Queensland Health

Consultation Paper

Audiology Decision RIS

Queensland Government

Contents

Preface

At the 13 December 2023 Health Minister's Meeting (HMM), State and Territory Health Ministers decided to develop a Decision Regulatory Impact Statement (Decision RIS) that considers options for the future regulation of the audiology profession[1], including regulation under the National Registration and Accreditation Scheme (NRAS). The Decision RIS will be prepared in accordance with the Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard Setting Bodies, administered by the Office of Impact Analysis (OIA).

Queensland is leading the development of the Decision RIS. Deloitte has been engaged by the Queensland Department of Health to assist in the Decision RIS' preparation.

This consultation paper has been produced to support the development of the Decision RIS by obtaining stakeholder input into:

- *the nature of the problem*
- *options to address the problem*
- *the anticipated impacts of different options, including implementation considerations.*

1 Context

The following sections provide additional background context in relation to the audiology workforce, the regulation of audiology, other relevant health workforce regulation and the scope and processes of the Decision RIS.

1.1 The audiology profession

The diagnosis, treatment and management of hearing and balance disorders may involve a range of health care professionals, including:

- audiologists (holding a Masters-level degree in clinical audiology)
- audiometrists (holding a diploma in audiometry).

An overview of the differences in scope is provided on the following page:[2]

[1] HMM is not currently considering the future regulation of audiometry through this Decision RIS mechanism.

[2] Audiology Australia, the Australian College of Audiology, and the Hearing Aid Audiology Society of Australia (2016), 'Scope of Practice for Audiologists and Audiometrists'.

Audiologists[3]

Audiologists in Australia work with clients of all ages – from infants to older adults– and clients with complex needs. They can assess hearing and auditory function, vestibular (balance) function, tinnitus, auditory processing function, and neural function. Audiologists can do this by performing diagnostic tests, including advanced tests using electrophysiological methods. Audiologists provide aural, vestibular (balance) and tinnitus (re)habilitation as well as communication training. They can provide a range of (re)habilitation services including counselling and the prescription and fitting of devices/aids (e.g., bone conduction aids; earplugs (custom noise/swim/musician plugs); FM and other remote sensing systems; hearing aids; and hearing assistive technology). Audiologists have knowledge of implantable devices (e.g., cochlear implants, middle ear implantable hearing aids, fully implantable hearing aids, bone anchored hearing aids) and collaborate with other professionals in their applications in (re)habilitation.

Audiometrists[4]

Audiometrists in Australia primarily work with adult clients (including older adults) and provide a range of services to school-aged children. They focus on hearing and auditory function assessment and (re)habilitation. Audiometrists achieve this by applying a range of diagnostic tests and rehabilitation approaches including counselling and the prescription and fitting of non-implantable devices/aids (e.g., bone conduction aids; earplugs (custom noise/swim/musician plugs); FM and other remote sensing systems; hearing aids; and hearing assistive technology). Audiometrists may also provide rehabilitation for tinnitus using education and hearing aids.

As of the 2021 Census, there were approximately 2,636 audiologists employed in Australia, with 11% working in the public sector (across Federal and State and Territory) and 89% working in the private sector.[5] Audiologists work closely with other allied health disciplines (particularly speech pathologists) as well as the medical profession (e.g., ear, nose and throat specialists).

1.2 Self-regulation of audiology

Audiology is a self-regulated allied health profession. Self-regulation involves individual audiologists voluntarily applying to become a member of a practitioner professional body (PPB), which may offer[6]:

- a post-graduate clinical internship (required for accreditation/full membership of the PPB)
- continuing professional development activities and events

[3] The authors state that *"The Scope of Practice cannot be used to define, regulate or restrict the scope of an individual's practice. These regulatory aims are instead achieved via a suite of other relevant policies and by-laws that Audiology Australia, the Australian College of Audiology and Hearing Aid Audiology Society of Australia members must adhere to… It is the responsibility of the individual to be aware of, and only engage in, aspects of the Scope of Practice that they have the appropriate educational qualifications, knowledge, skills and experience to practice lawfully, safely and effectively, in a way that meets professional practice standards and does not pose any danger to the public or to themselves"*(p4).

[4] As above.

[5] Australian Bureau of Statistics (2021) Census Data - Table Builder, accessed 10 April 2024 from ABS website.

[6] Audiology Australia and Australian College of Audiology websites.

- professional networking opportunities.

Membership with a PPB also involves requirements that include adherence to that PPB's code of conduct.[7] Consumers or health services representatives are able to make a complaint to an individual practitioner's PPB in reference to that code of conduct. While a PPB is able to implement sanctions, these primarily relate to membership of the PPB (i.e., membership suspension or termination). A PPB is not able to issue Interim Prohibition Orders or Prohibition Orders to prevent an audiologist from practicing their profession.

1.3 Other relevant regulation for the Decision RIS

Two other relevant pieces of regulation for this Decision RIS are:

- **The National Law**: The National Law **does not currently apply** to the audiology profession. However, one of the options under consideration in the Decision RIS is for this to change and for the National Law to apply to the audiology profession. Due to this, elements of the National Law are described in Section 1.3.1.
- **The National Code of Conduct for Health Care Workers (hereafter, the National Code)**: The National Code **does currently apply** to the audiology profession, however only six out of eight Australian jurisdictions have enacted this legislation. A summary of the National Code is provided in Section1.3.2.

1.3.1 The National Law

The National Law is a nationally consistent law passed in each State and Territory. The goal of the National Law was to create a National Registration and Accreditation Scheme (NRAS) for health practitioners practicing in specified health professions.[8] Health professions that are included in the NRAS are commonly referred to as 'registered' health professions, whereas health professions that are not included in the NRAS are referred to as 'unregistered' health professions. The National Law establishes:

- the Australian Health Practitioner Regulation Agency (AHPRA)
- a framework for the National Health Practitioner Boards for each health profession included in the NRAS
- the role of the Ombudsman and Commissioner.

AHPRA

The role of AHPRA includes:

- maintaining a public register of health practitioners
- managing health practitioner registration applications

[7] Audiology Australia and the Australian College of Audiology note that their shared Code of Conduct is aligned to the National Code of Conduct for Health Care Workers. See: https://audiology.asn.au/new-code-of-conduct-for-audiologists/.

[8] Audiology is not included in the NRAS. Health professions currently in the NRAS include: chiropractors; dental practitioners (including dentists, oral health therapists, dental hygienists, dental prosthetists & dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; psychologists; Aboriginal and Torres Strait Islander Health Practitioners; Chinese medicine practitioners (including acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers); medical radiation practitioners (including diagnostic radiographers, radiation therapists and nuclear medicine technologists); occupational therapists and paramedicine. Nursing and midwifery are under the Nursing and Midwifery Board of Australia.

- receiving and investigating complaints about health practitioner performance.

National Boards

Each National Board administers the National Law for their profession, with a primary function of the protection of the public. Their role includes:

- **Probity checking:** powers to undertake probity checking of all applicants for registration before deciding to grant registration (including demonstrating practitioners are qualified and competent to practise)
- **Monitoring of suitability to practise**: practitioners seeking to renew their registration must make an annual statement and satisfy the relevant National Board that they remain fit and suitable to practise
- **Disciplinary powers**: powers to deal with any registered practitioner whom the relevant National Board considers has acted unprofessionally or has an impairment
- **Powers to prohibit practice**: powers to cancel a practitioner's registration and prohibit the person from using a specified title or providing a specified health service.

The NRAS allows members of the registered health professions to have a single registration recognised anywhere in Australia, and is a 'protection of title' model, with powers to prosecute persons who falsely hold out to be registered or use a restricted professional title. It is funded by practitioner registration fees, where each National Board sets the fee required to cover costs for their profession.

For health professions to be considered for addition to the NRAS, an intergovernmental agreement specifies six criteria that must be met:

- *Is it appropriate for health ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another ministry?*
- *Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?*
- *Do the existing regulatory and other mechanisms fail to address health and safety issues?*
- *Is regulation possible to implement for the occupation in question?*
- *Is regulation practical to implement for the occupation in question?*
- *Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?*

1.3.2 The National Code of Conduct for Health Care Workers

The National Code sets a minimum standard of conduct for public and private health care sector workers providing a health service.[9] It has been enacted in six of Australia's eight jurisdictions (see Figure 1.1), and audiologists are subject to regulation under this mechanism.

[9] Health services are recognised to occur in a variety of settings including hospitals, residential aged care facilities, community health settings or a home.

Figure 1.1 Jurisdictions which have enacted National Code regulation

A number of states and territories (coloured in green) have enacted the National Code of Conduct. This strengthens public protection for consumers who use the services of unregistered healthcare workers. States and territories shaded grey have not yet enacted the National Code of Conduct.

Source: Deloitte (2024)

For jurisdictions with the National Code enacted, their health complaints entity (HCE) is able to issue Interim Prohibition Orders and Prohibition Orders against audiologists. Jurisdictions may also mutually recognise prohibition orders made in other States and Territories.

1.4 Scope and process of the Decision RIS

A RIS provides a balanced assessment of different regulatory options and enables stakeholders to inform and be informed on regulatory changes. Since the Decision RIS was commissioned by the decision-maker (HMM), a combination of work completed to date and this consultation process have been designed to meet the requirements of a Consultation RIS (commonly a precursor step to a Decision RIS).

The Decision RIS will examine non-regulatory as well as regulatory options to reduce or resolve current concerns identified in relation to audiology. It is acknowledged that the implementation of certain options for audiologists may impact audiometry practice. These factors will be taken into consideration in the identification of benefits and costs, as well in relation to implementation.

The Decision RIS report structure will follow OIA guidance in relation to the key questions which need to be answered. These include:[10]

- *What is the policy problem?*
- *Why is government action needed?*
- *What policy options are to be considered?*
- *What is the likely net benefit of each option?*
- *Who was consulted and how was their feedback incorporated?*
- *What is the best option from those considered and how will it be implemented?*
- *How will the chosen option be evaluated?*

[10] Office of Impact Analysis (2023), *Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies.*

2 Problem statements and risk of harm

The following problem statements have been developed to summarise the issues which have been identified related to audiology services provided to the community.

Problem Statement 1: Audiology patients (particularly paediatric patients) are a vulnerable cohort. This is due to difficulties patients may experience in:

- **communicating symptoms (and the impact of this on the timeliness and quality of diagnosis)**
- **communicating the effectiveness of treatment decisions made.**

Household members may also face difficulties judging the quality of audiology treatment received on a patient's behalf. As a result of this, episodes of sub-standard care may not be identified for months or years. For paediatric patients, this can potentially lead to significant harm including developmental delays.

Within the last ten years, there have been three public-facing reviews into significant adverse outcomes experienced by patients within paediatric diagnostic audiology and cochlear implant (CI) care services across Australia.

- *Investigation into the quality of health services provided by Logan Hospital audiology department (2018)*
- *Independent Governance Review: Paediatric Cochlear Implant Program – Women and Children's Health Network South Australia (2023)*
- *Townsville University Hospital Part 9 Health Service Investigation Audiology Services (2023).*

At each site, an initial set of patients were identified, and findings triggered external reviews. These reviews involved retrospective audits of services provided to a broader cohort of potentially affected patients. For Townsville and Logan sites, additional cases were identified through this process as requiring treatment.[11] Thus, separate to the harms which occurred for the initial group of patients, without the intervention of audit processes, it is not known how long additional patients may have remained undiscovered, and how long appropriate treatment may have been delayed as a result.

The severity of harms associated with hearing impairment may be influenced by a variety of factors including:

- age of onset
- patient comorbidities
- degree of hearing loss (including which frequencies are impacted)
- timeliness of clinical intervention – which may be impacted by:
    - socioeconomic background
    - geographic location
    - health literacy (including the extent to which information is provided via appropriate communication methods such as in preferred languages)
    - previous experiences with health care services.

[11] For South Australia, an independent external clinical review of the potentially affected cohort is underway.

For children, profound hearing loss that is not addressed in a timely manner may result in developmental delays associated with language skills, social development, and potentially academic achievement.

While a range of causal factors were identified across these reports, the South Australia and Townsville sites highlighted parent perceptions that they were not always listened to when they raised concerns about their child's progress[12,13]. As part of this, parents stated perceptions that clinicians had made them feel as though they were not sufficiently supporting their children to achieve progress.

In summary, given the challenges associated with identifying substandard treatment and the potential patient harms occurring as a result, there is need for action to ensure that:

- the scope of service delivery performed by audiologists is aligned to their knowledge, skills, experience and professional qualifications
- mechanisms exist to manage underperforming audiologists.

Problem Statement 2: For the minority of cases where an audiologist practices in an unethical or unsafe manner, the current regulatory landscape for self-regulated professions creates barriers to enacting professional sanctions that would protect the public from harm.

The regulatory landscape in relation to complaints against audiologists is fragmented, depending on the entity to which a complaint is made. This is due to**:**

- the non-statutory nature of the PPBs (limiting the type of professional sanctions able to be applied and the information which is able to be shared with other bodies or potential employers)
- the powers that health complaints entities (HCEs) have within their jurisdiction, including those related to the National Code (e.g., does the HCE have the ability to issue an Interim Prohibition Order or Prohibition Order as a result of a complaint made).

It is important to note that if an audiologist faces termination of their PPB membership and a complaint is not lodged elsewhere, the practitioner is free to provide audiology services to private fee-paying patients without membership of any PPB.[14]

While self-regulating health professions face similar challenges, the ability to enact professional sanctions is especially important for health professions at greater (actual or perceived) risk of unethical behaviour or unsafe practices. In 2017, the Australian Competition and Consumer Commission (ACCC)[15] raised concerns about unethical behaviour occurring in the audiology profession due to conflicts of business interests between hearing clinic

[12] Townsville University Hospital Part 9 Health Services Investigation Audiology Services (2023), p25.

[13] Independent Governance Review – Paediatric Cochlear Implant Program Women's and Children's Health Network South Australia (2023), p63.

[14] Public sector employers do not generally require membership with a PPB, and have their own recruitment and selection policies that require verification of qualifications at the point of employment.

[15] Australian Competition & Consumer Commission 2017, Issues around the sale of hearing aids – Consumer and clinician perspectives, available from: https://www.accc.gov.au/about-us/publications/issues-around-the-sale-of-hearing-aids.

providers and hearing aid manufacturers.[16,17] As part of this report, the ACCC conducted a survey aimed at consumers and industry and received concerns that included[18]:

- **Consumers**:
    - perceptions of pressure to purchase hearing aids or more expensive hearing aids than clinically necessary
    - a lack of trust that clinicians were providing independent advice and recommendations
- **Clinicians**:
    - the fact that several large hearing clinic operators are owned by hearing aid manufacturers
    - the view that some hearing clinics were focussing on sales at the expense of consumers' best interests.

Overall, there is no single organisation that has oversight or authority to investigate and consistently manage complaints and apply sanctions for a self-regulated profession such as audiology, to protect the public at a national level.

Problem Statement 3: There are perceptions that audiology graduates are not sufficiently trained to practise independently upon graduation and that accreditation standards require strengthening to improve the quality of clinical services.

In Australia, audiology is a Masters-level university program. Following this, certain PPBs offer clinical internships for graduates in order to become accredited, or to be considered a "Qualified Practitioner."[19] However, this step is not mandatory and audiologists may choose to provide services to private fee-paying patients. Recent reviews into paediatric diagnostic audiology and CI care services listed above have raised themes in relation to an increased need for formal training, formal competency assessment, engagement with continuing professional development programs, and a current reliance on manufacturer training.

See Section 3.1 for a discussion of recent changes in relation to this Problem Statement.

Problem Statement 4: There is a perceived lack of understanding by the public in relation to the difference in scope of practice between an audiologist and audiometrist. This may lead to the public being confused in relation to the appropriate health care provider to seek diagnosis and treatment from.

Audiologists and audiometrists have different levels of training, and hence different scopes of practice. There is also currently no 'protection of title' for audiology as a profession. While a co-branded 'Scope of Practice' document was published by Audiology Australia, Australian

[16] Sarki B, Simpson A, Heine C. The cost of privatisation to the profession: Media representation of audiology in Australia. Health Promot J Austral. 2023;34(2): 603–11.

[17] Subsequent to this report the ACCC instituted proceedings in Federal Court against specific hearing aid retailers and issued infringement notices to a specific hearing clinic.

[18] Australian Competition & Consumer Commission 2017, Issues around the sale of hearing aids – Consumer and clinician perspectives, available from: https://www.accc.gov.au/about-us/publications/issues-around-the-sale-of-hearing-aids.

[19] Services provided under the Hearing Services Program are required to be performed by a Qualified Practitioner (or provisional practitioner under supervision of a Qualified Practitioner) as defined. See: < https://www.health.gov.au/our-work/hearing-services-program/providing-services/practitioner-requirements>.

College of Audiology and Hearing Aid Audiology Society of Australia in 2016, there is a perceived concern that the public is not able to effectively distinguish between these two types of health professionals.

Problem Statement 5: Employers lack the information they need to efficiently and effectively assess applicants for audiology role vacancies. This is due to:

- **a requirement to individually assess the appropriateness of overseas qualifications**
- **a requirement to form a judgement about an applicant's recency of practice.**

As a self-regulated profession, employers are required to take on several elements of administrative burden in relation to assessment of audiology role applicants. This includes a requirement to individually form an opinion about the appropriateness of overseas qualifications (where this would be handled as a centralised process under the NRAS), and whether the prospective audiologist had practised sufficiently recently (where registered professions are required to prove recency of practice, or undergo a specified period of supervised practice).

3 Preliminary consideration of shortlisted options

The *Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies* states that the Decision RIS must identify a range of genuine and viable alternative policy options, ranging from non-regulatory to explicit government regulation. The recommended option is the option offering the greatest net benefit, which can be considered with regard to feasibility and expected impact.
A longlist of options has been considered with respect to their feasibility and impact to resolve or reduce the problems outlined in Section 2. These options are outlined in the remainder of this section.

3.1 Option 1 -Status Quo (Current state)

Overview: This option represents the current state regulatory and non-regulatory arrangements.
Shortlisted: **Yes**
Main rationale for inclusion: The status quo must be considered the benchmark regulatory option, against which all other options are assessed. It is noted here that the current state includes multiple non-regulatory elements developed by PPBs and industry which are in their early stages of rollout. These include:

- **Strengthening of competency standards for audiology**. Competency standards are designed to articulate a minimum level of knowledge, skills and behaviours required for 'entry level' practice. Audiology Australia released National Competency Standards, which went into effect 1 January 2022. The full impact of this change will take a considerable length of time to observe. This is due to the fact that assessment against these competency standards occurs through the mechanism of a clinical internship, and only prospective clinical internship cohorts will be required to show evidence (rather than as a general requirement for PPB membership).

- **Strengthening of paediatric competency standards for audiology (including a new voluntary certification in advanced paediatric audiology)**. The Australian Government Department of Health funded the development of Paediatric Competency Standards for Audiologists[20], which were published in 2022.[21] Audiology Australia has since implemented a voluntary certification for Audiology Australia Accredited Audiologists in Advanced Paediatric Audiology in July 2023. Demonstration of competency against the Paediatric Competency Standards is one of three pillars required for certification as an Advanced Paediatric Audiologist, alongside degree of experience and recency of practice. It is noted that this certification is purely voluntary - there are no restrictions to an audiologist's scope of practice as a result of not holding the certification.
- **Strengthening of accreditation standards for university programs**. Audiology Australia[22] released an updated version of the Accreditation Standards for Audiology Programs in January 2023.[23] University programs are accredited for up to five years, with an accreditation assessment occurring in the final year of the cycle. Additionally, universities are required to submit an annual report to verify if it continues to meet Accreditation Standards. As such, the full impact of this process is likely to take several years to observe.

The current state also includes the continued implementation of the following regulatory element:

- **Jurisdictional negative licensing of audiologists through the National Code.[24]** The National Code is continuing to be implemented across Australia, with Western Australia the most recent jurisdiction as of July 2023. As this regulation is required to be enacted by the States and Territories, there is limited ability for the decision-maker (HMM) to compel or hasten implementation in remaining jurisdictions. Furthermore, according to 2021 ABS Census data, approximately 3% of audiologists are employed in a jurisdiction where the National Code is not yet enforced (Northern Territory and Tasmania). Thus, implementation across the remaining jurisdictions is not expected to have significant impact on addressing problem statements.

Based on the factors outlined above, the current state is an evolving space in relation to both non-regulatory and regulatory elements. This will be considered in the impact analysis process, including consideration of the pace and scale of change.

[20] These development of these standards was led by Audiology Australia for the Hearing Health Sector Alliance.

[21] Audiology Australia (2024), Paediatric Competency Standards, accessed from <https://audiology.asn.au/standards-guidelines/paediatric-competency-standards/>.

[22] Audiology Australia is the organisation responsible for accrediting Audiology Masters programs in Australia.

[23] Audiology Australia (2024), University Accreditation, accessed from <https://audiology.asn.au/policy-advocacy/university-accreditation/>.

[24] Please refer to Section 1.3.2 for an explanation of the National Code of Conduct.

3.2 Option 2 - Consolidation of the two audiology-specific PPBs to a single PPB

Overview: This option involves government working with industry to enact an industry-led consolidation of the two current audiology PPBs (Audiology Australia and Australian College of Audiology) to a single PPB.

Shortlisted: **No**

Main rationale for exclusion: As a general principle, consolidation of this nature would try to eliminate incentives for practitioners with self-knowledge of lower skill levels to select a PPB with weaker standards, or for practitioners who have had their membership terminated for cause to join a different PPB. At this time, there is no evidence to suggest that individual audiologists are engaging in 'PPB shopping', and therefore the impact of this option on reducing or resolving the problem statements is considered to be low.

3.3 Option 3 - Mandatory membership of a PPB

Overview: This option involves industry setting a standard for all audiologists to be a member of a PPB.

Shortlisted: **No**

Main rationale for exclusion: This option achieves limited impact against a number of the problem statements, in that PPBs are limited in their ability to enact professional sanctions where harm has been shown to occur.

3.4 Option 4 - License private providers of audiology services

Overview: This option establishes a State and Territory-based licensing scheme for private employers (including those who may provide audiologists under contract for services). In practice, a private provider would be required to hold a license to provide audiology services, and a licensing authority would require that specified standards are met. Standards could include ensuring qualifications of personnel and creating reporting and complaints mechanisms.

Shortlisted: **No**

Main rationale for exclusion: According to 2021 ABS Census data, 89% of audiologists practice in the private sector. As a result, this option would impact the vast majority of practising audiologists. However, given the three external reviews listed in Section 2 examine public sector sites, the burden of regulation is not proportionally matched to the case mix of higher-acuity services provided across both public and private sectors.

3.5 Option 5 - Regulation of audiologists that perform paediatric diagnostic and cochlear implant care services

Overview: This option would regulate a subset of the audiology profession that perform paediatric diagnostic and cochlear implant care services. It is recognised that these

audiologists work across the public and private sector, and may perform this work as the majority of their caseload, or as one component of a broader caseload. Thus, different mechanisms for regulation would create differentiated impact across these cohorts. As well, many regulatory mechanisms would require a credentialling step in order to identify audiologists that need to be included under the regulatory approach. Audiology Australia's Certification of Advanced Paediatric Audiology is the only existing framework for credentialling advanced practice in paediatric audiology known to be operating an Australian context at this time.[25] However, an alternate credentialling framework could be developed. While design choices for regulation in relation to specific cohorts can be more complex, identified mechanisms could include funding arrangements and/or employment requirements as mandated by government.

Shortlisted: Yes

Main rationale for inclusion: This option is included for consideration in the Decision RIS due to the evidence of harms occurring in a specific subset of audiology practice. The consultation process will invite participants to provide their views in relation to the feasibility and impact of the identified mechanisms outlined above, as well as suggestions of other regulatory mechanisms which could be implemented.

3.6 Option 6 - Jurisdictional registration of audiology profession

Overview: This option requires audiologists to register in their jurisdiction to practise. A Registration Board is created which has functions including endorsing professional standards, determining applications for registration and complaints handling (including disciplinary proceedings). Jurisdictions make a voluntary decision whether to enact this regulation, based on their localised assessment of benefits and costs.

Shortlisted: **Yes**

Main rationale for inclusion: This option allows jurisdictions to make different decisions in relation to the problems identified in the Decision RIS, to better reflect community preferences on the appropriate course of action. A recent example of this type of regulatory approach is the jurisdictional registration of social work in South Australia (due to be implemented in July 2025).[26]

3.7 Option 7 - National registration of audiology profession under the NRAS

Overview: This option amends the NRAS to include the audiology profession.

[25] It is noted that Audiology Australia specifically states, "*The certification framework is a voluntary system. The framework is not a barrier to delivering services to children and their families. In line with the Scope of Practice, AudA Accredited Audiologists are able, and will remain able, to work with all ages, from infants to older adults*." See < https://audiology.asn.au/standards-guidelines/advanced-paediatric-certification-framework/>. Thus, this option would change the intent of the certification and require consultation with industry.

[26] Government of South Australia (2024), Social Workers Registration Scheme – South Australia, accessed from < https://www.swrs.sa.gov.au/>.

Note: An extension version of this option would involve inclusion of audiology in the NRAS, with a specialist title created for audiologists performing services considered to be high-risk. This extension option was not pursued at this time, due to challenges estimating the additional difference in impact between the proposed and extension option, given that audiology is not currently included in the NRAS.

Shortlisted: **Yes**

Main rationale for inclusion: There are established mechanisms to add an additional profession to the NRAS. Regulation under the NRAS is considered appropriate for a range of health professionals whose scope of practice includes activities considered to be of higher risk. Further, this option addresses aspects of the problem statement as they relate to recency of practice, protection of title, recognition of overseas qualifications and nationally consistent complaints mechanisms.

3.8 Summary

From the preliminary considerations, the following options are shortlisted at this time:

- Option 1 – Status Quo (current state)
- Option 5 – Regulation of audiologists that perform paediatric diagnostic and cochlear implant care services
- Option 6 – Jurisdictional registration of the audiology profession
- Option 7 – National registration of the audiology profession under the NRAS.

4 Benefits and costs of shortlisted options

In considering the benefits and costs of the shortlisted options, several key stakeholder groups are considered, including:

- patients and their families
- audiologists
- employers
- PPBs
- government.

The following tables present a high-level summary of costs and benefits for the four options shortlisted. Interpretations of costs and benefits are made with reference to Option 1 – Status Quo.

Note i: Given the recency of the external reviews referenced above, there is nil longitudinal data available in relation to harms incurred. As such, a description of harms has been generated with reference to unaddressed hearing loss. ***This does not represent, and should not be interpreted as, findings of individual patient-level harms experienced by patient cohorts of the aforementioned sites.***

Note ii: Audiometrists are not currently listed as a key stakeholder in reference to these costs and benefits, as the focus of the potential regulatory approach is audiologists. However, once a preferred option is identified, there will be consideration given to whether there are indirect or unintended consequences on audiometrists.

Table 4.1 Key benefits and costs of Status Quo (Growing self-regulation and jurisdictional implementation of the National Code)

Key Benefits
Patients and their families • Avoidance of costs passed through to the community associated with alternative regulatory mechanisms • Higher levels of access to audiology services (relative to a regulatory mechanism which seeks to restrict scope of practice for higher-risk services) **Audiologists** • Avoidance of compliance costs associated with alternative regulatory mechanisms (e.g., time costs and fees) • Fewer restrictions on practice (relative to a regulatory mechanism which seeks to restrict scope of practice for higher-risk services) **Employers** • Avoidance compliance costs with alternative regulatory mechanisms (e.g., publication and documentation costs) **Government** • Avoidance of additional legislative costs and establishment costs associated with alternative regulatory mechanisms.
Key Costs
Patients and their families • Costs and harms for patients associated with unaddressed hearing impairment: – increased probability of paediatric patient cohorts being identified as 'vulnerable' on one or more domains of the Australian Early Development Census (e.g., language and cognitive skills or communication skills and general knowledge)[27] and subsequent long-term impacts on employment outcomes – reduced self-esteem and social activity – costs of lost earnings associated with reduced employment outcomes (for working-age patient cohorts) – costs associated with increased dementia risk in elderly patient cohorts • Costs and harms for family members or caregivers of patients associated with unaddressed hearing impairment: – lost wages from reduced time spent in the workforce to attend to caregiving needs[28] – out-of-pocket health and education costs associated with increased needs – stress associated with elevated caregiving needs, communication difficulties and increased need for support and financial resources [29,30] • Time costs for patients and their families associated with searching and understanding complaints procedures and completing complaints requirements • Time costs (and potential duplication of out-of-pocket costs) for patients and their families associated with finding the correct clinician type for their health care needs. **Audiologists** • Voluntary membership costs for Audiology Australia or the Australian College of Audiology. **Employers** • Time costs and administrative costs associated with recruitment to assess appropriateness to practice • Time costs and administrative costs associated with searching and understanding complaints procedures. **Practitioner professional bodies** • Organisational costs associated with operation. **Government** • Health and social welfare service utilisation (e.g., NDIS, Disability Support Pension) • Needs-based educational funding requirements • Receipt, assessment and investigation of complaints by HCEs • Compensation claims for instances of substandard care.

Table 4.2 Key benefits and costs of Option 5 - Regulation of audiologists that perform paediatric diagnostic and cochlear implant care services

Key Benefits
Key benefits are generalised at this time, as specific design choices will change the nature of benefits. **Patients and their families** • Improved standard of care for vulnerable paediatric cohorts **Audiologists** • Improved recognition of professional ability to deliver an advanced scope of practice **Employers** • Reduced time costs associated with uncertainty under the current state.
Key Costs
Key costs are generalised at this time, as specific design choices will change the nature of costs. **Patients and their families** • Continued costs associated with harms occurring outside of paediatric settings **Audiologists** • Initial costs to register compliance with regulatory mechanism • Ongoing costs to maintain compliance with regulatory mechanism • Transition costs for audiologists that are unable to comply with new regulatory mechanism **Employers** • Compliance costs associated with regulatory mechanism **Government** • Costs to government of legislative change and establishment of regulatory mechanism • Additional ongoing costs of the regulatory mechanism.

Table 4.3 Key benefits and costs of Option 6 - Jurisdictional registration of the audiology profession

Key Benefits
Benefits for Option 6 are similar to Option 7, except occurring at a jurisdictional level for patients and families, audiologists, employers and governments that choose to enact the regulation. Additional benefits are described below. **Government** • Maintains freedom of choice for States and Territories on whether to pursue this mechanism based on their assessment of costs and benefits.
Key Costs
Costs for Option 6 are similar to Option 7, at a jurisdictional level for patients and families, audiologists, employers and governments that choose to enact the regulation. Additional costs are described below. **Employers** • Increased time and administrative costs associated with checking an additional register for suitability to practise (for prospective employees who have worked in a jurisdiction with registration) • Potential for adverse selection issues where poorly performing clinicians seek to work in jurisdictions without jurisdictional registration.

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[28] Barton GR, Stacey PC, Fortnum HM, Summerfield AQ (2006), Hearing-impaired children in the United Kingdom, IV: cost-effectiveness of pediatric cochlear implantation. Ear Hear. 27(5):575-88. doi: 10.1097/01.aud.0000233967.11072.24. PMID: 16957506.

[29] Krug E, Cieza A, Chadha S, Sminkey L, Martinez R, Stevens G, White K, Neumann K, Olusanya B, Stringer P, Kameswaran M, Vaughan G, Warick R, Bohnert A, Henderson L, Basanez I, LeGeoff M, Fougner V, Bright T, Brown S (2016), *Childhood hearing loss: strategies for prevention and care.* In WHO Library Cataloguing-in-Publication Data. See: <https://www.who.int/docs/default-source/imported2/childhood-hearing-loss--strategies-for-prevention-and-care.pdf?sfvrsn=cbbbb3cc_0>.

[30] Zaidman-Zait A, Most T, Tarrasch R, Haddad-eid E, Brand D (2016), *The Impact of Childhood Hearing Loss on the Family: Mothers' and Fathers' Stress and Coping Resources.* J Deaf Stud Deaf Educ.21(1):23-33. doi: 10.1093/deafed/env038. Epub 2015 Sep 11. PMID: 26363022.

Table 4.4 Key benefits and costs of Option 7 - National registration of audiology profession under the NRAS

Key Benefits

Patients and their families
• Reduction in harms and costs associated with unaddressed hearing loss (See Option 1 – Status Quo) for example:
  – Reduced probability of developmental vulnerability
  – Improved self-esteem and social activity
  – Reduction in lost earnings
  – Reduced stress associated with caregiving needs
• Reduced time costs associated with searching and understanding complaints procedures and completing complaints requirements
• Peace of mind associated with nationally consistent complaints mechanism to enact professional sanctions for unethical or improper practice.
Audiologists
• Protection of title
• Nationally consistent and enforced complaints mechanisms with the power to prohibit practice – increasing the standard of care delivered by the profession
• Nationally recognised recognition of appropriateness to practice, reducing costs associated with changing employers (including across jurisdictions)
Employers
• Reduced recruitment costs for employers assessing appropriateness to practice
• Reduced time costs associated with searching and understanding complaints procedures
Government
• Reduced health and social welfare service utilisation
• Reduced needs-based educational funding requirements
• Reduced costs for HCEs associated with receipt, assessment and investigation of complaints against audiologists
• Improved understanding of audiology workforce supply through inclusion in the National Health Workforce Dataset
• Reduced costs associated with compensation claims for instances of substandard care.

Key Costs
Patients and their families • Any costs passed through to the community as a result of registration. **Audiologists** • Initial time and fee costs to register under the NRAS • Annual registration fees • Time costs associated with increased requirements (e.g., continuing professional development) • Transition costs for audiologists that are unable to register under NRAS **Employers** • Compliance costs associated with regulatory change (e.g. compliance with protection of title) **Government** • Costs to government of legislative change • Establishment costs for administrative components of registration under the NRAS (e.g., a National Board).

5 Consultation questions

The following consultation questions are posed to key stakeholders.

Context

- *Are you comfortable this context is an accurate representation of the audiology profession and sector more broadly? If not, please explain why.*
- *Has the regulatory landscape and current operating environment (e.g., current complaints mechanisms) been described correctly?*

Harms

- *To what extent are you aware of harms that occur but go unreported or undetected?*
- *Are there other harms that are not mentioned above?*
- *Do any of the harms in this Consultation Paper seem misrepresented? (i.e., under or overstated?)*
- *Are you able to provide data sets or information to quantify the harms of current state? This could include number of complaints, or secondary costs associated with the ongoing treatment of developmental delays.*

Options

- *Are there any other options that you think would help address the problems and reduce the risk of harm?*
- *Are there any adjustments to the feasibility or impact assessments that have been made regarding the options?*
- *Are there adjustments you would make to the definition of any of the options, that you think would have a meaningful impact on the feasibility or impact of the option to address the problem statements?*
- *Do you have a preference in relation to the regulatory mechanism that could be used under Option 5 to regulate audiologists that perform paediatric diagnostic and cochlear implant care services?*

Benefits and costs

- *What other benefits and costs haven't been included in Section 4, but should be?*
- *Are you able to provide data sets or information to quantify the benefits and costs described in the shortlisted options?*