AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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MBS Review Advisory Committee Review - Inclusion of audiometrists under the MBS to provide limited audiology services

By email: mrac.secretariat@Health.gov.au

The AMA welcomes the opportunity to respond to the MBS Review Advisory Committee (MRAC) review on the proposed inclusion of audiometrists as eligible providers under the Medicare Benefits Schedule (MBS) for limited audiology services. The AMA supports evidence-based reforms that improve patient access and equity, provided they are underpinned by robust clinical governance, high standards of education and training, and collaborative models of care. The AMA does not support autonomous expansion of scope for non-medical professionals where it risks fragmentation, undermines safety, or is not supported by evidence.

Our submission emphasises the principles of patient safety, clinical quality, and equity as the foundation for any scope-of-practice reform. We argue expanding audiometrists' access to MBS items must be strictly limited to services for which they are demonstrably competent, underpinned by rigorous education, credentialling, and robust clinical governance. Any expansion must occur within collaborative, medically-led multidisciplinary teams, with clear referral and escalation pathways, to avoid fragmentation, cost escalation, and compromised care.

The AMA does not support autonomous expansion of scope for non-medical professionals, and cautions that access and equity must never come at the expense of safety or clinical appropriateness.

Are the proposed services within the scope of practice for audiometrists?

The AMA's position is that scope of practice must be defined by the professional activities in which a practitioner is educated, competent, and authorised to perform, and for which they are accountable. The MBS items under review (82306, 82309, 82312, 82315, 82318, 82324, 10952, and 81310) include diagnostic and management services with varying complexity. The AMA does not support expansion based on workforce shortages or title alone; rather, eligibility must be service-specific and contingent on independently verified competence and robust clinical governance.

Consistent with AMA policy, any inclusion of audiometrists should be limited to services where their education, training, and assessed capability clearly match the clinical demands of the item, and delivered within collaborative pathways (with defined escalation to audiologists, ENT specialists, and GPs) to preserve diagnostic accuracy, continuity, and safety.

Education, training, and capability of audiometrists to provide these services in comparison to audiologists

The AMA insists scope expansion be anchored in rigorous, accredited education and training. Audiometrists are trained primarily to conduct hearing assessments, audiometric testing, and fit hearing aids — typically for adult hearing loss. Training is vocational and focused on practical skills for non-complex cases. Audiologists are university-trained allied health specialists with advanced diagnostic and rehabilitative skills across paediatric, vestibular, and neurological domains, and are equipped to manage complex presentations and provide comprehensive rehabilitation within multidisciplinary teams.

These different training pathways and responsibilities create substantively different scopes of practice. Audiologists can independently diagnose and manage complex auditory/vestibular disorders, while audiometrists are appropriately limited to non-complex hearing loss and, depending on the service, may require supervision or structured team-based support.

As of September 2025, health ministers agreed to regulate audiologists under the National Registration and Accreditation Scheme (NRAS), administered by Ahpra. The AMA understands this will provide national registration, title protection, and a formal complaints process — bringing audiologists in line with other registered health professions. This is consistent with the anticipated Ahpra-regulated scope and aligned with audiologists' advanced qualifications and clinical training.

In terms of education and competency, there is no parity between audiometrists and audiologists, and while collaboration is encouraged, the roles are distinctly separate. An audiometrist has no formal reporting relationship to an audiologist, which would be required if access to the MBS items in question were to be expanded. Accordingly, any expanded access to the listed MBS items would require:

- mandatory, accredited upskilling and credentialling (service-specific)
- ongoing professional development
- structured collaborative practice, including multi-professional learning, so all providers understand their roles and limits, and work safely across boundaries.

The AMA opposes any dilution of training requirements as a shortcut to address workforce gaps. Reform must protect safety, quality, and public trust.

Safety and efficacy of services provided by audiometrists

Patient safety and clinical efficacy are paramount. The AMA's review of international evidence and experience demonstrates expanding scope without adequate training and governance can lead to increased diagnostic errors, inappropriate management, and poorer outcomes. Fragmented care — patients seeing multiple providers without coordination — drives higher rates of inappropriate medication, increased mortality, and greater system costs.

The AMA supports expansion only where there is clear evidence audiometrists can deliver services to the same standard as audiologists, within a framework of clinical governance, supervision, and ongoing quality assurance. Competency-based frameworks must ensure professionals only assume new responsibilities after demonstrating sufficient education and training. The UK experience with

physician associates, for example, revealed that unclear role definitions and limited emphasis on collaborative decision-making contributed to poor and, in some cases, fatal patient outcomes.

Any audiometrist MBS access must be conditioned on:

- rigorous credentialling and independent competence verification for each item
- ongoing supervision and audit
- clear escalation pathways to medical practitioners — including GPs and ear, nose and throat surgeons (ENTs) — and audiologists for atypical, complex, paediatric, vestibular, or neurological presentations.

Autonomous practice by non-medical professionals risks siloed care and missed diagnostic cues. Collaborative, protocol-driven team models, such as National Partnered Pharmacist Medication Charting[1] and the Nuka System of Care, demonstrate the safety and efficiency of integrated models, and the risks of operating outside them.

Risks for patients

The AMA identifies several risks if audiometrists are permitted to independently provide complex diagnostic and management services. These risks include:

- increased risk of misdiagnosis or delayed referral for complex or atypical presentations
- potential for fragmented care if audiometrists operate outside established multidisciplinary pathways
- inconsistent quality of care due to variability in training and clinical experience
- increased system costs due to duplication of services, unnecessary diagnostics, and repeat consultations
- erosion of standards if expansion is not matched by equivalent training and governance.

The AMA recommends, where audiometrists are involved, there must be clear protocols for escalation and referral to audiologists, otolaryngologists, or GPs, and their role always be integrated within a collaborative, medically-led multidisciplinary team.

Benefits of increased provider eligibility (rural and remote context)

The AMA acknowledges access to audiology services is a significant challenge in rural and remote Australia. Expanding provider eligibility could improve access, provided it does not compromise safety or quality. The AMA supports targeted measures to address workforce shortages, such as incentives for rural practice, telehealth expansion, and investment in multidisciplinary teams. However, the AMA cautions against using scope expansion as a substitute for genuine workforce planning and investment. Any expansion of audiometrist eligibility must be accompanied by robust safeguards to ensure standards are maintained, and must not be used to justify lower standards of care for rural and remote populations. Increased provider eligibility may improve access if:

- standards are not compromised for rural communities
- audiometrists work within collaborative pathways with defined supervision/escalation
- telehealth and outreach are used to connect with GP and specialist oversight

[1] The Partnered Pharmacist Medication Charting model involves pharmacists independently leading the medication reconciliation and charting process and generating a medication plan for admission in consultation with the admitting medical practitioner. Studies demonstrate this collaborative model improves outcomes for patients and is well received by practitioners.

- incentives, scholarships, and workforce programmes target distribution and retention for audiologists and audiometrists.

Professional relationships and patient pathways between audiometrists, audiologists, otolaryngologists, and GPs for patient management

The AMA supports medically-led, multidisciplinary care as the optimal model for hearing health. Effective pathways require:

- seamless communication, shared protocols, and interoperable records
- role clarity and item-specific credentialling
- mandatory collaboration for complex/atypical presentations
- defined referral and escalation, including paediatric, vestibular, and neurological signs.

For audiometrists, inclusion under the MBS must explicitly require team-based practice — never autonomous care — so patients receive comprehensive management and continuity. Proven collaborative models deliver better outcomes and reduce errors and duplication.

Unintended consequences of allowing audiometrist access

Potential consequences if expansion proceeds without safeguards include:

- fragmentation and loss of continuity for complex needs
- cost escalation from duplication, unnecessary diagnostics, and repeat consultations
- erosion of standards, due to training and governance gaps
- workforce disruption, due to blurred boundaries undermining audiology sustainability
- increased adverse events and poorer outcomes, as seen in international examples where role boundaries and governance were weak.

The AMA recommends ongoing evaluation, with mandatory reporting of adverse events, periodic review of protocols and credentialling requirements, and the capacity to adjust or retract access where safety or value is not demonstrated.

Below we have provided answers to some of the specific consultation questions, which we address according to themes

1. Access

Service gaps in Australia, including Aboriginal and Torres Strait Islander peoples, older Australians, and rural/remote communities:

The AMA acknowledges service gaps in audiology, especially in rural and remote communities. Addressing these gaps requires a multifaceted approach, including investment in workforce development, incentives for rural practice, and support for collaborative models. Expanding scope alone is insufficient and must not compromise safety or quality.

Would audiometrist access to selected MBS items improve equity?

Potentially, yes — provided audiometrists meet rigorous standards of education, training, and operate within collaborative, medically-led teams with explicit escalation and referral pathways. Equity must not come at the expense of safety or quality.

2. Service provision

Do audiometrists currently work in team-based care with audiologists, ENTs and GPs?

The AMA supports team-based care and expects any expansion of audiometrists' scope under the MBS to be contingent on demonstrated collaborative practice, with clear referral and escalation pathways.

Are audiometrists appropriately qualified to independently perform the diagnostic items 82306, 82309, 82312, 82315, 82318, and 82324?

The AMA wishes to see evidence of equivalence in education, training, and competency before supporting independent provision of these services by audiometrists. Where such equivalence cannot be demonstrated, services should remain restricted to audiologists.

Complexity of diagnostic services and the role of the audiologist

Items 82312, 82315, 82318, and 82324 involve advanced diagnostic procedures, such as air and bone conduction audiograms, speech discrimination, impedance audiograms, tympanometry, and acoustic reflex testing. These tests require nuanced interpretation and may uncover complex or atypical pathology, including retrocochlear disorders, paediatric hearing loss, and vestibular dysfunction.

Audiometrists' vocational training does not equip them to independently diagnose or manage complex auditory, vestibular, or neurological disorders. These items must remain restricted to audiologists unless there is robust evidence of equivalent competency and mandatory supervision and escalation protocols.

All items require a written request from a medical practitioner and provision of results back to the referrer. While this provides a degree of oversight, it is no substitute for the advanced clinical judgement required to interpret abnormal findings, initiate appropriate referrals, or manage complex cases. The AMA recommends explicit protocols for escalation to audiologists, ENTs, or GPs for any abnormal or complex findings.

Chronic condition management items 10952 and 81310

Items 10952 and 81310 involve ongoing management of patients with chronic and complex needs, including Aboriginal and Torres Strait Islander populations. Chronic condition management often requires multidisciplinary input and the ability to recognise comorbidities and complications. This illustrates why the AMA insists audiometrists only participate as part of a medically-led, multidisciplinary team, with clear boundaries and supervision.

Conclusion

The AMA supports evidence-based reforms that improve access and equity without compromising safety, continuity of care, or appropriateness. Inclusion of audiometrists under the MBS should be limited, credentialled, and team-based, with mandatory supervision, escalation, and ongoing evaluation mechanisms in place. The AMA does not support autonomous expansion for non-medical professionals and will oppose any reform that dilutes standards or undermines patient safety.

Regardless of any alteration, we urge the department to track the effects of MBS access changes on patient behaviour and treatment adherence, with a commitment to remedial action if quality of care, safety, access, or affordability is compromised.

Contact

president@ama.com.au