Queensland Health

Consultation Paper 2

Audiology Decision RIS

Queensland Government

Contents

1 Introduction

1.1 Background

At the 13 December 2023 Health Ministers Meeting (HMM), state and territory Health Ministers commissioned a Decision Regulatory Impact Statement (Decision RIS) to assess future options for regulating the audiology profession, including national registration under the National Registration and Accreditation Scheme (NRAS) administered by the Australian Health Practitioner Regulation Agency (AHPRA).

The Decision RIS was prepared in accordance with the *Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies June 2023*, administered by the Office of Impact Analysis (OIA).

The Decision RIS employed a targeted consultation strategy involving one-on-one semi-structured interviews and focus groups with stakeholders directly affected by the proposal, as well as a public submission process.

The Decision RIS was finalised in July 2024 and assessed by OIA as compliant. The Decision RIS was considered by state and territory Health Ministers at the 16 August 2024 HMM.

The audiology profession in Australia

Key points related to the audiology profession in Australia:

- Audiology is a self-regulated profession of approximately 3,800 (noting data challenges associated with verifying workforce numbers).
- Approximately 90% of the profession practices in the private sector, and 10% in the public sector.
- Audiologists (holding a Masters-level degree) have a shared scope of practice with audiometrists (who primarily have a Diploma in audiometry). However, audiologists' additional qualifications generate a non-overlapping advanced scope of practice.
- Audiology has a number of specialisations of practice, which include paediatric diagnostic services, cochlear implant care services, and vestibular disorders.

1.1.1 Outcome of Ministerial Council review of the Audiology Decision RIS

At the 16 August 2024 HMM, the Ministerial Council considered the Decision RIS. Ministers agreed in-principle to inclusion of the audiology profession in the NRAS, however requested further work to inform a final decision. This further work includes targeted consultation with stakeholders to consider issues including costs, implementation, risks, and impacts on First Nations communities.

At the 5 September 2024 Health Workforce Taskforce meeting, members discussed steps for progressing the requested work following the August HMM. It was agreed that the Queensland Health project team would progress the next phase of research and analysis on behalf of the Health Workforce Taskforce, with a planned update to the Ministerial Council in early 2025.

1.1.2 Consultation scope and format

Targeted consultation to inform this next phase of research and analysis will occur from late 2024 through to early 2025. The consultation process includes on-one-one interviews and focus groups with selected stakeholders. All other stakeholders are invited to provide input via a public written submission process hosted on the Queensland Health website. This Consultation Paper is intended to guide and inform the stakeholder consultation.

This scope of stakeholder consultation includes gathering feedback on:

- Implementation considerations associated with national registration of the audiology profession under the NRAS – including timing, costs, and the feasibility of a multi-profession Board or a Board with two professions.
- Consideration of the key risks and unintended consequences of national registration of the audiology profession under the NRAS.
- Consideration of the impacts of national registration of the audiology profession under the NRAS on First Nations communities.
- Consideration of the audiology profession against the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*, which contains six criteria occupations must meet in order to be considered for registration under the NRAS.
- Consideration of the Audiology Decision RIS in the context of preliminary findings from the following government reviews:
    - *Regulating for Results - Review of complexity in the National Registration and Accreditation Scheme*, and
    - *Unleashing the Potential of our Health Workforce – Scope of Practice Review*.

Definition of the audiology profession

The Decision RIS of the audiology profession requested by HMM (the decision-maker) defined the audiology profession as referring to the audiologist workforce, rather than the audiologist and audiometrist workforce. To this end, the Decision RIS only considered options for the regulation of audiologists.

This current phase of research and analysis retains this definition of the audiology profession, and thus regulation of the audiometrist profession is considered out of scope for consultation. However, it is recognised that there are risks and potential unintended consequences to the audiometry profession if the audiology profession is included under the NRAS. Consideration of risks and unintended consequences to the audiometry profession is thus considered in-scope for consultation.

1.2 Structure of this document

This document contains select summarised content from the Decision RIS (and related government reviews) coupled with a series of targeted questions to solicit stakeholder feedback. The information presented in this document is not intended to be a summary of the Decision RIS. Rather, select content is provided to enable stakeholders to respond to the key questions in scope for stakeholder consultation.

The remainder of this document is structured as follows:

- **Chapter 2.** Summary of problem statements and shortlisted options considered in the Decision RIS.
- **Chapter 3.** National registration of the audiology profession under the NRAS – risks, impacts on First Nations communities, and implementation considerations.
- **Chapter 4.** Consideration of the audiology profession in the context of the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* and other government reviews.

2 Decision RIS – summary of problem statements and shortlisted options

This chapter provides a summary of the policy problem, the problem statements and the shortlisted regulatory options presented in the Decision RIS. This chapter provides context for the key questions posed in chapter 4.

2.1 Policy problem

The Decision RIS examined the policy problem of instances of substandard care occurring in the provision of audiology services in Australia. The Decision RIS identified that that the causal factors contributing to instances of substandard care are complex. Key issues were summarised across the following four problem statements:

1. For audiology services, information asymmetries, principal-agent issues and patient vulnerabilities pose an increased risk of substandard care.
2. Audiologists have limited opportunities for formalised assessments of competency (including for specialised scopes of practice), and may have inconsistent or insufficient access to continuing professional development, training and clinical governance mechanisms that support high quality care.
3. Across the sector, stakeholders note the influence of organisation-level pressures on audiologists' delivery of care.
4. For the minority of cases where an audiologist practices in an unethical or unsafe manner, factors specific to the delivery of audiology services generate barriers to enacting professional sanctions that would protect the public from harm.

External reviews of public sector audiology services

Three public-facing reviews identified significant adverse outcomes experienced by patients within paediatric diagnostic audiology and cochlear implant care services across public sector hospitals in Australia: Townsville University Hospital (2023)[1]; Women and Children's Health Network (WCHN) (2023)[2]; and Logan Hospital (2018)[3].

Please refer to these reviews for a detailed description of the findings.

Where substandard audiology care results in delayed time to diagnosis or appropriate treatment, this can have both short-term and long-term social and economic consequences for patients, families/carers, and government services, especially when diagnosis occurs after a 'critical period'.[4] Critical period refers to the specific window of time during development when the brain is receptive to certain types of auditory input. Delayed diagnosis beyond this period for can have a negative effect on speech and language development and result in long-term sensory, cognitive, emotional impairments.[5] The Decision RIS identified the following social and economic impacts associated with substandard audiology care:

- patient short-term adverse quality of life impacts associated with the immediate period of unaddressed hearing loss
- patient long-term adverse quality of life and productivity impacts associated with delayed time to diagnosis or appropriate treatment
- family/carer financial burden and informal care costs
- increased utilisation of government services (e.g., healthcare, National Disability Insurance Services (NDIS)) and welfare payments.

1 Queensland Health 2023, Investigation into Audiology Services at Townsville University Hospital, accessed from <https://www.health.qld.gov.au/__data/assets/pdf_file/0021/1281225/Townsville-University-Hospital-Part-9-Health-Service-Investigation-Audiology-Services.pdf>.

2 Independent Governance Review 2023, Paediatric Cochlear Implant Program Women's and Children's Health Network South Australia, accessed from < https://www.sahealth.sa.gov.au/wps/wcm/connect/3ea94b77-d993-40ae-a3d1-90b55d7cba20/External+Governance+Review-PaediatricCochlearImplant-Review-FinalReport-9thAugust2023.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-3ea94b77-d993-40ae-a3d1-90b55d7cba20-oEm3CkI>.

3 Office of the Health Ombudsman 2018, Investigation into the quality of health services provided by Logan Hospitalaudiology department, accessed from <https://www.oho.qld.gov.au/reports/investigation-into-the-quality-of-healthservices-provided-by-logan-hospital-audiology-department>.

4 Shojaei E, Jafari Z, Gholami M. Effect of Early Intervention on Language Development in Hearing-Impaired Children. Iran J Otorhinolaryngol. 2016 Jan;28(84):13-21.

5 Shojaei E, Jafari Z, Gholami M. Effect of Early Intervention on Language Development in Hearing-Impaired Children. Iran J Otorhinolaryngol. 2016 Jan;28(84):13-21.

2.2 Problem statements

2.2.1 Problem 1: For audiology services, information asymmetries, principal-agent issues and patient vulnerabilities pose an increased risk of substandard care.

2.2.1.1 Information asymmetries and principal agent issues

The relationship between a patient and healthcare provider is, in most circumstances, characterised by an imbalance of information between these two parties.[6] Patients are required to seek the services of an appropriate health care provider in order to make treatment decisions. In this context, the appropriate health care provider is a person who has the skills and knowledge to provide accurate information to the patient, and, if needed, high-quality goods and services. Ideally, this appropriate healthcare provider would provide all of the information needed for the patient to make an independent and rational treatment decision. Instead, patients will often elect to delegate decision-making authority to the healthcare provider, creating a principal-agent relationship. In this circumstance, the patient (the principal) is entrusting the healthcare provider (the agent) to take into account the patient's circumstances and preferences, and select the same treatment that the patient would choose if they had all of the relevant information possessed by the healthcare provider.[7]

Information asymmetries in the context of a principal-agent relationship create core challenges for a patient. Specifically, having encountered a health care provider, patients may not be able to judge:

- the accuracy of information received or quality of goods and services delivered[8]
- whether the healthcare provider made a different treatment decision to the one that the patient would have made if they had all the relevant information (i.e., if a conflict of interest resulted in a treatment decision that prioritised the agent's preferences).

It is explicitly acknowledged that these issues are characteristic of health markets in general.[9] However, audiology services have specific factors that can place the patient at greater risk of vulnerability. Stakeholder feedback was provided in relation to two specific sources of information asymmetry in audiology – scope of practice and protection of title.

[6] Poterba J 1996, Government Intervention in the Markets for Education and Health Care: How and Why?, accessed from <https://www.nber.org/system/files/chapters/c6566/c6566.pdf>.

[7] Pauly M 1980, Physicians as Agents, accessed from <https://www.nber.org/system/files/chapters/c11521/c11521.pdf>.

[8] Ibid.

[9] Poterba J 1996, Government Intervention in the Markets for Education and Health Care: How and Why?, accessed from <https://www.nber.org/system/files/chapters/c6566/c6566.pdf>.

- **Scope of practice.** Across the consultation period, there was marked disagreement between stakeholders as to whether there are scope of practice issues currently occurring between the audiologist and audiometrist professions, and if so, their importance. Where stakeholders raised scope of practice issues, it was commonly linked to it's potential to lead to patient harm, or a witnessing of patient harm which had occurred as a result of this issue. Stakeholders' concerns included:
  - scope of practice is not clearly defined between the two workforces
  - audiologists and audiometrists may be working outside of their scope of practice due to organisational pressures, where stakeholder feedback conveyed this theme primarily in relation to pressure on audiometrists working in the private sector.
- **Protection of title.** The National Law protects titles as well as specialist titles for recognised specialities. It is an offence for a person to present themselves to be a registered practitioner (or refer to themself as a protected title) if they are not, including the use of language that may lead a reasonable person to believe that they are a registered practitioner.[10] The following themes were raised from stakeholder consultation in relation to protection of title.
  - Differences of opinion on the relationship between audiometry (and audiometrists) and the word "audiology", with some stakeholders considering audiometry to be included in the definition and others not.
  - A view that there is a lack of consumer awareness of audiometry as a profession, and potentially a lack of awareness of audiometry among other health professionals as well.
  - A lack of clarity of language used in consumer-facing communication, in relation to:
    - "audiology" (e.g., use of professional titles that indicate membership with a professional body that has the word audiology in it when the person is an audiometrist)
    - "hearing specialist" (while not raised in reference to the Australian College of Audiology it is noted that until June 2024 the Australian College of Audiology defined audiometrists as having a Hearing Rehabilitation Specialist competency as the name of the credential issued by them)
    - "hearing healthcare practitioner" as a generic term used where it is unclear what the qualifications are of the treating person.

  In summary, stakeholders described issues in relation to information asymmetry that had the effect of reducing the transparency of information provided to consumers to judge whether the person treating them is an appropriate health care provider.

[10] AHPRA 2023, What we do, accessed from <https://www.ahpra.gov.au/About-Ahpra/What-We-Do.aspx>

2.2.1.2 Patient vulnerability

Stakeholders provided strong feedback that audiology patients are vulnerable across their lifespan for a range of reasons.

Paediatric cohorts

The external reviews of public sector paediatric audiology services and stakeholder consultation highlighted that paediatric cohorts may be at increased risk of substandard care due to their inability to verbalise symptoms or identify inadequate treatment. Common audiology paediatric personas include newborns with a suspected hearing condition (i.e., diagnostic cases) or infants who require a Cochlear Implant. Academic literature suggests where delayed to time to diagnosis or appropriate treatment occurs, the period of delay can lead to deterioration and subsequent long-term social and economic consequences for the individual and their family/carer.[11]

It is important to note that the events which occurred in the public sector external reviews involve processes for patients and families which are still ongoing. Due to the highly individual circumstances of each affected person, the Decision RIS did not attempt to, and should not be construed as, having assessed the social and economic impacts as a result of these specific events.

Non-paediatric cohorts

With regard to non-paediatric cohorts at increased risk of harm, stakeholders noted:

- To the extent that paediatric cohorts may be unable to verbalise their symptoms and require specialised audiologist skills in relation to testing procedures, in practice, similar skills and testing procedures may be required for other patient groups (e.g., older children and older adults).
- Elderly patients with dementia may require skilled assessment in order to determine the contribution of hearing issues to behavioural patterns, and appropriate treatment decisions.
- Cochlear implant surgeries occur across the lifespan, with 65% of cochlear prosthetic device implantations (unilateral or bilateral) occurring in patients aged 55 and over in 2021-2022.[12]
- Audiology patients may have concurrent physical and mental comorbidities and are likely to have communication difficulties. This can limit their ability to verbalise symptoms or identify inadequate treatment.

[11] Shojaei E, Jafari Z, Gholami M. Effect of Early Intervention on Language Development in Hearing-Impaired Children. Iran J Otorhinolaryngol. 2016 Jan;28(84):13-21.

[12] AIHW 2023, *Procedures data cubes*, accessed from <https://www.aihw.gov.au/reports/hospitals/procedures-data-cubes/contents/summary>.

2.2.2 Problem 2: Audiologists have limited opportunities for formalised assessment of competency (including for specialised scopes of practice), and may have inconsistent or insufficient access to continuing professional development, training and clinical governance mechanisms that support high quality care.

From stakeholder feedback, a series of profession-level goods and services were described as important for the delivery of high-quality services.

- university program with appropriate content and accreditation standards
- clinical internships that have appropriate supervision and demonstration of competencies
- continuing professional development and training that is practical, relevant and available (including for specialised scopes of practice)
- clinical governance frameworks (including clinical mentoring, case conferencing, clinical guidelines and clinical audits as relevant)
- credentialling mechanisms for specialised scopes of practice (e.g., cochlear implant care).

The following factors are noted in relation to the audiology profession.

2.2.2.1 Clinical Internships

Audiology has a range of specialised scopes of practice. Stakeholders noted that interns seeking to gain experience with paediatric cohorts may face challenges including whether their organisation has the correct equipment for diagnostic services, or whether their organisation offers paediatric hearing aids.

Stakeholder feedback included the observation that the ability for public sector audiology services to offer clinical internships faced barriers including funding for the role and the feasibility of meeting time requirements to provide appropriate supervision. Hence, there may be difficulties for graduating audiologists to access clinical internships for specialised scopes of practice as part of a hospital service caseload.

2.2.2.2 Specialised scopes of practice

An element of the Status Quo which has been implemented over the past year is Audiology Australia's Advanced Paediatric Certification Framework. Noting audiology's small profession size, voluntary nature of the credential, recent implementation and small part of sectoral

activity, at the time of writing[13], the publicly available register of Certified Advanced Paediatric Audiologists had 21 audiologists. The certification does not include a formal examination of skills, rather it is a portfolio-based approach that requires applicants to provide written responses to the competencies, a referee form, followed by an online interview with assessors to discuss the applicant's experience with competencies. Stakeholder views from the consultation process included the impact of time costs, price and lack of consumer awareness of the certification on their decision whether to apply for recognition. The Decision RIS noted that a formal examination of skills (including an in-person examination) would likely increase the cost of this certification.

A number of stakeholders acknowledged that assessment of specialist competencies through a university course would likely face challenges associated with the small size of the profession, increasing per-unit cost.

A lack of certification for specialised scopes of practice creates challenges for employers to identify high-quality applicants. A similar dynamic was raised by stakeholders in relation to referral processes, where audiologists may be required to rely on individual professional networks as it is difficult to identify the scope of practice of an unknown colleague.

2.2.2.3 Continuing professional development and training

Stakeholder feedback in the public and private sector spoke of wanting to see increased access to high-quality CPD and training. It was recognised that CPD and training may be:

- provided by an employer to an audiologist (creating inconsistent access)
- sought out independently by the audiologist to meet their CPD requirements or as a personal decision (where insufficient availability of desired training was noted as an issue).

Where stakeholders provided views on training offered by manufacturers, responses were mixed. Positive opinions of manufacturer-sponsored training included the practicality and relevance of training (e.g., how to use a particular piece of equipment). Negative opinions included a perception of an inherent conflict of interest (i.e. sale of manufacturer products versus supporting best practice through the provision of appropriate evidence).

2.2.2.4 Clinical governance

Stakeholders highlighted a need for improvements in the production and availability of clinical guidance documentation across a number of areas in the sector, including cochlear implant mapping, auditory brainstem response testing and tinnitus. Stakeholders raised examples of trying to source clinical guidance documentation from other health services (for public sector audiologists), as well as searching for international documentation.

In consultation, stakeholders offered positive examples of practices that were viewed to increase the quality of services, including peer review (either one colleague or a group of colleagues), referrals for second opinions, clinical mentorship as part of multidisciplinary

[13] July 2024

team, and standardised clinical audits. It was recognised that these examples were not consistently available to audiologists, as access to these practices were dependent on:

- organisation-level decisions (particularly systematic clinical auditing)
- site-specific cultural factors (e.g., multidisciplinary team dynamics which encourage clinical mentorship between audiologists and ear, nose and throat specialists, and positive cultures for second opinions and peer reviews).

2.2.3 Problem 3: Across the sector, stakeholders note the influence of organisation-level pressures on audiologists' delivery of services.

Stakeholders described a series of organisational-level pressures that play a role in the delivery of audiology services, which can have downstream impacts on the quality of care received by the patient (including the role of conflicts of interest in delivery of services).

- **Public Sector**. In reference to the external reviews of public sector audiology services, a number of stakeholders emphasised the role of site-specific factors on the delivery of audiology services, and the contribution of these factors to the patient harms which occurred.
- **Private Sector**. One of the strongest themes that emerged across the stakeholder consultation period was the impact of commercial incentives on the delivery of patient care in the private sector. Stakeholders provided a series of views in relation to harms and conflicts of interest related to the private sector which included:
  - Ownership of hearing clinics by hearing aid manufacturers (i.e. vertical integration of market)[14]
  - Sales-based renumeration structures and sales-based performance targets[15]
  - Selling of hearing aids to vulnerable patients which are more expensive than clinically necessary or where there is a limited evidence base for recommendation
  - High profit margins on hearing aids
  - Loss leader pricing activities (i.e. offering of free hearing screenings)[16]
  - Management pressures on audiometrists to work outside of their scope of practice (i.e., to provide services at an audiologist level)

[14] Described in: Australian Competition and & Consumer Commission 2017, *Issues around the sale of hearing aids*, accessed from <https://www.accc.gov.au/about-us/publications/issues-around-the-sale-of-hearing-aids> and Woods and Burgess 2021, *Report of the Independent Review of the Hearing Services Program*, p102, accessed from < https://www.health.gov.au/sites/default/files/documents/2021/09/report-of-the-independent-review-of-the-hearing-services-program-report.pdf>.

[15] Described in the abovementioned ACCC report and returned to in: Simpson A, Fawcett M, McLeod L, Lin J, Tuncer S and Sarkic B (2023), 'Financial incentives and moral distress in Australian audiologists and audiometrists', Clinical Ethics, 18(1): 20-25.

[16] A range of organisations offer these services, as seen by an online query of the search term 'Australia free hearing checks'.

– Management of conflicts of interest in relation to hearing device manufacturers and Practitioner Professional Body (PPB) Board membership.

These concerns were raised despite sectoral changes implemented in response to the Australian Competition and Consumer Commission 2017 review 'Issues around the sale of hearing aids'[17], which included changes to the sectoral *Code of Conduct*.

2.2.4 Problem 4: For the minority of cases where an audiologist practices in an unethical or unsafe manner, factors specific to the delivery of audiology services generate barriers to enacting professional sanctions that would protect the public from harm.

From qualitative observations made in stakeholder interviews and public submissions, a disconnect emerged in relation to perceived levels of harms occurring in the current state compared to quantitative complaints data able to be obtained. For stakeholders, perceived harms included both clinical harms (including missed diagnoses and inappropriate treatment decisions) as well as financial harms to patients. It is explicitly acknowledged that the voluntary completion of a public submission may have been driven by the perception of harm occurring. As a result, this sample of stakeholder views may not be representative of the views of the profession or the sector more broadly. It may also not be representative of the actual underlying risk of harm to the public or the level of harm occurring. However, if stakeholder perceptions are valid, then under-reporting of harms may be due to a range of factors which include:

- the ability of patients, families and clinicians to recognise and act upon harm
- the ability of current state regulatory settings to manage harm effectively (including audiology as a self-regulated profession).

The following observations are noted in relation to current state regulatory settings.

- **Ethics Review Committee**[18]. The two audiology PPBs [Audiology Australia (AudA) and the Australian College of Audiology incorporating Hearing Aid Audiology Society of Australia (AcAud inc. HAASA[19])] have an identical *Complaints Management and Resolution Procedure* managed through an independent Ethics Review Committee (ERC). If the ERC's Hearing and Investigation Panel makes a finding that the respondent has breached any

[17] Australian Competition and & Consumer Commission 2017, *Issues around the sale of hearing aids*, accessed from Cf<https://www.accc.gov.au/about-us/publications/issues-around-the-sale-of-hearing-aids>.

[18] Since the time of writing the Decision RIS, the Ethics Review Committee has been replaced by the Hearing Professional Conduct and Complaints Body.

[19] The Australian College of Audiology incorporating HAASA includes both audiologist and audiometrist members.

of the principles of the *Code of Conduct*, the [PPB] ERC may recommend a sanction. However:

  - Without mechanisms to force mandatory inclusion in the ERC scope, it is not possible for the ERC to provide a complaints handling function to the entire practising audiology profession in Australia.
  - The ERC does not have the power to prohibit an audiologist from practising their profession (while noting that sanctions applied to membership and/or clinical certification status would be financially prohibitive for private sector audiologists).
  - In relation to business practices, there are several standards within the sectoral *Code of Conduct* which relate to individual audiologists and issues such as financial incentives. Thus, sanctions are able to be applied at this level. However, the *Code of Conduct* is not able to be enforced against people not within the Ethics Review Committee's remit (e.g., business owners who are not audiologists).

- **Jurisdictional Health Complaints Entitles (HCEs).** For jurisdictions with the National Code of Conduct for Health Care Workers enacted, their health complaints entity (HCE) is able to issue Interim Prohibition Orders and Prohibition Orders against audiologists if they believe that there has been a breach to the code, and there is a serious risk to the public. These orders prohibit the delivery of part or all of a health service for the period specified, including permanently. There is mutual recognition of orders made in other states and territories, however members of the public and employers are required to search individual jurisdictional websites to obtain this information. Jurisdictional HCEs also have remit over health service providers, however this was observed to not be well known among stakeholders.

Complaints against audiologists may be reported to providers directly (e.g., large corporate entities that may have internal complaints mechanisms), PPBs (including the ERC), jurisdictional HCEs or national entities such as the Hearing Services Program. Complaints data was sourced from several of these entities to inform the Decision RIS. Overall, the number of complaints received between FY2018-19 and FY2022-23 was low, with a limited number of sanctions noted overall. Due to the low numbers of complaints, trends were not able to be observed.

Overall, if stakeholder perceptions are valid and there is under-reporting of substandard care, this may have:

- significant impacts on the patient (particularly if they are unaware that substandard care has occurred as they would be unable to seek appropriate treatment or recompense)
- significant impacts on the audiologist (as they would not have the ability to undertake corrective actions to address skills issues, or would not face appropriate sanctions in the event of unethical treatment decisions).

Stakeholder descriptions of substandard care appear to describe events that are in breach of current regulatory settings (e.g., the sectoral *Code of Conduct*). While limited stakeholders provided reasoning for not reporting (or factors that contributed to decision-making regarding whether to report), issues described included the inability for the ERC to investigate business practices and fear of potential retaliation. It could also be inferred from stakeholder responses that there are gaps in awareness of the remit of HCEs to investigate health service providers. Hence, to the extent that stakeholder perceptions are valid and

instances of substandard care are being under-reported, this represents an ineffective system of complaints management under the current state.

2.3 Shortlisted options

In the Decision RIS, four regulatory options for the audiology profession were considered in an impact analysis (i.e., assessment of costs and benefits). These four options were shortlisted based on stakeholder feedback and an assessment of feasibility and impact in addressing the problem statements. The four options included:

- Status Quo - the current state
- Strengthened Status Quo – jurisdictional clinical certification of public sector audiologists and uplift in CPD
- Jurisdictional registration of the audiology profession
- National registration of the audiology profession under NRAS.

A description of each option is summarised in the following sections.

2.3.1 Status Quo

Audiology is currently a self-regulated allied health profession. The Status Quo includes the following elements.

- **PPB Membership with NASRHP**. As part of the broader landscape of self-regulating health professions, the National Alliance of Self-Regulating Health Professionals (NASRHP) is a self-organised independent body that provides a quality framework for self-regulating health professions.[20] NASRHP's decision-making powers are related to its membership. PPBs that seek membership with NASRHP are required to meet benchmark standards for regulation and accreditation of practitioners.

  AudA is a Full Member of NASRHP. AcAud inc. HAASA states that they have completed the necessary actions to comply with Full Membership, envisioning acceptance within 12 months.[21]
- **Current clinical certification**. As a signal of currency of skills, ongoing continual professional development (CPD) and recency of practice requirements are reflected in the membership/current clinical certification requirements of the PPBs as outlined below.
  - AudA: As per Audiology Australia's *Mandatory Declarations Policy*, there are nil recency of practice or CPD requirements for initial membership or renewal of

[20] National Alliance for Self-Regulating Health Professionals 2024, *About NASRHP*, accessed from <https://nasrhp.org.au/about/>.

[21] Australian College of Audiology 2024, information submitted.

membership as a Full Member of Audiology Australia.[22] However, in order to annually renew clinical certification, individuals are required to:[23]

- practise 200 hours in the past 12 months or 1000 hours over the past 5 years (or have a Resumption of Practice Plan in place in accordance with Audiology Australia's *Recency and Resumption of Practice Policy*)
- complete a minimum of 20 CPD points (or pro-rata equivalent) in accordance with the requirements of Audiology Australia's *CPD Policy and Procedure for Participants*.

Audiologists are able to pay for current clinical certification with AudA without paying for membership. AudA states that 5% of audiologists with current clinical certification are audited with respect to CPD each year.[24]

– AcAud inc. HAASA: Prior to 1 July 2024, to be a Full/Ordinary/ Fellow member of AcAud, members must have current clinical certification, which included CPD and compliance with resumption of practice requirements. AcAud inc. HAASA had a two-year CPD cycle where audiologists were required to complete 50 CPD points over two years. Since 1 July 2024, audiologists are able to apply for current clinical certification separate to membership. From 1 July 2025, consistent with AudA, audiologists will be required to complete 20 CPD points annually, with an annual membership and audit cycle.[25]

Audiologists are required to hold membership and/or current clinical certification in order to claim for services provided under a range of government funded programs (e.g., Medicare, NDIS, Australian Government Hearing Services Program) and services covered by private health insurance.

- **Public sector requirements**. Public sector employers do not have membership and/or current clinical certification with a PPB as a minimum employment standard. Jurisdictions advised that the employment frameworks do not support the imposition of an 'accreditation'-type requirement on non-registered health practitioner employees. A requirement for certification for audiologists is likely to set a precedent for requiring mandatory certification for the other self-regulated allied health profession employed by public health services. Instead, jurisdictions have a university qualification requirement, with some stating an additional requirement for 'eligibility for membership with AudA'. As a result, public sector audiologists may not be within the scope of the ERC if they are not a member and/or clinically certified with a PPB.

[22] Audiology Australia 2024, *Mandatory Declarations Policy*, accessed from the Resource Library of the Audiology Australia website.

[23] Ibid.

[24] Audiology Australia 2023, *Advanced Paediatric Certification Framework*, accessed from the Resource Library of the Audiology Australia website.

[25] Australian College of Audiology 2024, information submitted.

2.3.2 Strengthened Status Quo – jurisdictional clinical certification of public sector audiologists and uplift in CPD

This option retains the current self-regulatory model, with the addition of jurisdictional current clinical certification for public sector audiologists and an uplift in CPD. Under this option, state and territory health departments would voluntarily decide to amend their minimum employment standards for audiologists to mandate current clinical certification. In addition, national government expenditure would directly fund CPD for topics considered to be of high priority for the profession, which may include:

- topics where there is evidence of public harm which has already occurred
- topics where it is considered there is a risk of public harm and the market is unlikely to provide this CPD otherwise (e.g., specialty areas of practice).

2.3.3 Jurisdictional registration of the audiology profession

This option requires audiologists to register in their jurisdiction to practise. It is noted that state and territory-based registration was the regulatory model for workforce regulation in Australia prior to the introduction of the NRAS[26], and is the current regulatory approach for audiology in the United States and Canada. A Registration Board is created which has functions including endorsing professional standards, determining applications for registration and complaints handling (including disciplinary proceedings).

Jurisdictional registration boards would have powers and functions similar to those of a National Board under the NRAS. Under this model of regulation, individual boards in each jurisdiction would establish and administer a register of audiologists with a set of registration standards. An unregistered person would not be legally allowed to use the title of 'audiologist' or to hold themselves out as being a registered audiologist. If an audiologist wished to work across jurisdiction boundaries, they would need to maintain registration in any jurisdiction which requires it. Using jurisdictional regulation of social work as an exemplar, this option would also define a scope of practice.

The functions of jurisdictional boards for registration of audiologists would be expected to mimic those as outlined per the Social Workers Registration Board of South Australia.[27] Specifically, these functions include:

- to administer the provisions for the regulation of the practice of audiology;
- to provide a definition of audiology services;

[26] Australian Government, Productivity Commission, Australia's Health Workforce – Productivity Commission Research Report, 2005.

[27] Social Workers Registration Act – South Australia (2021)

- to establish and maintain a register of audiologists;
- to prepare or endorse codes of conduct, professional standards and ethical guidelines for registered audiologists;
- to determine the qualifications and other requirements appropriate for registration;
- to receive and determine applications for registration of audiologists;
- to establish processes for handling complaints relating to the practice of audiology;
- to hear and make determinations in disciplinary proceedings against a person;
- to carry out other functions assigned to the Board or by the Minister.

It is anticipated jurisdictional registration of the audiology profession would have similar impacts as national registration under NRAS, compared to the current state. However, it would be more costly due to the loss of economies of scale achieved with one National Board.

2.3.4 National registration of the audiology profession under NRAS

This option proposes the inclusion of the audiology profession under the NRAS. The goal of the National Law was to create a national registration and accreditation scheme for health practitioners practising in specified health professions. 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 (hereafter, the National Boards) for each health profession included in the National Scheme
- the role of the Ombudsman and Commissioner.

2.3.4.1 Australian Health Practitioner Regulation Agency (AHPRA)

AHPRA's primary function is to provide administrative support and assistance to the National Boards and the National Board's committees in the exercise of their functions.[28] The core regulatory functions of AHPRA include:[29]

- **Professional standards**: AHPRA provides advice to the National Boards for each profession about registration standards, codes and guidelines for health practitioners.
- **Registration**: In partnership with National Boards, AHPRA ensures that only health practitioners with skills and qualifications to provide competent and ethical care are

[28] AHPRA 2023, *Regulatory Guide*, accessed from <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>.

[29] AHPRA 2023, *What we do*, accessed from <https://www.ahpra.gov.au/About-Ahpra/What-We-Do.aspx>.

registered to practise. In addition, AHPRA manages registration and renewal processes for local and overseas qualified health practitioners and manage student registration.

- **Notifications**: AHPRA manages concerns and complaints raised about individual health practitioners in relation to their health, performance and conduct on behalf of the National Boards, except in Queensland and New South Wales where AHPRA manages only notifications referred to AHPRA. AHPRA works with jurisdictional HCEs to have community concerns about health practitioners managed by the appropriate organisation.
- **Compliance**: AHPRA performs monitoring and audit activities to ensure that registered health practitioners are complying with Board requirements.
- **Accreditation**: AHPRA works with accreditation authorities and committees to ensure graduating students are suitably qualified and skilled to apply to register as a health practitioner.

2.3.4.2 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:

- **Registration Standards**. The National Board sets registration standards that practitioners must meet in order to register.
- **Accreditation Standards.** The National Board approves accreditation standards and accredited courses as providing qualifications for registration. It also determines if a practitioner with overseas qualifications qualifies for registration. The National Board also decides on an accreditation authority (either a committee or external entity) which performs roles including developing accreditation standards and assessing programs of study.[30]
- **Regulatory Processes including Complaints Management**. The National Board is involved in regulatory processes including the conduction of hearing panels and referring relevant matters to tribunals.[31]

The National Boards can delegate certain decision-making powers to state and territory Boards, national committees or to AHPRA.[32]

2.3.4.3 Complaints management for registered professions

Following a notification, AHPRA must refer the notification to the relevant Board (or relevant co-regulatory agency). A Board may:

[30] AHPRA 2023, *Accreditation*, accessed from <https://www.ahpra.gov.au/Accreditation.aspx>.

[31] Parliament of Australia (2023), *Health practitioner regulation: a quick guide*, accessed from <https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2324/Quick_Guides/HealthPractitionerRegulation>.

[32] AHPRA 2023, *Delegations*, accessed from <https://www.ahpra.gov.au/National-Boards/Delegations.aspx>.

- not take further action
- start an investigation into the practitioner (where the Board directs an appropriate investigator – usually an AHPRA employee)
- consider immediate action about the practitioner
- consider cautioning the practitioner
- consider imposing conditions (or accepting an undertaking) from a practitioner
- requiring the practitioner to undergo a health or performance assessment
- referring the practitioner to a hearing by panel
- referring the practitioner to a responsible tribunal.

As part of these processes, they are key distinctions between behaviour which constitutes unprofessional conduct (where unsatisfactory professional performance is a subset of unprofessional conduct) or professional misconduct.[33] As per AHPRA's Regulatory Guide, "*A substantial departure from standards may constitute professional misconduct, whereas a lesser departure is more likely to be characterised as unprofessional conduct or unsatisfactory professional performance*."[34] A Board must refer a matter about a registered health practitioner to a responsible tribunal if the Board reasonably believes that the practitioner has behaved in a way that constitutes professional misconduct or that registration was improperly obtained, or a panel established by the Board required the Board to refer the matter to a responsible tribunal. The tribunals in each state and territory are the jurisdiction's Civil and Administrative Tribunal (in Western Australia –the State Administrative Tribunal).[35]

In relation to the potential sanctions, AHPRA states:[36]

- Only a court or tribunal has the power to cancel a health practitioner's registration.
- A health practitioner whose registration has been cancelled is forbidden from practising the profession or working in any way as a health practitioner in that profession in all Australian states and territories. All health practitioners who have had their registration cancelled by a court or tribunal, been disqualified from practice or had their registration prohibited appear on the (publicly available) cancelled health practitioners register.
- There is also a (publicly available) list of practitioners who have agreed not to practice when a National Board thinks this is in the public interest.

The Decision RIS noted that a centralised searchable register of cancelled health practitioners is not available for professions that are not registered under the NRAS. Under

[33] AHPRA 2023, *Regulatory Guide*, accessed from <https://www.ahpra.gov.au/Publications/Corporate-publications.aspx>.

[34] Ibid, p55.

[35] AHPRA 2023, *Tribunal hearings*, accessed from <https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Tribunal-hearing.aspx>.

[36] AHPRA 2023, Possible outcomes, accessed from < https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Possible-outcomes.aspx# >.

the National Code, health professionals which are subject to an Interim Prohibition Order or Prohibition Order appear on individual jurisdiction websites instead.

The following complaints management procedures are noted for specified jurisdictions:

- **Queensland:** Queensland has a single-entry complaints entity called the Office of the Health Ombudsman (Queensland's HCE). Upon receiving a notification, AHPRA must refer complaints about registered practitioners to the relevant National Board and OHO.
- **New South Wales:** New South Wales retained its existing health complaints process when the National Law was introduced. The NSW HCE (the HCCC) works with NSW's Health Professional Councils Authority (and each relevant health professional council) to manage concerns. Upon receiving a notification, AHPRA must refer complaints about registered practitioners to the relevant National Board, and the aforementioned co-regulatory agencies.

2.3.4.4 Relevant impacts of National Scheme Inclusion

National Scheme inclusion has the following relevant impacts for this Decision RIS:

- **Protection of title**: The National Law protects titles as well as specialist titles for recognised specialities. It is an offence for a person to present themself to be a registered practitioner (or refer to themself as a protected title) if they are not, including the use of language that may lead a reasonable person to believe that they are a registered practitioner.[37]
- **Practitioner registration**: AHPRA maintains a publicly available register of practitioners, including any conditions or undertakings that have been placed on a person's registration. AHPRA also maintains a searchable register of cancelled, disqualified and/or prohibited health practitioners.
- **Notifier protections:** As per AHPRA's website, "*Section 237 of the National Law applies to a person who, in good faith, makes a notification under the National Law, or gives information to an investigator in the course of an investigation. It also states that such a person is not liable, civilly, criminally or under an administrative process, for the giving of that information. This is deemed to include defamation, and professional regulation (i.e. it is not a breach of professional etiquette or ethics, or a departure from professional standards).*"[38] In summary, notifier protections seek to protect the public from harm by providing safeguards for notifiers that minimise fear of financial or professional harm that may result from making a compliant.
- **Mandatory notifications:** Registered health practitioners and employers of registered health practitioners may be required to make a mandatory notification to AHPRA in relation to four types of concerns, noting that the key issue is an assessment of the risk of harm to the public. These four concerns are impairment, intoxication while practising,

[37] AHPRA 2023, *What we do*, accessed from <https://www.ahpra.gov.au/About-Ahpra/What-We-Do.aspx>.

[38] AHPRA 2023, *Protections for notifiers*, accessed from <https://www.ahpra.gov.au/Resources/Cosmetic-surgery-hub/Information-for-practitioners/Protections-for-notifiers.aspx>.

sexual misconduct or significant departure from accepted professional standards.[39] Mandatory notifications help to protect the public by ensuring that AHPRA and the National Boards are alerted to instances of serious potential risk to the public.

However, in relation to scope of practice and organisational pressures mentioned above, the following points are noted.

- As per AHPRA, "*The National Scheme is not a scope of practice model. With a few exceptions (that apply to restricted dental acts, prescription of optical appliances and manipulation of the cervical spine), the National Law does not define what a registered health practitioner can do.*" As such, stakeholder feedback that wanted a more defined and enforced scope of practice for audiologists may not be able to see this achieved, unless activities that stakeholders voiced concerns about meet the threshold of designating a restricted act, with wording to this effect requiring inclusion in National Law legislation.
- As per AHPRA, "*Under the National Scheme, notifications can be made about the health, conduct or performance of individual health practitioners; **we do not have power to investigate or take regulatory action against organisations.***[40] *Health Complaint Entities, such as the Health Ombudsman of Queensland (OHO) are able to look at system-wide issues, as occurred with the Queensland OHO's investigation into the quality of health services at Logan Hospital's audiology department*." Hence, stakeholder preferences that are based on increased regulation and enforcement of business practices may not see these objectives achieved.

[39] AHPRA 2023, *Making a mandatory notification*, accessed from < https://www.ahpra.gov.au/Notifications/mandatorynotifications/Mandatory-notifications.aspx#>.

[40] Emphasis added.

3 National registration under the NRAS – risks, impacts on First Nations communities, and implementation considerations

This chapter provides an overview of select content from the Decision RIS related to the option to implement national registration of the audiology profession under the NRAS. This includes:

- risks
- competition impacts
- impacts on First Nations communities
- implementation considerations

A series of questions are posed to gather stakeholder feedback on each of these areas.

3.1 Risks of National Registration under the NRAS

The Decisions RIS identified a number of implementation risks associated with the option to regulate the audiology profession under the NRAS. These risks are outlined below.

Table 1.1 National registration of the audiology profession under the NRAS – implementation risks

#	Risk	Likelihood	Consequence
1	**Loss of PPB revenue leads to reduction in profession-level goods**. To the extent that redundant functions of PPBs are able to have their operational costs fully removed, proportionate reductions in membership fees should not impact financial viability. However, if PPBs face additional price sensitivity from audiologist members due to the addition of NRAS registration fees, PPBs may be required to reduce their membership fees further and seek cost saving measures. If these cost-saving measures impact the production of profession-level goods such as CPD, this may have negative impacts for the profession.	Moderate	High
2	**Increased professional indemnity insurance costs for audiologists (and potentially audiometrists).** As a result of national registration, there may be increases to professional indemnity insurance costs which could effect audiologists and potentially audiometrists. Potential increases were not able to be estimated, however are part of proposed implementation monitoring.	Moderate	Moderate/High

#	Risk	Likelihood	Consequence
3	**Substantial burden for small businesses to meet one-off implementation costs associated with protection of title.** Protection of title decisions that are required to be made at a future date may lead to increasingly restrictive language for private sector business materials. While this is a one-off implementation cost, small businesses may face proportionally greater burden in meeting this one-off cost.	Moderate	Minor
4	**Increased salary expectations in private sector leading to higher out-of-pocket consumer costs.** A potential unintended consequence raised was that increased regulatory costs for audiologists may lead to increased salary expectations from employee audiologists. Here, regional and rural businesses were considered more vulnerable due to workforce supply issues. If these wage expectations were required to be met, these costs may be passed through to consumers.	Moderate	Moderate
5	**Avoidance of regulatory burden by employers.** An additional potential unintended consequence raised through the consultation period was businesses attempting to avoid regulatory burden associated with audiologists by hiring audiometrists instead. There are several dynamics observed to be associated with this potential concern, including: • the similar scope of practice between audiologists and audiometrists working in private sector rehabilitation services (including the limited differentiation between these professions in the eligibility requirements for providing services under the Hearing Services Program) • the relatively small Australian audiometrist workforce (acknowledging that new audiometrist training courses could be created or workforce could be sourced from overseas) • the fact that individual site-level decisions regarding hiring of audiologists versus audiometrists would have follow-on consequences for business materials associated with protection of title (i.e. the absence of an audiologist would change the language requirements for business materials in order to comply with protection of title). Potential impacts include reduction in access to audiology services, and the transfer of regional and rural audiometrists to metropolitan areas (see below).	Unlikely/ Moderate	High
6	**Reduced consumer confidence in audiometrist services.** From the Hearing Health Workforce Audit, it can be seen that close to 60% of audiometrists are located in areas classified as MMM 2-7 (where 70% the Australian population is located in MMM1 – Metropolitan). Hence, audiometrists play a large role in the delivery of services in regional and rural areas. Reduced consumer confidence in audiometrist services may reduce the likelihood of seeking care, or affect the profitability of regional and rural businesses hiring audiometrists. Balanced against this is whether consumer awareness of this issue is sufficiently raised following national registration of audiologists to impact health care decision-making.	Unlikely	High

Key questions

3.1. Can you provide insights or evidence to support the likelihood that the identified risks will occur and/or the materiality of the risks?

3.2. Risk #3 outlines one potential business compliance cost associated with national registration. Are there other business compliance costs that should be considered?

3.3. Are there other substantive risks or unintended consequences of national registration under the NRAS that should be accounted for? What strategies could mitigate these risks?

To support your responses, please refer to case studies from other professions, where relevant.

3.2 Competition impacts of national registration under the NRAS

With regard to competition impacts, the Decision RIS noted that national registration may have some effect on competition relative to the Status Quo. Individuals would be prevented from using the title 'audiologist' unless they held national registration. Some stakeholders raised concerns that:

- current practicing audiologists may become audiometrists to avoid paying registration fees
- private providers may choose to hire an audiometrist as a substitute for an audiologist to avoid regulatory burden.

From this perspective, national registration would slightly reduce the number of practitioners employed as audiologists in the private sector. However, overall, stakeholders felt that national registration was not expected to materially influence a practitioner's decision to enter or exit the audiology profession.

As noted in Table 3.1 (Risk #4), there is a risk that national registration may increase labour costs in thin markets (e.g. regional and rural areas) where the labour market holds the negotiating power. Private providers may be required to offer higher wages and/or expand salary packages to cover the cost of mandatory registration/renewal and application fees. Some stakeholders raised concerns that these costs could be passed on to consumers.

Key questions

3.4. Do you have any further observations regarding the type, likelihood and materiality of possible competition impacts associated with national registration of the audiology profession under the NRAS?

To support your responses, please refer to case studies from other professions, where relevant.

3.3 Impacts on First Nations communities

The Decision RIS noted that First Nations communities are disproportionality affected by hearing conditions. To this end, any adverse patient impacts associated with national registration of the audiology profession under the NRAS would disproportionately affect people from First Nations backgrounds. In addition, the Decision RIS noted that if the risk associated with increased salary expectations in the private sector leading to higher out-of-pocket consumer costs is realised (i.e., Risk #4 in Table 3.1), this may disproportionately affect people from First Nations backgrounds as they are overrepresented in regional and rural areas where the labour market holds the negotiating power.

Key questions

3.5. When considering national registration of the audiology profession under the NRAS, are there any other potential impacts specific to First Nations communities that should be considered and accounted for?

3.4 Implementation considerations

To implement national registration of the audiology profession under the NRAS, the Decision RIS noted the following implementation considerations.

3.4.1.1 Board structure

As per advice from AHPRA, there are currently three ways a National Board under the NRAS could be established.

- **National Board for a single profession.** This is the current model for most professions.
- **National Board for two or more professions.** This would involve two or more new professions being regulated under the scheme with one Board established for these professions. Health Ministers would need to decide the composition of the National Board, with at least one member of each health profession for which the Board is established being appointed.
- **Multi-profession National Boards.** This would involve merging a new profession and existing National Board, to create a multi-profession board for the current and new professions. This approach would require existing National Board/s to be dissolved and a replacement multi-National Board established under the National Law regulation.

Each National Board is required to be responsible for meeting the full costs of regulating their profession. Hence, ongoing financial sustainability of each individual Board is a key priority. Given the relatively small size of the audiology workforce, the audiology profession is a candidate for a National Board with two or more professions or a Multi-Profession Board. Direct Board costs, corporate overheads and board support services would be shared across the two (or more) professions governed by the Board. This type of Board structure would significantly reduce the total costs of a Board (and thereby, registration fees for practitioners) relative to a National Board for the audiology profession only.

Drawing on benchmarks from other professions and advice from AHPRA, the Decision RIS estimates that practitioner registration fees would be approximately $500 per annum for

practicing audiologists and $100 for non-practicing audiologists if a single Audiology National Board is established. These costs may be reduced by 40% to 70% under a multi-profession National Board or a Board with two or more professions.[41]

3.4.1.2 Implementation milestones

As per AHPRA's guidance, the addition of paramedicine into the National Scheme included the following four phases:[42]

- Phase 1: Project Scoping (December 2015-March 2016)
- Phase 2: Settlement of Policy Parameters (December 2015-July 2016)
- Phase 3: Legislative Process (February 2017-March 2017)
- Phase 4: AHPRA establishing administrative arrangements and implementing regulation (March 2017-November 2018).

AHPRA's advice was that a two-year implementation timeframe for Phase 4 should be considered, for a profession that is largely in the private sector.

Key milestones include:

- Commencement of the work of the National Board
- Extensive stakeholder engagement
- Develop mandatory registration standards and any 'grandparenting' registration standards for approval by Ministerial Council
- Deciding on an accreditation authority (either delegated to an external accreditation entity or exercised internally by a committee)
- Approve qualifications for registration
- Approve accreditation standards
- Complete IT upgrades
- Enable AHPRA regulatory operations.

In relation to ongoing communication and engagement with the sector throughout implementation, it is noted that the structure of the private sector market has enabling factors for efficient communication (e.g., through large service providers such as Hearing Australia). For stakeholders that provided feedback on preferred methods of engagement, given the time-poor nature of many working audiologists and employers there was a preference for either written communication or recordings that could be watched at a time of convenience.

[41] Assumptions drawn from AHPRA, submission to Decision RIS Consultation Paper

[42] AHPRA, submission to Decision RIS Consultation Paper.

3.4.1.3 Timing considerations

- Based on paramedicine (the most recent entrant to the NRAS), it is considered likely that the inclusion of a new profession into the NRAS would take 3-4 years from the time of the Ministerial Council decision.
- The independent complexity review of the NRAS will respond to the Term of Reference: *"Consider whether the National Scheme entry criteria as specified in the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions are still fit for purpose, including what mechanisms for admission of future professions and establishment of future Boards will best support further expansion of the National Scheme, particularly in relation to allied health professions."* It is recognised that National Boards are required to be individually financially viable, and thus a new National Board structure (e.g., a National Board with two or more professions) may offer significantly reduced total costs relative to a National Board for the audiology profession only. This is considered particularly important for audiology due to the small size of the profession driving a higher initial estimate of individual registration fees for audiologists.

  Depending on the lag time between the outcome of the Decision RIS and the final settlement of policy parameters and legislation, audiology could be:

  - implemented under existing Board structures and mechanisms
  - implemented as a 'pilot' profession under new Board structures and mechanisms.

3.4.1.4 Legislative considerations

The inclusion of audiology in the National Scheme would require legislative changes to the National Law. As per the National Health Practitioner Ombudsman:[43]

- Queensland is the lead jurisdiction for implementing the National Law. If amendments are made to the National Law after approval by the Ministerial Council, Queensland:
  - submits a Bill to its parliament, in a form agreed by the Ministerial Council, which has the effect of amending the legislation in the manner agreed
  - takes all reasonable steps to secure the passage of the Bill and bring it into force in accordance with a timetable agreed by the Ministerial Council.
- These changes are automatically applied in all other parliaments that are part of the National Scheme, except South Australia (which enacts a regulation to modify the *Health Practitioner Regulation National Law (South Australia) 2010*).
- The following legislation and scheme requirements that define funding eligibility for audiologists would need to be updated to replace references to PPB membership and/or current clinical certification:
  - Hearing Services Rules of Conduct

[43] National Health Practitioner Ombudsman 2024, Legislation, accessed from <https://www.nhpo.gov.au/legislation>.

- *Private Health Insurance (Accreditation) Rules 2011*
- *Health Insurance Regulations 2018*
- *Health Insurance (Allied Health Services) Determination 2014.*

3.4.1.5 Evaluation

An evaluation of the policy change should be undertaken to evaluate whether the outcomes of implementing national registration of the audiology profession under the NRAS are aligned to the original objectives of the policy. A high-level evaluation plan was provided in the Decision RIS and is summarised below.

For a comprehensive understanding of the causes and drivers of achievement of outcomes, two types of evaluation are proposed.

- **Implementation evaluation.** Implementation evaluation is important to distinguish the outcomes of a program from it's implementation. In the event that objectives of a policy are not achieved, evaluating the implementation of the policy separately allows for insight regarding whether implementation decisions played a material role in the ability for the policy to achieve it's outcomes. Implementation evaluations also allow for rapid feedback mechanisms and findings to inform operational decisions. As an example, an evaluation of the awareness of audiologist and employers of National Scheme obligations may be undertaken by collecting survey data from these stakeholders leading up to the go-live date. In the hypothetical event that an implementation evaluation revealed low awareness of obligations, recommendations could be proposed to allocate resources to an additional set of stakeholder engagement activities to drive improved understanding moving forward.
- **Outcome evaluation.** Outcome evaluation assess the extent to which intended outcomes of the policy have been achieved. Outcome evaluations typically also include an assessment of policy outcomes relative to costs.

3.4.1.6 Evaluation plan

The first phase of evaluation activities is proposed to include the development of an Evaluation Plan, which includes:

1. The scope of the evaluation (e.g., the Terms of Reference)
2. The program objectives
3. A program logic (which outlines the theory of change of the policy including program inputs, activities, outputs, and short-, medium- and long-term outcomes)
4. The key evaluation questions that will be pursued to understand whether objectives have been achieved
5. The sources of data that will be used to answer each evaluation question (including the use of existing secondary data complemented with primary data collection methods)
6. A stakeholder engagement, a communication plan and a risk management plan
7. Governance arrangements for the evaluation.

Indicative evaluation questions are provided in the table below.

Table 3.1. Indicative evaluation questions

Criteria	Questions	Data Source
Implementation		
Awareness	To what extent are consumers aware of their rights in relation to audiology's inclusion in the National Scheme? (i.e., right to notify AHPRA of protection of title concerns) To what extent do audiologists understand their obligations under the National Scheme? To what extent do employers understand their obligations under the National Scheme?	Stakeholder consultation
Appropriateness	Have governance mechanisms been implemented as intended? Is the National Bard starting operations in a financially sustainable position?	Stakeholder consultation National Board financial documents
Outcome		
Effectiveness	To what extent has National Registration influenced harm minimisation? To what extent has National Registration increased the identification and treatment of cases of substandard care? To what extent has National Registration enhanced consumer understanding of the difference between an audiologist and an audiometrist?	Stakeholder consultation National Board, HCE and health service quality, safety and complaints data
Costs	Are the costs associated with National Registration in line with what was anticipated? (including professional indemnity insurance costs) Are there any unnecessary costs that could be mitigated?	Stakeholder consultation, including a survey of private providers National Board financial documents
Unintended consequences	To what extent have the identified implementation risks materialised? What is the impact and are they being mitigated? Are there any unintended market impacts across the hearing health provider landscape? Are there any other unintended consequence associated with national registration?	Stakeholder consultation National Board, HCE and health service quality and complaints data IBISWorld and ABS market statistics

Key questions

When considering National Registration of the audiology profession under the NRAS:

3.6. In your view, what are the strengths, weaknesses or issues associated with including the audiology profession on a National Board with two or more professions or a Multi-Profession Board?

3.7. Are there other key implementation considerations (Board structure, milestones, timing, legislative) that should be considered aside from those outlined?

3.8. Are there other lines of inquiry that the proposed evaluation plan should include?

3.9. Do you have any other relevant implementation related points to raise?

4 The audiology profession in the context of the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* and other government reviews

This chapter provides an overview of:

- The *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*, which contains six criteria occupations must meet in order to be considered for registration under the NRAS.
- A summary of key relevant preliminary findings from the *Regulating for Results - Review of NRAS Regulatory Complexity* and the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*.

A series of questions are posed to gather stakeholder feedback on:

- The extent to which to the audiology profession meets the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions criteria.
- National registration of the audiology profession under the NRAS in the context of findings from *Regulating for Results - Review of NRAS Regulatory Complexity* and the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*.

4.1 Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions

The NRAS is subject to an Intergovernmental Agreement that regulates the health professions in Australia. Additional health professions may only be included in the NRAS if the Australian Health Workforce Ministerial Council agrees, and the Health Practitioner Regulation National Law is amended accordingly.

The Intergovernmental Agreement contains criteria that occupations must meet in order to be considered for registration under the NRAS. These criteria are:

1. 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?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
3. Do the existing regulatory or other mechanisms fail to address health and safety issues?
4. Is regulation possible to implement for the occupation in question?
5. Is regulation practical to implement for the occupation in question?

6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Key questions

4.1. To what extent to do you believe national registration of the audiology profession under the NRAS meets the Intergovernmental Agreement criteria? Please provide evidence and insights to support your responses.

- For Criterion #2, consider the problem statements presented in Chapter 3. You may also choose to provide other evidence or case studies.
- For Criterion #3, consider the shortlisted regulatory options presented in Chapter 3.

4.2 Regulating for Results - Review of NRAS Regulatory Complexity

In early 2024, Health Ministers established the Independent Review*: Regulating for Results - Review of Complexity in the National Accreditation and Registration Scheme* (the Complexity Review*)* – to look behind the inherent complexity of health practitioner regulation, to identify areas of unproductive and unnecessary complexity, and propose reforms that will enable the National Scheme to work to its full potential.

The ultimate objective is to ensure that the NRAS remains 'fit-for-purpose' and meets community expectations.

A Consultation Paper with preliminary finding was released to the public in September 2024. A Final Report with identification of preferred solutions will be delivered to Health Ministers in March 2025. Of relevance to the Audiology Decision RIS, the Consultation Paper notes[44]:

There are many allied professions that are not included in the National Scheme and seek to be. While the argument in favour of this often focusses on risk, wider considerations are also in play and include professional recognition and trust and the expectation of equitable access to opportunities (such as access to Medicare benefits or ability to participate in funded programs or wider service delivery fora). There is currently only one model of registration within the National Scheme. This is a costly and complex model and there is a prospect that adding additional professions under the current governance arrangements will be unsustainable. There are other models operating overseas which could be considered, that are less cumbersome, but effective. If there were other registration pathways within the National Scheme (modelled on successful international initiatives) these could be applied to those lower risk professions seeking to join the National Scheme, where costs of regulation under the current model outweigh the benefits.

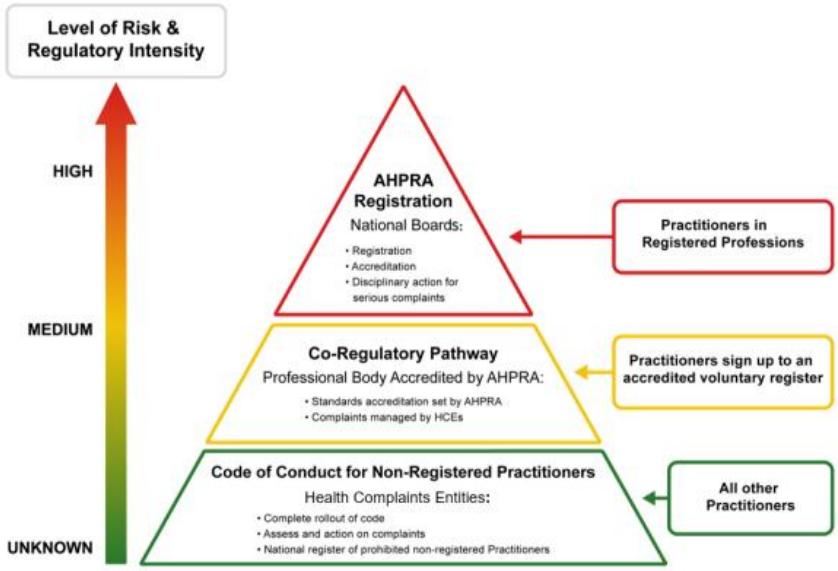
[44] Dawson, S. *Regulating for Results - Review of Complexity in the National Accreditation and Registration Scheme ('the Review') (2024). Consultation Paper 1. < https://www.health.gov.au/resources/publications/consultation-paper-1-review-of-complexity-in-the-national-registration-and-accreditation-scheme?language=en>*

As a potential solution, the Complexity Review proposes to strengthen regulation through adoption of a whole-of-system view of health workforce regulation that encompasses three-tiers of occupational regulation of health practitioners:

- *AHPRA Registration - risk and benefit-based entry to the National Scheme.*
- *Introduce a second alternative model of registration through Accreditation of Professional Bodies to maintain Voluntary Practitioner Registers.*
- *Complete the implementation and strengthen transparency of Code of Conduct for non-registered health care workers.*

The potential structure of a model to deliver these proposed reform directions is presented below in Figure 4.1.2

Figure 4.1.2 Proposed integrated 3-tier health practitioner regulation model



Source: Consultation Paper 1: Regulating for Results – Review of NRAS Regulatory Complexity

The concept is guided by the following considerations, as described in the Consultation Paper:[45]

- *As things stand there are two tiers of statutory regulation of health practitioners – AHPRA registration and regulation by State and Territory HCEs via the National Code of Conduct. There are also profession-led self-regulatory arrangements in place that have an important part to play into the future.*
- *One reform objective is to bring the two existing levels of statutory regulation or registered and non-registered health practitioners into a coherent model.*
  - *Describing the regulation of non-registered practitioners more clearly as part of a broader model of health practitioner regulation would draw attention to the*

[45] Note: Only some points are summarsied. Please refer to the Consultation Paper for a full description.

contribution of that to protection of public health and safety and the potential to strengthen that tier of regulation.

- *Under this reform concept regulation of non-registered practitioners would continue through the state and territory HCEs, but with further actions to support implementation.*

The second objective in this reform concept is to provide scope for evidence-driven and sustainable growth of the National Scheme.

- *Statutory registration under the National Scheme would continue to deliver full registration administered by AHPRA and the National Boards, through the National Law.*
- *Sustainable health practitioner regulation requires a structured and evidence informed policy basis for determining whether AHPRA registration is a necessary and beneficial solution for a specific occupation, compared with other regulatory and non-regulatory options that may also address risks to public health and safety at a lower cost.*
- *The current two staged policy and risk analysis process should therefore continue as the mechanism used to decide the inclusion of additional professions as registered professions under the national Scheme.*
- *A new "middle tier" of regulation, where AHPRA accredits a professional membership body to establish and maintain a register of practitioners (who voluntarily sign up), drawing on the successful UK model of Accredited Registers. There would need to be recognition of practitioners on these registers within the National Law. This could potentially provide another registration pathway for those professions where full statutory registration is not yet considered to be necessary. There would be costs involved with registrant fees and costs associated with AHPRA accreditation/certification processes.*

Key questions

4.2. Do you have any observations regarding the Complexity Review's proposed 3-tier health practioner regulation model as it relates to audiology?

4.3 Unleashing the Potential of our Health Workforce – Scope of Practice Review

The *Unleashing the Potential of our Health Workforce – Scope of Practice Review* ('SOP Review') Final Report was released to the public in October 2024. The work aims to understand the evidence related to health professional scope of practice in primary care, as well as the enablers and challenges to working to full scope and providing multidisciplinary team-based care. The health professionals who were considered for this Review include: general practitioners, nurses (including nurse practitioners, registered nurses and enrolled nurses), midwives, pharmacists, allied health professionals, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers and paramedics.

The SOP Review makes similar observations to Problem Statement #1 in the Decision RIS (see Section 2.2.1). It notes:

- *Audiology is a self-regulated profession and a member of NASRHP. Audiologists achieve a Masters' level qualification to provide their primary care role. This may also involve*

collaboration with ear, nose and throat specialists, GPs and other members of the primary care team.

- *The audiometry profession is regulated by non-National Law legislation and jurisdiction-based regulatory processes.*
- *Audiometrists complete a range of certifications, including to Diploma level, and conduct hearing tests across a range of settings.*
- *Currently, there is the potential for public (and health professional) confusion about the expected role of the two professions. Without registration and title protection, there is no mechanism to address this.*[46]

While there are a range of benefits to title protection that would occur if national registration of the audiology profession under the NRAS is implemented (e.g., improved consumer and employer understanding and assurance of practitioner competence), the SOP Review notes that "*because the definition of a health professional is linked to the National Law, professionals who are not included in this definition are blocked from carrying out myriad activities governed by a range of legislation and regulation that refer to that definition, in a way which is not consistent with their actual skills and competence. Further, these scope of practice issues carry implications for public access to self-regulated professions, as well as consumer understanding and confidence in relation to these professions' scopes of practice, because there is reduced visibility to the consumer about the activities which these professions are educated and competent to perform.*"

It is acknowledged that there are some overlapping scopes of practice between an audiologist and audiometrist. Given the findings of the SOP Review related to non-regulated health professions not practicing to their full scope of practice, it is possible that an unintended consequence of including the audiology profession under the NRAS could result in audiometrists not practicing to their full scope of practice.

Key questions

4.3. What is the likelihood that an audiometrist may be reluctant to provide particular services if the audiology profession is included under the NRAS? What is the impact of fewer audiometrists providing these services?

4.4. How could this issue be managed to ensure both professions are operating at their full scope of practice?

[46] Cormack, M, Unleashing the Potential of our Health Workforce (Scope of Practice Review) 2023-24. <https://www.health.gov.au/our-work/scope-of-practice-review>