Overview of the current regulatory landscape for audiologists and audiometrists.

1.1 The audiology and audiometry professions are currently self-regulated, and like all unregistered healthcare practitioners are covered by the National Code of Conduct for unregulated health workers (see 1.10 below for further discussion). Associations for practising audiologists and audiometrists provide additional oversight and standards, *should the individual practitioner choose to belong to an association*.

1.2 IAA provides a more stringent code of conduct than other industry associations; this more closely aligns with current national standards regarding the conduct of regulated health professionals.

1.3 In the case of infringement of ethical standards by an individual belonging to any hearing health practitioner association, the association will investigate the complaint and make recommendations including member expulsion.

1.4 Audiology Australia (AudA) and The Australian College of Audiology (ACAud) have formed a single ethics committee; any sanctions applied to a member of either of these membership associations is automatically extended to both. The Hearing Aid Audiology Society of Australia (HAASA) sits apart from this. These three are recognised by the government as *chosen Practitioner Professional Bodies* (PPBs). Any changes made to these PPB associations are *not subject to government oversight* nor are regulated; this lack of oversight highlights just how inadequate *ad-hoc* recognition of these self-regulating associations really is. It is unknown and highly probable that many of the current ethics committee members on these bodies have no formal ethics training.

LIMITATION: Following sanction and/or expulsion from an association, the individual practitioner is free to work with private fee paying Australians either with membership of another association or without membership of any association. Whatever their choice, the infringing practitioner still remains covered by the National Code of Conduct for unregulated health workers.

1.5 Importantly, the National Code of Conduct for unregulated health workers does not extend to the practice of businesses. Codes of conduct for unregistered health practitioners operate on a system of negative licensing – complaints, where a breach of practise is identified to be contravened by a business – not a healthcare practitioner. For example, business owners who offer to supply patients in exchange for (a commission) percentage payment of professional fees or device charges, will not be subject to the code of conduct for unregistered healthcare practitioners as they are business owners and not necessarily trained health care professionals.

1.6 Further, any complaints brought for investigation by membership associations are seldom of the nature presented at the *Still Waiting to be Heard… Inquiry* ('the Inquiry') to the Federal Standing Committee on Health, Aged Care and Sport, that subsequently resulted in 22 recommendations for change.

1.7 The National Alliance of Self-Regulating Health Professions (NASRHP) has extended its membership to AudA. AudA is represented on the NASRHP Board and was a founding member of NASHRP. AudA was listed as a member of NASRHP in late 2018.

1.8 NASRHP membership is only extended to a peak professional body that meets its requirements around self-regulation and accreditation of practitioners within that profession. NASRHP does not investigate complaints of individual practitioner behaviour.

1.9 NASRHP's lack of transparency is alarming.

- There is no publicly advertised information regarding the monitoring mechanism/s that NASRHP applies to ensure members remain compliant with membership requirements.
- There is no publicly available policy information regarding NASRHP's process of investigation of complaints or subsequent sanctioning of members who fail to maintain membership standards.
- Also, IAA is interested to understand how NASRHP would communicate to the public about a peak professional body which fails to meet its prescribed standards and is subsequently suspended or expelled from membership. This information is also not publicly available.
- Information regarding NASHRP member organisations (including any who may have failed to meet NASHRP standards) begs the question, what benefits in accountability are offered by NASRHP membership?

LIMITATION: A membership body that provides *limited transparency* regarding the probity standards maintained by its membership base provides *little to no assurance*. In effect, it is limited to function as a 'rubber stamp', rather than wielding any real influence over membership conduct.

LIMITATION: NASRHP does not cover individual practitioner behaviour. Neither does it provide assurance regarding those who choose to practise *without* association to peak professional membership bodies.

1.10 As previously stated, the National Code of Conduct protects the public by setting minimum standards of conduct and practice for all unregistered health care workers who provide a health service. This means that all hearing health practitioners, with or without peak association membership must adhere to a minimum set of standards.

LIMITATION: In practice, application of this protection is fragmented. A code-regulation regime is not yet in force in every State and Territory and complaints are selectively investigated.

1.11 Furthermore, there may be no legislative power available to local Commissioners to address complaints or issue sanctions including prohibition orders or public statements.

1.12 Currently, those States that have implemented the code-regulation regime have published prohibition orders. There is agreement that this needs to happen at a national level, but this is yet to be implemented.

LIMITATION: There is currently *no centralised register* that records and monitors hearing health practitioners who provide sub-optimal care and treatment, leaving the Australian public exposed to recurrent risky practitioner behaviour by this unregistered group.

1.13 Further, without a formal register that is afforded by a centralised regulatory scheme, any person can undertake audiology work regardless of qualifications (see Box 1).

1.14 A level of protection from exploitation in this way is extended to Medicare, Hearing Services Program Voucher Scheme, Department of Veterans Affairs and Workcover programs. These all require professional membership to peak associations as a minimum requirement for clinical practise and hearing aid dispensation.

It does however leave the National Disability Insurance Scheme (NDIS) wide open to unethical behaviour, as this Scheme does not provide basic qualification requirements for the provision of hearing health services (see 3.9 below). It also leaves the hospital system in many States and Territories wide open, where membership of any group is based on eligibility – not actual current membership – to peak associations.

LIMITATION: There is no protection of title for audiology or audiometry. Whilst any unqualified person offering these services will be precluded from belonging to professional membership bodies and providing services under some government funds/initiatives, they will nonetheless be able to practise relatively unabated, putting individuals at risk of a range of serious hearing and health complications. Currently, they will also be able to accept NDIS funding for service provision.

1.15 Health consumers who receive sub-optimal hearing health care are also able to raise a complaint to the Health Care Complaints Commission (HCCC). It should also be noted that few hearing-related complaints are made to HCCC, and usually do not tend to be of the magnitude of those raised in the Inquiry.

In IAA's view, this could be due to a lack of widespread knowledge of the role of HCCCs and lack of understanding on how to raise a formal complaint. The Internet is the main communication vehicle for HCCCs including complaints forms, complaints process, tracking and communicating regarding the status of complaints. More Australians aged 70 and over experience hearing loss, and this demographic also happens to be one of the lowest groups for 'digital inclusion' or online access in Australia.[1] The internet therefore becomes a highly problematic platform for engaging with this group, even for the purposes of raising a health care complaint.

1.16 By and large, PPBs and industry groups argue that the lack of formal clinical/ethical complaints indicates there are no issues within the hearing sector. Again, IAA argues that the range of issues raised by the Australian Competition and Consumer Commission report[2] coupled with the Inquiry, and those which seem to prevail across the sector, provide ample evidence that the current paradigm is broken.

Box 1. Contemporary example of a rural and regional community receiving service provision from an unqualified individual

"I have been aware of a provider operating in Western QLD for over 15 years who to my knowledge has no formal qualification in either audiometry or audiology. He is not a member of any professional body.

He has a long history of selling second-hand hearing aids, custom made for their first owner. Following enquiry to the hearing aid manufacturer, these hearing aids were discovered to have been sourced from a Veterans Affairs program in the United States. I was provided clinic names and former patients/owners of the aids.

Members of the public who have seen this provider frequently report no basic audiometric processes such as otoscopy, air, bone and speech audiometry prior to prescription of the hearing aid. The provider makes impressions without performing otoscopy and does not use otoblocks.

These practices mean that this provider is at risk of causing permanent ear damage that might require surgical correction, result in infection, and/or cause permanent hearing loss.

The unqualified supplier of hearing aids usually only fits one aid per person – telling the patients that the sound will travel to the other ear and the other ear will come good using the device, or that the sound will carry along the jawbone so they don't need a second device. He tells them to come back in the afternoon or in a day or so and he will have made the device for them. He does not use the impression taken (one would expect that any unskilled person would not produce usable earmoulds in any case because a high level of skill and expertise is required to achieve usable ear impressions).

He also takes hearing aids from those which have either been purchased from elsewhere or fitted through the Hearing Service Program and then sells them to others.

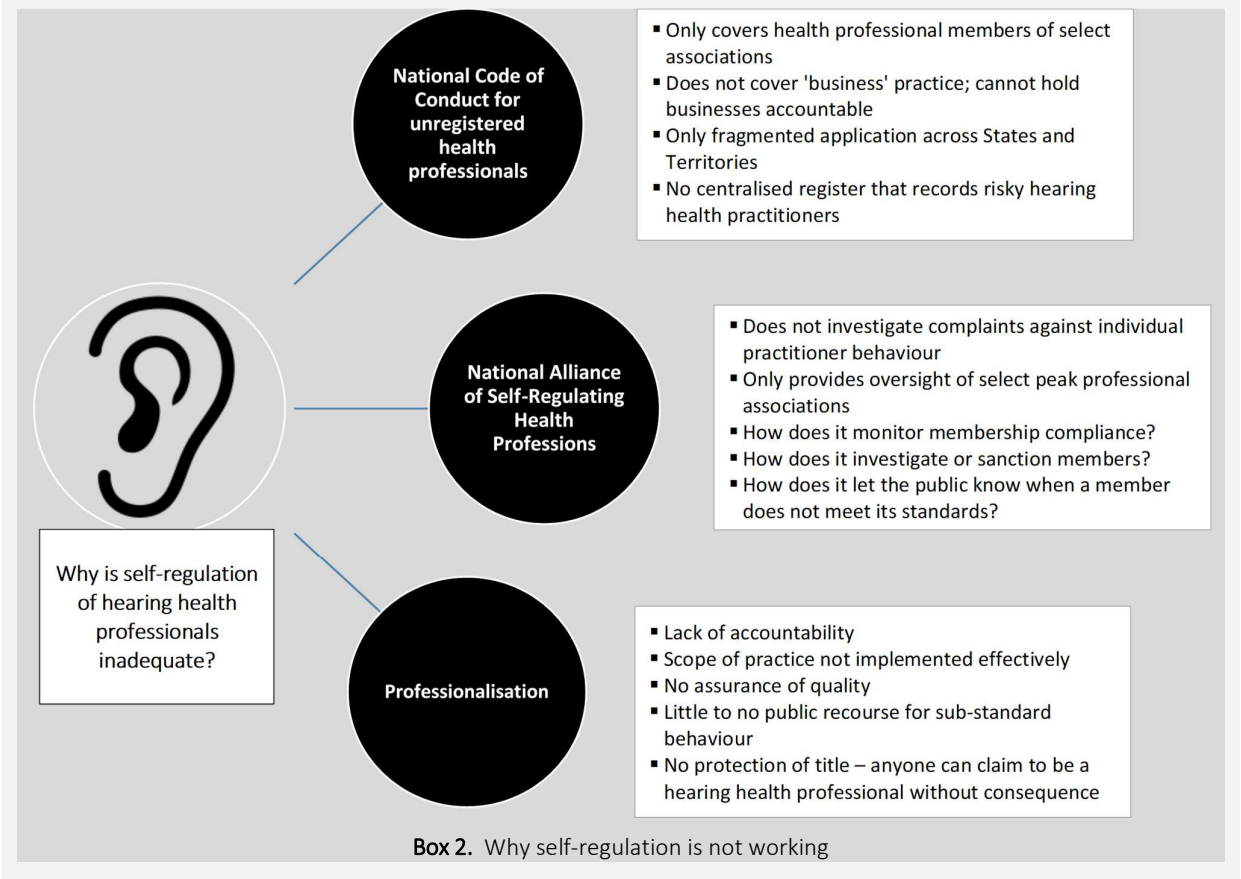
Also of particular concern is that we received funding to provide Audiology assessments to primary schools in these areas which have high numbers of indigenous children – the schools advised us they did not require the service as this provider (albeit without any qualifications) was performing the tests."

– Qualified audiologist servicing remote, rural QLD

[1] Roy Morgan Research Australian Digital Inclusion Index (2017) Accessed August 2018
[2] ACCC (2017) Issues around the sale of hearing aids. Consumer and clinician perspectives. Accessed October 2017

It does not necessarily follow that fewer complains means less problems. Low public awareness of formal processes for raising a complaint, lack of empowerment to complain by an already vulnerable cohort, normalisation of 'hearing aids as expensive' and a lack of knowledge on what constitutes quality provision of hearing services, are all factors that contribute to fewer complaints.

1.17 Inconsistencies arising from the administrative and membership requirements of several associations, combined with the lack of oversight of those opting to practice without holding membership with peak professional associations presents opportunity for serious exploitation of persons who are hard of hearing (see Box 2).



Box 2. Why self-regulation is not working

1.18 A key driver for IAA in pursuing national regulation is the continued and ongoing unscrupulous practises occurring within the hearing health industry. It must be emphasised that this has taken place under the current approach comprising self-regulation by professional bodies and a National Code of Conduct for unregulated health workers, with the additional HCCC oversight. In the existing environment that largely supports this conduct - through inaction and fragmentation of accountability and oversight - this kind of practice is likely to continue.

1. Issues arising from the scope of practice of hearing professional types.

2.1 There is a significant difference between the skill and training of audiologists and audiometrists. An audiologist receives a Master's degree qualification in Audiology, following a minimum of five years of university study. The minimum qualification for an audiometrist is the successful completion of a TAFE Diploma of Audiometry, followed by a further two years of on-the-job training, often focussed on sales techniques and upselling.

2.2 Audiologists are experts who can help to prevent, diagnose, and treat ***hearing and balance disorders*** for people of all ages, beginning with newborns within the hospital setting in the first days of life. Audiologists' scope of practice is one in which hearing aids; implantable devices or assistive technology forms just one aspect of treatment.

Audiologists are engaged in diagnostic audiological assessments to identify the type of auditory and vestibular disorder (whether it occurs in the ear, brain or combination of those), noise measurements and control, assessing the psychosocial impact of communication difficulties and formulating individualised intervention programmes to address those. Also, hearing loss prevention and dealing with complex auditory-related conditions such as tinnitus, hyperacusis, misophonia, auditory processing and attention difficulties, all of which involve peripheral (ear) and central (neurological) assessments that paint a holistic picture of hearing health. Audiologists are also responsible for the diagnosis of central auditory processing disorders in school-aged children.

2.3 By comparison, an audiometrists' scope of practice is more limited. it includes conducting hearing assessments, prescribing and dispensing hearing devices, care management and generalised education programs. Treatment should also include referring of clients for further audiological or medical assessment whenever indicated – including whenever hearing device benefit does not resolve all communication difficulties experienced by an individual, their family and peers.

2.4 There is a Scope of Practice for audiologists and audiometrists that was jointly developed by AudA, ACAud and HAASA.

Box 3. Contemporary example of misdiagnosis by audiologists who are not association members.

"Following a newborn hearing test in a public hospital located in rural Australia, some babies were diagnosed with profound hearing loss. It was decided that they were to be implanted with a Cochlear device and in the interim a hearing aid was to be fitted. These children were subjected to a range of specialised allied and health care services, to support this diagnosis and prior to the planned implantation. These included:

- *Speech pathology*
- *Counselling with Hearing Loss Family Support facilitator*
- *An external psychologist for family, extended family and friends to process the cycle of grief that commonly follows a hearing diagnosis*
- *Advice on decision-marking regarding signing or other communication*
- *Learning Auslan or other communication*
- *Ear, Nose, Throat specialist for approval for fitting of the hearing aid*
- *Further hearing testing that didn't pick up on earlier results as Australian Hearing does not understand Auditory Brain-Stem Response testing*
- *Advisory Teacher of Hearing Impairment visit for training on communication with child and strengthening child-parent bond in absence of verbal communication*

These were accessed before progressing to the Cochlear Implant candidacy process, where the child and family were psychologically assessed for readiness, subjected to an MRI under sedation and a CT scan to make sure the cochlear was fully formed. These babies were exposed to MRI, sedation drugs and a CT scan – all before the age of one.

Just before these babies were going to have their cochlear implant done, a further audiology review revealed that there was no hearing loss. All this treatment was for nothing – all because someone had incorrectly diagnosed these babies as profoundly deaf.

This extensive treatment came at significant personal and financial cost to families, as they often had to travel to the city for treatment/services. The hospital where these audiologists practiced rated this as a significant risk (Code 2 – where a Code 1 is a risk of death); these families could have taken legal action against the hospital. ***In addition, the children were at significant risk of permanent hearing impairment from wearing hearing aids set to levels suited to profound deafness.***

But, without a central register for audiologists, people have no way of knowing if any of these audiologists are their treating professional – and I know they are still out there practicing."

– Qualified audiologist servicing QLD

The Scope of Practice provides an overview of all services that may be provided by audiologists and audiometrists in Australia, however, the Scope of Practice does not provide "*assurance that an individual audiologist or audiometrist has the appropriate educational qualifications, knowledge, skills and experience to practice lawfully, safely and effectively, in a way that meets professional standards, and does not pose any danger to the public or to themselves*."[3]

LIMITATION: In theory there are clear referral pathways for lesser-qualified hearing health professionals to refer patients on to professionals with higher qualifications (greater scope of practice, expertise skill set, knowledge). The reality is that these referral pathways are not mandated for individual practitioners and definitely not monitored.

2.5 The Scope of Practice advises that membership to these bodies (2.4 above) provides further assurance that practising professionals will be appropriately qualified. However, once again, this *neglects to provide assurance of the appropriate qualifications of those* ***who are not members*** of these professional associations (see Box 3).

2.6 A key issue raised in relation to the scope of practice is the risk of misdiagnosis of hearing loss, or under-treatment. This can arise from:

- Assessment by a hearing health professional who is unsuitably qualified to make a comprehensive hearing assessment of all hearing health consequences.
- Failure by the hearing health professional to then refer the patient onto a hearing health professional who is suitably qualified to undertake a comprehensive assessment and provide a tailored hearing health solution.

2.7 This can often arise from business-oriented practice taking priority over individual health outcomes. *Business-oriented practise* is the focus upon the sale of hearing devices. An *outcome-based approach* focuses on meeting individual need, preceded by a holistic hearing health assessment, professional diagnosis and support. Where business-oriented practise is prioritised, it can lead to inferior hearing health advice and ultimately, diminished individual health outcomes.

2.8 The Government Response to the Inquiry notes that The Office of Hearing Services administered Australian Government Hearing Services Program offers "a range of services to people with hearing impairment who meet eligibility criteria"[4].

2.9 However, in practice only 5% of Office of Hearing Services clients are offered rehabilitation services by existing eligible service providers.[5] This figure clearly demonstrates an unbalanced focus upon the sale of hearing devices, with widespread business-oriented practise largely subsidised by Australian government funding.

LIMITATION: It is IAA's view that business interests have succeeded in narrowing the regulation conversation to a 'hearing device debate' about the ethical behaviour of an industry, as opposed to the regulation conversation focusing on the ethical behaviour of **individual hearing health professional practice** and what is the most appropriate application of regulation to minimise risk to public safety.

[3] Australian Government Department of Health (2016) Scope of Practice for Audiologists and Audiometrists. Accessed August 2018.
[4] Australian Government (2018) Government Response to Still Waiting to Be Heard… *Report on the Inquiry into the Hearing Health and Wellbeing of Australia*. Commonwealth of Australia: Canberra. Accessed August 2018
[5] Op. cit., paragraph 5.81

2.10 Narrowing the focus to the ethical behaviour of an industry rather than the ethics of individual practise means businesses are free to continue to prioritise business-oriented practise. More specifically, the business of selling hearing devices takes precedence over and above the hearing health needs of individuals that may extend beyond the testing and fitting of a hearing device.

2.11 Currently, at least one third of hearing devices are utilised rarely or not all. This represents up to $888.7 million in waste[1] for the Australian Government funding scheme responsible for supplying a large majority of hearing aid devices in Australia. Critically, the 'costs' of incorrect diagnosis including under-treatment are not just financial. These are burdens on individuals who experience a poorer quality of life, are excluded from effectively and optimally participating in the Australian community, and who may live in ongoing physical pain. These costs could have been averted by an accurate and comprehensive hearing health assessment that was focused on delivering individual health outcomes - not on meeting sales targets.[6]

What is clear is that the government gives ad-hoc recognition and reliance for self-regulation of hearing health professionals to three PPBs (HAASA, ACAud or AudA), and yet these PPB associations are not subject to government oversight themselves. By extension, to continue to promote adherence to a scope of practice that is:

- limited in implementation for its hearing health practitioner members,
- unregulated,
- provides no assurance for the practise of individuals who are not members of HAASA, ACAud or AudA, continues to be a very risky, fragmented and confusing approach to standardising and providing quality assurance of the professional practise of hearing health practitioners.

Box 4. Contemporary example of inconsistent audiological protocol guidelines between public health audiology and private audiology services with a practitioner holding peak association membership.

"A patient of mine in a small remote town required cochlear implantation but had no private health insurance. I assisted in getting them implanted publicly.

He travelled seven hours for the surgery and was switched on but could not afford to stay in Brisbane for the two weeks required post-surgery for approximately two or three mappings.

The public hospital enquired if I as a private provider, could take over the mappings locally; the hospital audiologist rightly questioned whether this is appropriate as there is scant content for clinical standards guidelines for Cochlear implantation post switch-on supplied from 2013 onwards, for members covered by Audiology Australia.

The current clinical guidelines of AudA were inadequate for the public Audiologist to feel that appropriate practice standards were available in the private sector, even though I hold a current membership with a peak audiology association.

– Qualified audiologist servicing remote, rural QLD

2. The hearing health of vulnerable groups

3.1 Before progressing this correspondence to directly address the issue of 'risk' (4.0 below), IAA will focus upon key population groups across Australia who continue to be most severely impacted by the existing modus operandi of hearing health professionals practising without the protective provisions afforded by an AHPRA regulatory scheme.

3.2 **People residing in more rural and remote areas of Australia.** The lack of regulation currently allows any person to call themselves an audiologist or audiometrists despite having zero qualifications.

[6] ACCC (2017) Issues around the sale of hearing aids. Consumer and clinician perspectives. Accessed October 2017

Unfortunately, to IAA's knowledge, rural and remotely-located communities seem to bear the brunt of this kind of exploitative practise which includes unqualified individuals testing hearing and dispensing second-hand hearing devices as new aids (see Box 1).

Potential public health risks include noise-induced hearing loss arising from an incorrectly-fitted hearing device, failure to address the actual individual audiological needs, and the subsequent chain of effects leading to a poorer quality of life.

3.3 Rural and remotely located persons with hearing impairment are usually those most impacted by severe service gaps in public health audiology services. Services for rural and remote Australians are not extensive, particularly paediatric hearing health services. For example, there is no public health hospital audiology department servicing the population between Townsville and the Sunshine Coast (1,200+kms). For some regional hospitals, the waiting list for audiology services is several months. Where public health service gaps exist, there is prime opportunity for private hearing health services to enter and capture the market.

3.4 However, the audiological practice protocol guidelines for many of the public health audiology services are not consistent or necessarily even present in the private sector so there is no scope for the private sector to safely take on the caseloads where there is a public health shortfall (see Box 4).

LIMITATION: The lack of regulation combined with public health or subsidised service gaps provides great opportunity for predatory business practice to target vulnerable population groups and flourish. These businesses can be safe in the knowledge that there is no real competition or consequence for hearing health practitioners for sub-standard service delivery to these remote and rural communities.

3.5 Indigenous Australians. Aboriginal and Torres Strait Islander children currently have one of the highest rates of otitis media (middle ear disease) in the world (at 14% prevalence). The World Health Organisation has declared this a public health problem requiring urgent attention.[7] Screening usually involves a visual assessment of the outer ear, canal and tympanic membrane, assessment of middle ear function, and a hearing test to identify children 'at risk' of hearing problems and who require further assessment.

It will often involve the expertise of a range of health professionals including Aboriginal health workers, community nurses, audiologists and physicians. Children who have had an ear or hearing concern identified by a trained screener should be referred for further assessment and treatment, and for further hearing testing if there is evidence of hearing loss.

Within the current self-regulatory paradigm there is inadequate assurance on referral pathways and scopes of practice, leaving continued exposure to misdiagnosis and/or under-treatment for this vulnerable group (see Box 5).

3.6 Hearing loss associated with otitis media impacts upon auditory processing skills, behaviour, speech, language and literacy. Some children will continue to experience long-term educational difficulties even once hearing is restored.

[7] World Health Organisation (2004) Chronic suppurative otitis media: Burden of illness and management options. Accessed August 2018

This extends beyond childhood, with a higher-than-average prevalence of hearing loss observed amongst Aboriginal inmates. Research raises the possibility that hearing loss may indirectly contribute to involvement in the criminal justice system,[8] demonstrating the potential for hearing health issues to have far-reaching long-term implications for an individual's outlook and life prospects.

Indigenous children experiencing hearing health concerns should receive optimal hearing health service delivery at all treatment touch-points. This can only be safeguarded by the assurance offered by a national regulatory scheme.

3.7 The only Inquiry recommendation that is currently supported by the Australian Government relates to Indigenous hearing health and IAA is supportive of this proposed implementation. However, only a national, regulated and uniform approach will provide the quality assurance of services delivered by hearing health practitioners to Aboriginal and Torres Strait Islander communities.

LIMITATION: How will the government progress the development of a coordinated national strategy to improve hearing health of Aboriginal and Torres Strait Islander communities, without also implementing uniform regulation measures for the hearing health practitioners who will service these communities?

Box 5. Contemporary example of the consequences of sub-optimal service delivery by hearing health professionals to Indigenous communities

"Following a state-wide audit of public hospital audiology services in Queensland, I discovered several cases of incorrect diagnoses of the hearing of older children from an Indigenous community in south east Queensland.

Each child had received a hearing test from a public audiologist in a Queensland hospital; the audiologist had underestimated some hearing issues in each child, and, thinking that these issues would self-resolve, each child was subsequently sent home following testing.

The audiologist had the opportunity to rectify by calling the child back for a review. They did not do this, exposing the child to further irreparable damage.

By the time I discovered it, the children had suffered permanent hearing loss.

It's important to know that to practice audiology within Queensland Health, you don't need to be member of Audiology Australia, you just need to be eligible *for membership. So if you provide sub-par audiological services in the public health system you won't necessarily be subject to any sanctions from an association because you don't have to be a part of one.*

Those audiologists received disciplinary action from the hospital, but in the absence of any real consequences, I know that each of these audiologists continue to practice in Queensland."

– Qualified audiologist servicing QLD

3.8 IAA knows that that Federal government does not decide on regulation, however *support in principle* for national regulation would assist IAA in advocating to State governments. Without effectively monitored national regulation containing an accessible complaints process with appropriate disciplinary measures, hearing health professionals as a whole have little substance with which to reassure Indigenous communities that they are receiving optimal and quality health care.

With hearing healthcare internationally recognised as a public health priority for this population group, any overarching policy actions need to be supported by the right ingredients for efficacy. In the case of Indigenous health, IAA believes a national regulatory scheme is an essential and fundamental ingredient for positive policy outcomes in this space.

3.9 People with a disability who qualify for National Disability Insurance Scheme (NDIS) funding. Hearing services delivered by those who are under-qualified or unqualified poses significant risk for NDIS participants and the public.

[8] THD Vanderpoll (2012) Massive prevalence of hearing loss among Aboriginal inmates in the Northern Territory. Indigenous Law Bulletin.

Hearing service providers who are not clinically qualified are required to employ qualified practitioners (audiologists or audiometrists) to attend to Hearing Services Program patients, but this requirement does not extend to NDIS or other clients outside of the Hearing Service Program voucher scheme, who are eventually meant to roll into the NDIS.

3.10 Multinational companies with close associations to the hearing device manufacturing and distribution industry form the majority of contracted providers to the NDIS, and yet, audiologists are currently excluded from registering as NDIS providers. Further, in a regulated profession, advertising and promotion is only allowed within determined rules thus providing a level of protection from predatory marketing practices to vulnerable groups such as NDIS participants. Currently, as NDIS-funded services and devices can be sourced from anyone, this group is vulnerable to the largely unchecked advertising and marketing of hearing devices.

3.11 The core of NDIS is participant choice, but the Community Service Obligation (CSO) program currently sits apart from this funding scheme (as it is funding that is allocated only to Australian Hearing to meet some service delivery needs for special needs groups). National regulation and registration is a means towards achieving this contestability and ensuring public safety of these more vulnerable CSO populations.

LIMITATION: Choice of provider is an element of the NDIS, however, in the absence of mandatory registration, NDIS participants who self-manage funds may not be able to identify if providers are appropriately qualified to properly assess and manage their hearing health needs. This leave them exposed to risk of poorer health and quality of life outcomes.

3.12 The inadequacy of the current self-regulated model is also highlighted when one considers that the practice and ethical standards of hearing health professional body clinical guidelines and accreditation are considered insufficient for audiologists outside of public health to see certain (publicly-funded) populations and caseloads, including persons with a disability (also addressed at 3.4). Also jarringly contradictory with the NDIS 'self-choice' philosophy.

3.13 **Older Australians with vestibular or balance disorders.** Importantly, prioritising hearing devices costs/benefits means that the impacts of vestibular and balance disorders are largely diminished or even ignored. One in four emergency department presentations are currently attributed to acute episodes of dizziness arising from balance disorders.[9] Individuals with a balance dysfunction have a four-fold increase of falling and those who reported dizziness at emergency departments had a 12-fold risk of falling. Falls are highly prevalent among older population groups, and the annual cost of fall-related acute care in Australian hospitals for older people was estimated to exceed $600 million.[10] Further impacts from vestibular disorders include: loss of productivity, difficulties with travel, mood and cognitive status.

Providing regulatory oversight gives the public assurance on health professional skill and standards, and will provide assurance to the public that audiologists in particular, will be able to advise in these kinds of cases, alleviating public health system utilisation and cost implications for these kinds of episodes.

[9] Dizziness and Balance Disorders Centre (2018) Glossary of Vestibular Disorders. Accessed August 2018.
[10] Public Health Association of Australia (2015) Fall-Injury Prevention in Older People Policy. Accessed August 2018.

3. Addressing the question of 'risk'

4.1 As stated in the government's response to the Still Waiting to be Heard.. report "*due to the regulatory impact on individual practitioners, new professions would be included in the [National Registration and Accreditation] Scheme, only where a significant risk to public safety was identified…*".

4.2 The application of the weighting/assessment of 'risk to public safety' is particularly confusing when one considers the case of optometrists, who, as a body have been the recipients of regulatory oversight for over 100 years.

4.3 Hearing impairment is a condition estimated to affect one in six Australians including as many as three out of four people over 70 years of age. IAA has presented several examples and current evidence of the wide-ranging impacts experienced by the large number of people in Australia with a hearing impairment, subjected to the current paradigm of *self-regulation* for hearing health professionals. These impacts include quality of life, longer-term health implications, lifestyle outcomes and financial burden upon individuals and also the Australian Government as a key funder of hearing health services and schemes. Unless the current system changes, there is continued exposure to risk of these impacts and more.

4.4 IAA seeks a clear definition of what would be deemed an acceptable level of risk [including human, financial, other implications].

4.5 If the current system is to remain per the Government's response[11], will continue to raise awareness of aforementioned impacts and question how they could possibly be mitigated under the self-regulatory regime.

4.6 An IAA survey of audiologists found that 97% of audiologists indicated that they supported mandatory registration. This would indicate that as individual practitioners, audiologists would be comfortable to accept the regulatory impacts arising from NRAS regulation. Furthermore, these impacts would be happily accepted in exchange for greater accountability, assurance and increased professionalization of this health practitioner group.

Box 6. International regulation of hearing health professionals

Canada	Registration with a regulatory body in a regulated province or territory is required.
Europe	Hearing aid professions regulated in Austria, Belgium, France, Germany, Ireland, Italy, Lichtenstein, Luxembourg, Norway, Poland, Portugal, Spain, Sweden Switzerland.
South Africa	Health Professions Council of South Africa provides audiologist registration
UK	Regulated by Health Professionals Council
USA	Licensing in each state in which an audiologist practice with a doctorate being the entry level qualification for

4.7 Adopting a NRAS regulatory approach would bring audiology and audiometry into line with the regulatory procedures used by other, broadly equivalent, healthcare professions and would bring hearing health professionals in line with international approaches (see Box 6).

4.8 In good faith, IAA recently explored voluntary election for regulation under the Professional Standards Authority (PSA), which exists to regulate self-regulating professions in Australia. This Scheme, much like existing self-regulation is voluntary.

[11] Australian Government (2018) Response to the Standing Committee on Health, Aged Care and Sport Inquiry into the Hearing Health and Wellbeing of Australia – August 2016

The outcome of PSA investigations was that a scheme would not be approved for an organisation like IAA, whose resources are focussed on supporting independent practitioners.

4.9 However, a PSA scheme is a real possibility for bodies such as Audiology Australia and the Australian College of Audiology. Audiology Australia considers the ongoing costs of PSA regulation prevents them going down that path. Government is happy to accept self-regulation through professional associations but could insist that PPBs must operate a PSA scheme. Yet, once again, consideration of the regulatory pathways for professional associations are not mandated by government offering no further assurance by this approach.

4.10 As shown above, AudA prefers to support NASRHP. PSA schemes offer extra assurance and oversight intervention should there be a code of conduct breach because the scheme itself requires associations to intervene in business related matters, something that the current self-regulatory system allows AudA to avoid. The PSA would regulate the activity of associations, who in turn regulate their individual members.

4.11 We see PSA schemes as a step towards full recognition (i.e. national regulation), but remain voluntary, and again, would not protect the public from those who operate services without belonging to a professional body.

4.12 In view of the above evidence, it is IAA's strong position and request that audiology and audiometry be professions with mandatory regulation by a board appointed by AHPRA.

4.13 **IAA has requested of government that the topic of registration of the audiology profession be placed on the agenda of the Council on Australian Governments support from a State or Territory Health Minister for the passage of enacting supporting legislation.**

About Independent Audiologists Australia Inc

Independent Audiologists Australia Inc. is a not for profit incorporated association with members who are university qualified audiologists who operate practices in which they have a financial interest. Our members offer audiological services across the full spectrum of diagnostic and rehabilitative audiology delivering services for auditory (hearing) and vestibular (balance) conditions for all ages (from newborns to the elderly) and for all degrees of complexity. Services are provided under a range of public and private funding schemes – including the Hearing Services Programme, Medicare, WorkSafe, Department of Veterans Affairs, National Disability Insurance Scheme (NDIS), private health funds and private fees.
https://independentaudiologists.net.au/