and what additional competencies should distinguish Bachelor and specialist practice?
3. What assessment and supervised-practice evidence is required at each transition point before a practitioner moves to greater autonomy?
4. What proportion of transition-to-practice should be embedded within the degree, and what should occur in paid employment?
5. Which specialty areas require Masters-level education, and where could a Graduate Certificate or Graduate Diploma be sufficient as part of a stackable pathway?
6. What recency thresholds are appropriate for each specialty, particularly in low-volume rural and remote practice?
7. How should accreditation and certification arrangements be structured to support nationally consistent standards, appropriate independence and transparency, while recognising the role of professional practitioner bodies in accrediting education programs and certifying practitioners?
8. How should existing clinician lookup mechanisms distinguish academic qualification, professional category, clinical certification and current specialist certification?
9. What transition evidence is sufficient for current Masters-qualified practitioners to receive specialist certifications without unfair requalification?

10. How will meaningful First Nations participation, appropriate data governance and community involvement be embedded in pathway design and evaluation, and how will existing Aboriginal and Torres Strait Islander Health Worker and Health Practitioner ear and hearing competencies be recognised?
11. How will governments and employers fund paid placements, residencies and supervisor capacity?
12. What progress should the taskforce demonstrate at the 18-month accountability review, and what further work should be completed within the five-year pathway development and evaluation horizon?

Appendix D – Glossary

Term	Meaning in this paper
Academic qualification	An award issued under the Australian Qualifications Framework by an authorised education provider.
Clinical certification	Recognition that a practitioner has met defined competency, conduct and maintenance requirements for a stated scope.
Scope of practice	The activities a practitioner is educated, competent, authorised and current to perform, taking account of context and conditions.
Specialist certification	Professional recognition that a practitioner has completed approved specialty education and supervised practice and currently meets maintenance requirements. Current specialist certification may be verified through the existing public clinician lookup mechanism.
Recency of practice	Sufficient recent practice or approved equivalent evidence to support current competence.
Articulation	A formal pathway that provides credit from one qualification into another.
Recognition of prior learning (RPL)	Assessment of prior learning and experience against specified learning outcomes or competencies.
Hearing rehabilitation	Person-centred assessment, device and non-device intervention, communication support, counselling, verification, outcome measurement, monitoring and ongoing hearing care within defined scope.
Specialty internship or residency	Supervised post-academic clinical formation in a defined advanced practice area, with specified case mix and assessment.
Supported Audiometry	Hearing screening and audiometric testing undertaken within the Certificate IV qualification, workplace scope and defined supervision and consultation arrangements. Supervision may be direct, indirect or remote where appropriate. The qualification does not include independent prescribing or dispensing.
First Nations health workforce	Aboriginal and Torres Strait Islander Health Workers and Health Practitioners practising within their own recognised qualification, registration where applicable, employment and clinical-governance frameworks, including ear and hearing health where relevant competencies are held.

References and source material

The proposal is grounded in ACAud's existing discussion papers and current official information. Web sources were checked during development in August 2026. Where included, hyperlinks lead to English-language pages on the relevant official websites.

[1] **Australian College of Audiology Inc HAASA. ACAud National Hearing Health Strategy - Discussion Paper. March 2026. Internal discussion paper supplied for this proposal.**

[2] **Australian College of Audiology Inc HAASA. The Future of Hearing Care Works Together: A Vision for Australia's Hearing Healthcare Workforce. 2026. Internal position paper supplied for this proposal**.

[3] **Australian Qualifications Framework.** AQF qualifications**: qualification type descriptors for the AQF Level 4 Certificate IV, Level 5 Diploma, Level 7 Bachelor Degree, Level 8 Graduate Certificate and Graduate Diploma, and Level 9 Masters Degree.**

[4] **National Training Register.** HLT47425 Certificate IV in Audiometry **and** HLT57425 Diploma of Audiometry**: current qualification descriptions, packaging requirements and progression information.**

[5] **Audiology Australia.** Audiology qualifications and training**: current description of the Masters-level education pathway.**

[6] **Audiology Australia.** University Accreditation**: current accreditation arrangements and accredited Australian postgraduate audiology programs.**

[7] **Australian Government Department of Health, Disability and Ageing.** Hearing Services Program**: program functions and 2024-25 client and service-site figures.**

[8] **Australian Government Department of Health, Disability and Ageing.** National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031**. Published 7 March 2022.**

[9] **University of Southampton.** Audiology BSc**: three-year undergraduate audiology program with clinical and professional preparation.**

[10] **Aston University.** Healthcare Science (Audiology) BSc (Hons)**: three-year undergraduate program with integrated clinical learning, degree-apprenticeship and direct-access options.**

[11] **Charles Darwin University.** Bachelor of Audiometry**: AQF Level 7 online pathway designed for Diploma-qualified Audiometrists and including work-integrated learning.**

[12] **Australian College of Audiology Inc HAASA. Professional Competency Standards for Audiologists and Audiometrists. Version 2, approved 29 May 2026.**

[13] **National Training Register.** HLT40121 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care **and** HLT40221 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice**: current qualification descriptions and ear/hearing health electives.**

[14] **National Training Register.** HLT50121 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice**: current qualification description and ear and hearing health elective group, including HLTAHCS014 and HLTAUD007-HLTAUD010.**

[15] Aboriginal and Torres Strait Islander Health Practice Board of Australia / Ahpra. **Current registration information, accredited programs and protected-title requirements for Aboriginal and Torres Strait Islander Health Practitioners.**

[16] National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP). **About us and workforce development information.**

[17] **National Training Register.** HLTAHA048 Provide allied health assistance in remote or isolated settings**: current unit description, including direct, indirect and remote supervision and delegation arrangements.**

[18] **Audiology Australia.** National Competency Standards**: current entry-level competency framework for Audiologists in Australia.**

Data limitation: the approximately 85% rehabilitation figure is an ACAud working estimate. It must be validated through national workforce and service-mix mapping before final scopes, titles, education standards or regulatory settings are adopted.