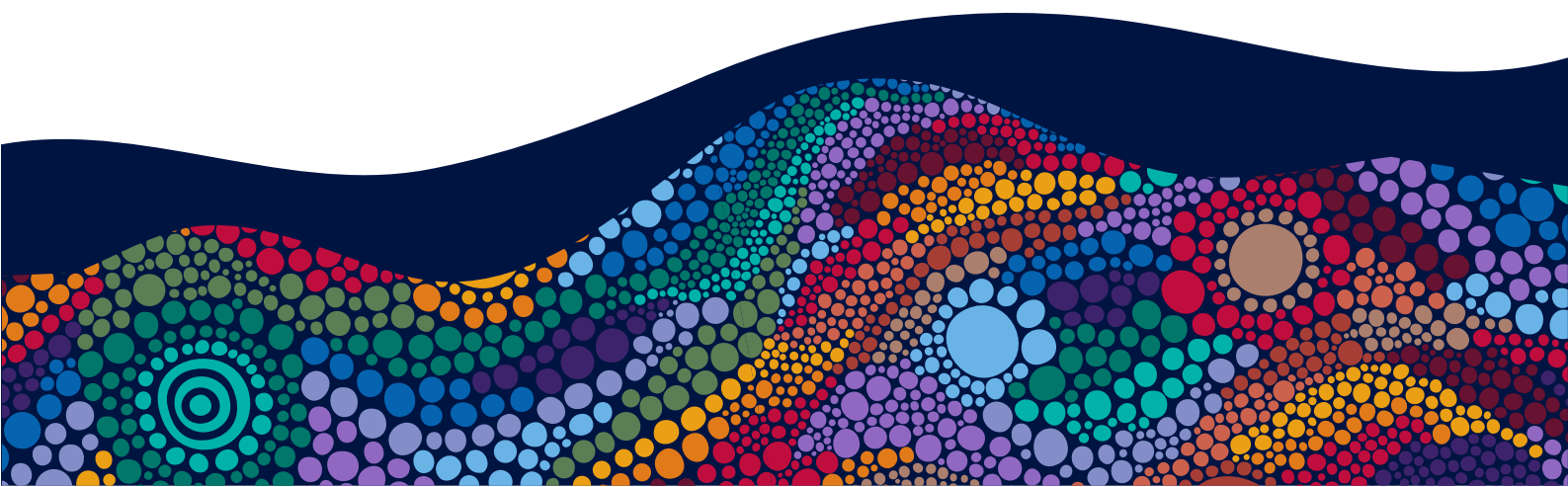


# **Review of the expansion of limited audiology Medicare Benefits Schedule items to audiometrists**

Submission to the Department of Health,  
Disability and Ageing

June 2026



# About NACCHO

NACCHO is the national peak body representing 148 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 148 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

Enquiries about this submission should be directed to:

## **NACCHO**

Level 5, 2 Constitution Avenue

Canberra City ACT 2601

Telephone: 02 6246 9300

Email: [hearinghealth@naccho.org.au](mailto:hearinghealth@naccho.org.au)

Website: [naccho.org.au](http://naccho.org.au)



# Recommendations

- 1 **NACCHO recommends** any changes to Medicare funded hearing services align with the National Agreement and its four Priority Reform Areas.
- 2 **NACCHO recommends** that MRAC does not support the Australian College of Audiology proposal to allow audiometrists to access diagnostic audiology services under the MBS. These services would continue to be limited to audiologists only. Audiometrists can continue to support the delivery of MBS services within their scope of practice by acting under the supervision of a medical practitioner delivering diagnostic otolaryngology MBS items (11300–11345, excluding item 11304).
- 3 **NACCHO recommends** investment in audiology and audiometry training pathways for Aboriginal and Torres Strait Islander people.
- 4 **NACCHO recommends** investment in the upskilling of registered and regulated MBS providers such as Aboriginal Health Workers and Aboriginal Health Practitioners who are already delivering ear and hearing health services.
- 5 **NACCHO recommends** that hearing and ear health investment is directed through the ACCHO sector and aligns with ACCHO sector funding reforms.
- 6 **NACCHO recommends** that the DoHDA continue to support further consultation with the Aboriginal and Torres Strait Islander community-controlled sector to guide policy, MBS funding criteria, and service provision.
- 7 **NACCHO recommends** that service fragmentation is addressed explicitly. DoHDA should commit to the coordinated mapping of ear and hearing health services across the MBS, HSP, NDIS, and ACCHO delivered hearing services with the objective of reducing duplication and fragmentation and improving accessibility and continuity of care for Aboriginal and Torres Strait Islander people.

## Acknowledgements

NACCHO welcomes the opportunity to provide a submission to the MBS Review Advisory Committee (MRAC) on the proposed inclusion of audiometrists as eligible providers under the Medicare Benefits Schedule (MBS) for limited audiology services. NACCHO would like to acknowledge the valuable input received from Aboriginal Medical Services Alliance Northern Territory (AMSANT), Aboriginal Health Council of Western Australia (AHCWA), Aboriginal Health and Medical Research Council (AH&MRC), and Aboriginal Health Council of South Australia (AHCSA) to this submission.

NACCHO supports the submissions to this consultation made by NACCHO Members and Affiliates.

## National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term.

### Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

### Priority Reform Area 2 – Building the community-controlled sector

This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.

### Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

### Priority Reform Area 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

## Review of Closing the Gap

In its first review of the National Agreement on Closing the Gap, the Productivity Commission found that governments are not adequately delivering on their commitments. Despite support for the Priority Reforms and some good practice, progress has been slow, uncoordinated, and piecemeal.

The Commission noted that to enable better outcomes, the Australian government needs to relinquish some control and acknowledge that Aboriginal and Torres Strait Islander people know what is best for their communities. It needs to share decision making with Aboriginal Community Controlled Organisations (ACCOs), recognise them as critical partners rather than passive funding recipients, and then trust them to design, deliver and measure government services in ways that are culturally safe and meaningful for their communities.

‘Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution’<sup>1</sup>

**NACCHO recommends** any changes to Medicare funded hearing services align with the National Agreement and its four Priority Reform Areas.

## Introduction

Aboriginal and Torres Strait Islander people experience disproportionately high rates of ear disease and hearing loss, with Aboriginal and Torres Strait Islander children experiencing some of the highest rates globally<sup>2</sup>. The vast majority of this is preventable. Action is needed to improve access to ear and hearing health care; both in diagnostic services, medical and surgical management, and overarching preventative care. This is crucial to preserving the strength of language and culture which exists in the world’s oldest continuing population.

After consideration, NACCHO does not support the Australian College of Audiology proposal to expand eligibility for diagnostic audiology MBS items to audiometrists. While improving access to ear and hearing health services is critical, NACCHO does not consider changes to MBS provider eligibility to be an effective or equitable mechanism for addressing the barriers experienced by Aboriginal and Torres Strait Islander people. The evidence indicates that workforce distribution, cultural safety, service fragmentation and underinvestment in community-controlled services are the primary barriers to access, rather than restrictions on who may claim existing MBS items.

To improve hearing care for Aboriginal and Torres Strait Islander people, investment must be directed through the ACCHO sector, designed in partnership with community-controlled organisations, and built on existing Aboriginal and Torres Strait Islander led infrastructure. The proposed expansion of MBS provider number eligibility was raised by the Australian College of Audiology, rather than from a need defined by Aboriginal and Torres Strait Islander communities or the community-controlled sector. It does not offer an equitable solution, and risks compounding service duplication and fragmentation. This has the potential to perpetuate a system that is already difficult for patients, families, providers, and clinicians to navigate. What is urgently needed are pathways to support ear and hearing health services through the community-controlled sector, to support and upskill Aboriginal Health Workers and Aboriginal Health Practitioners, and to improve accessibility and continuity of care.

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<sup>1</sup> Productivity Commission, Review of the National Agreement on Closing the Gap, Study Report, Canberra, 7 Feb 2024 <https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report>.

<sup>2</sup> AIHW (Australian Institute of Health and Welfare) (2025) [Ear and hearing health of Aboriginal and Torres Strait Islander people 2025](#), AIHW, Australian Government, accessed 21 May 2026.

The burden of ear and hearing related conditions for Aboriginal and Torres Strait Islander people is 3.6 times that of non-Indigenous Australians, and hearing loss remains a significant cause of morbidity for Aboriginal and Torres Strait Islander people<sup>2, 3</sup>. In 2022 to 2023, 13% of Aboriginal and Torres Strait Islander people self-reported a long-term ear or hearing health problem; however, most ear disease is undetected and unreported<sup>2</sup>. The 2018 National Aboriginal and Torres Strait Islander Health Survey found that 79% of Aboriginal and Torres Strait Islander people with measured hearing loss did not self-report hearing impairment<sup>4</sup>. This emphasises the importance of audiometry services for Aboriginal and Torres Strait Islander people to detect hearing loss. Despite this greater burden, fewer Aboriginal and Torres Strait Islander people receive MBS-subsidised audiology services than non-Indigenous Australians.

**NACCHO recommends** that MRAC does not support the Australian College of Audiology proposal to allow audiometrists to access diagnostic audiology services under the MBS. These services would continue to be limited to audiologists only. Audiometrists can continue to support the delivery of MBS services within their scope of practice by acting under the supervision of a medical practitioner delivering diagnostic otolaryngology MBS items (11300–11345, excluding item 11304).

## Ear and Hearing Health Services

### Scope of Practice

NACCHO acknowledges the MRAC findings regarding the differences in qualifications, training, and scope of practice between audiometrists and audiologists. NACCHO supports maintaining clinical quality, safety, and governance, and agrees that any changes to MBS eligibility must remain consistent with clearly defined scopes of practice.

### Workforce and Training

The AIHW reports that of the approximately 2,636 audiologists counted in the 2021 census, 77% live in major cities, and none lived in very remote areas<sup>2</sup>. The distribution of audiometrists is more balanced (68% in MM2-6 areas, compared with 42% of audiologists). However, only 9.6% of Hearing Services Program claims in very remote areas come from audiometrists, the lowest proportion across all remoteness categories<sup>2</sup>.

Pertinently, around 15% of Aboriginal and Torres Strait Islander people live in remote and very remote areas, where the community-controlled sector is positioned to effectively deliver culturally safe services. Adjusting MBS item eligibility will not address workforce distribution. Reform will be more effective if directed through the Aboriginal Community Controlled sector, where Aboriginal and Torres Strait Islander workforce development strengthens both service quality and cultural safety. Expanding the ear and hearing health workforce is critical in regional and remote areas where staff shortages, retention challenges, and pay disparities persist. Credentialed pathways for Aboriginal and Torres Strait Islander Health Workers (AHWs) and Aboriginal and Torres Strait Islander Health Practitioners (AHPs) to specialise in ear and hearing health, with qualifications that are nationally recognised are essential.

**NACCHO recommends** investment in audiology and audiometry training pathways for Aboriginal and Torres Strait Islander people.

**NACCHO recommends** investment in the upskilling of registered and regulated MBS providers such as Aboriginal Health Workers and Aboriginal Health Practitioners who are already delivering ear and hearing health services.

<sup>3</sup> Australian Institute of Health and Welfare & National Indigenous Australians Agency (2023) [Measure 1.15 Ear health, Aboriginal and Torres Strait Islander Health Performance Framework website](#), AIHW, Australian Government, accessed 21 May 2026.

<sup>4</sup> National Aboriginal and Torres Strait Islander Health Survey, 2018-2019 financial year. Australian Bureau of Statistics. December 11, 2019. Accessed May 21, 2026. <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/2018-19>

## Role of the ACCHO Sector

Co-designing adequate, long term and flexible funding models is essential to set ACCHOs up to succeed, and supports a focus on patient outcomes rather than activities and inputs. This provides ACCHOs with the flexibility and autonomy to design and deliver holistic, culturally safe ear and hearing health programs and services that are responsive to their communities defined needs and priorities. ACCHOs are systematically underfunded, receiving \$920,000 less per year than comparable mainstream GP clinics despite supporting communities with greater health needs and 2.3 times the burden of disease<sup>5</sup>.

**NACCHO recommends** that hearing and ear health investment is directed through the ACCHO sector and aligns with ACCHO sector funding reforms.

In principle, expanding the audiology workforce eligible to deliver MBS items could improve patient assessments and referral pathways, however in practice very few audiometrists currently provide services in ACCHOs, meaning an MBS rule would not translate into measurable access gains for community members. What will deliver measurable change is direct, sustained investment in the ACCHO sector.

Funding directed through ACCHOs, rather than through fee-for-service MBS items claimed predominantly in private settings, supports holistic community-led approaches to ear and hearing health, grounded in culturally appropriate models of care. This includes:

- Continuity of care across the ear and hearing health continuum
- Integration with primary care, child and family health, schools and other social supports
- Employment of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners
- Cultural safety and community trust; and

Accountability to community through community-controlled governance.

**NACCHO recommends** that the DoHDA continue to support further consultation with the Aboriginal and Torres Strait Islander community-controlled sector to guide policy, MBS funding criteria, and service provision.

## Medicare Audiology Services

Despite a greater burden of ear and hearing disease, Aboriginal and Torres Strait Islander people access MBS-subsidised audiology services at lower rates than non-Indigenous Australians. Adjusted for age structure of the population, 6.8 per 1,000 Aboriginal and Torres Strait Islander people received a Medicare subsidised audiology service in 2023-2024, compared with 9.4 per 1,000 non-Indigenous Australians<sup>2</sup>. In Western Australia, this was even less at just 2.9 per 1,000 Aboriginal and Torres Strait Islander people<sup>2</sup>. Expanding provider eligibility for existing MBS items does not address key barriers to access which include workforce availability and distribution, cultural safety and trust in services, complexity of referral pathways, and system fragmentation.

Duplication is evident within the MBS. The six diagnostic audiology items (82306, 82309, 82312, 82315, 82318, 82324) have directly equivalent otolaryngology item numbers in the 11300-11345 series (see Table 1). The 11300-11345 items may be performed by, or on behalf of a medical practitioner, and audiometrists are able to claim these on behalf of a medical practitioner in the existing schedule. The 11300-11345 otolaryngology items, which provide equivalent diagnostic services and may be claimed by or on behalf of a medical practitioner, are billed in significantly greater volumes than their 82306, 82309, 82312, 82315, 82318 and 82324 audiology equivalents across all paired services. Expanding the eligibility of diagnostic audiology items (82306, 82309, 82312, 82315, 82318, 82324) to audiometrists would introduce another overlapping

<sup>5</sup> Australian Institute of Health and Welfare 2025b, 'Aboriginal and Torres Strait Islander Health Performance Framework - Summary report', retrieved January 20, 2026, from <https://www.indigenoushpf.gov.au/reports/summary-reports/summary-report/6-tier-3-%E2%80%93-health-system-performance/barriers-to-accessing-health-services>

service, alongside the existing 11300-11345 and HSP item numbers audiometrists can already claim. The MBS is widely recognised by clinicians as being overly complex and ambiguous, and it is important that services have the confidence to bill 11300-11345 items where appropriate.

*Table 1. MBS Item Use 2022-2025<sup>6</sup>*

| MBS Item     | Descriptor                                                              | Fee     | Services 2022 | Services 2023 | Services 2024 | Services 2025 |
|--------------|-------------------------------------------------------------------------|---------|---------------|---------------|---------------|---------------|
| <b>82306</b> | non determinate audiometry                                              | \$20.40 | 374           | 1,485         | 4,145         | 6,714         |
| <b>11306</b> |                                                                         | \$25.55 | 25,141        | 26,224        | 24,217        | 21,642        |
| <b>82309</b> | air conduction audiogram                                                | \$24.50 | 1,261         | 4,323         | 6,206         | 7,007         |
| <b>11309</b> |                                                                         | \$30.65 | 31,262        | 34,307        | 34,785        | 32,773        |
| <b>82312</b> | air + bone conduction OR air + speech discrimination audiogram          | \$34.70 | 4,104         | 8,298         | 11,300        | 12,358        |
| <b>11312</b> |                                                                         | \$43.30 | 47,391        | 54,741        | 54,006        | 47,503        |
| <b>82315</b> | air + bone conduction speech discrimination audiogram                   | \$45.90 | 8,013         | 28,503        | 41,219        | 47,912        |
| <b>11315</b> |                                                                         | \$57.35 | 45,264        | 48,007        | 53,596        | 51,571        |
| <b>82318</b> | air + bone + speech discrimination audiogram + other cochlear tests     | \$56.70 | 2,882         | 8,545         | 10,848        | 16,841        |
| <b>11318</b> |                                                                         | \$70.85 | 56,900        | 52,262        | 34,708        | 27,851        |
| <b>82324</b> | impedance audiogram                                                     | \$18.65 | 250           | 43,997        | 68,301        | 81,481        |
| <b>11324</b> |                                                                         | \$23.15 | 26,105        | 165,557       | 190,773       | 173,305       |
| <b>10952</b> | chronic conduction management – Audiology                               | \$72.65 | 3,137         | 3,982         | 5,271         | 5,895         |
| <b>81310</b> | Aboriginal and Torres Strait Islander people – audiology health service | \$72.65 | 1,197         | 1,469         | 1,409         | 1,412         |

Existing referral pathways already accommodate broad GP led access. In March 2023, an important change was made to the diagnostic MBS items in question which allowed the written request for an audiology service to be made by any medical practitioner, rather than being limited to an ENT specialist or neurologist<sup>7</sup>.

<sup>6</sup> Services Australia – Statistics – Item Reports. Accessed May 21, 2026. [https://medicarestatistics.humanservices.gov.au/statistics/mbs\\_item.html](https://medicarestatistics.humanservices.gov.au/statistics/mbs_item.html)

<sup>7</sup> Care AGD of H and A. Otolaryngology, head and neck surgery MBS changes. Accessed May 21, 2026. [MBS Online - Otolaryngology, head and neck surgery MBS changes](#)



The referral and claiming pathways for member services therefore already exist; and rather than the constraint being in relation to MBS billing, exists with workforce availability, distribution, and service fragmentation. Changes to MBS provider eligibility are not, in themselves, an equity instrument. Closing the ear and hearing health gap for Aboriginal and Torres Strait Islander people requires sustained structural reform.

## Service fragmentation

The AIHW describes Australia's ear and hearing health system as "complex and fragmented"<sup>2</sup>. This is a national challenge. Services currently span the MBS, the Hearing Services Program (HSP), NDIS, Department of Veterans Affairs, Workcover, The Healthy Ears Program, Hearing Assessment Program - Early Ears (HAPEE), state and territory hospital services, ACCHO funded activities, and a range of outreach and school-based initiatives. These referral pathways are complex to navigate for patients, families, providers, and clinicians.

Studies of ear health and other conditions have highlighted how difficult Australia's health system can be for patients to navigate<sup>8</sup>. This is particularly true for populations who routinely encounter systemic and interpersonal racism, speak a language other than English, have a hearing or language impairment, or have experienced educational disruption or inequity. Referral pathways and processes are complex and can be difficult to understand, even for those who work within the system. Patients may be confused by which worker is performing which role, and this has been highlighted in the context of ear health with Aboriginal and Torres Strait Islander communities<sup>9</sup>.

Streamlining fragmented funding streams and redirecting mainstream ear and hearing health resources back into ACCHOs ensures that funding is aligned with community-defined priorities and strengthens self-determination, as well as Priority Reform 2 and 3, and the Primary Health Care 10 Year Plan.

**NACCHO recommends** that service fragmentation is addressed explicitly through a DoHDA commitment to the coordinated mapping of ear and hearing health services across the MBS, HSP, NDIS, and ACCHO sector with the objective of reducing duplication and fragmentation and improving accessibility and continuity of care for Aboriginal and Torres Strait Islander people.

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<sup>8</sup> Australian Institute of Health and Welfare (2023) Ear and hearing health of Aboriginal and Torres Strait Islander people 2023, catalogue number IHW 282, AIHW, Australian Government

<sup>9</sup> Stephens JH, Poirer BF, Machell A, Macfarlane PL, Spurrier NJ, Quirino L. Stakeholder Perspectives on Ear and Hearing Health Service Provision for Aboriginal and Torres Strait Islander Children. *Aust J Rural Health*. 2026;34(2):e70167. doi:10.1111/ajr.70167