

State of Hearing Aids and Cochlear Implants Provision in Europe

October 2026



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About EFHOH

The **European Federation of Hard of Hearing People** (EFHOH), established in 1993, is a non-profit organization representing hard of hearing and late-deafened individuals across Europe. EFHOH advocates for awareness and practical actions to eliminate barriers to accessing affordable hearing care and rehabilitation and to create an accessible society through public services and assistive technologies.

Its main objective is to protect and promote the rights of individuals with hearing loss in Europe, facilitating legislative and social protections through collaboration with decision-makers, members and other relevant stakeholders.

Acknowledgements

EFHOH gratefully acknowledges the organisations and individuals who contributed national information to the 2026 survey on access to hearing aids and cochlear implants: ÖSB – Österreichischer Schwerhörigenbund Dachverband (Austria); UCBA-CEUPA (Belgium); Association of the Deaf and Hard of Hearing in Czechia; Hrvatski savez gluhih i nagluhih – HSGN (Croatia); Høreforeningen (Denmark); Eesti Vaegkuuljate Liit (Estonia), Hoyr (Faroe Islands); Hörgeschädigte Bremen und Bremerhaven e.V. – HBB e.V. (Germany); Aures Foundation (Georgia); Hungarian Association of the Deaf and Hard of Hearing; Heyrnarhjálp (Iceland); Associazione Nazionale Sordi – ANS (Italy); Gozo Association for the Deaf (Malta); Stichting Plots- en Laatdoven (Netherlands); Hørselsforbundet (Norway); SUITA Association (Poland); OUVIR – Portuguese Association of Hearing Aids and Implants Users; Deaf and Hard of Hearing Clubs Association of Slovenia; Federació ACAPPS (Spain); Hörselskadades Riksförbund (Sweden); Pro Audito Schweiz (Switzerland); Association for Children With Bionic Ears (Türkiye); and NADP (United Kingdom); CIICA (Cochlear Implant International Community of Action); Mark Laureyns (AEA); Leo De Raeve (CIICA); Sue Archbold (CIICA).

Executive Summary

Hearing care is essential for equality, independence and full participation in society. Yet across Europe, access to hearing aids, cochlear implants and personal assistive listening devices remains unequal, limiting hard of hearing people's opportunities to access healthcare, education and employment, and to live independently. Even where public funding is available, it often fails to cover the full cost of hearing technologies and essential related services, leaving many users with significant out-of-pocket expenses.

In 2017, the World Health Assembly adopted its [Resolution WHA70.13 on the prevention of deafness and hearing loss](#), recognising the need to improve access to hearing technologies and rehabilitation. Following the resolution, EFHOH published assessments in [2018](#) and [2022](#) to monitor the provision of hearing aids across Europe. This third edition expands the assessment to cochlear implants and personal assistive listening devices across 26 European countries.

Drawing on national submissions from EFHOH members, complemented by desk research, the report examines the funding, eligibility and reimbursement of hearing aids, cochlear implants and personal assistive listening devices. It also assesses whether people can access these devices on time, whether rehabilitation services are available, and whether repairs and replacements are covered.

The findings are clear: **access to hearing technologies remains extremely unequal across Europe.**

- **Hearing aids:** Public funding is available in all 26 countries, but eligibility and financial support vary widely. Only 6 countries provide hearing aids free of charge without up-front payments. In 19 countries, support for adults is weak, which affects young adults transitioning into adult hearing care services.
- **Cochlear implants:** Public funding is available in all 26 countries, but access remains unequal. In 6 countries, despite clinical eligibility, adults only receive 1 cochlear implant. At least 9 countries report gaps in post-implant rehabilitation, especially for adults.
- **Assistive listening devices (ALDs):** Devices such as remote microphones and streamers are largely excluded from public funding. Norway is the only country where they are included in publicly funded provision for hearing-aid users. For cochlear-implant users, 12 countries report limited, separate or inconsistent funding arrangements.

Waiting to address these gaps is not an option. Every hard of hearing person who cannot access the hearing technologies they need is denied the opportunity to participate fully in public life. This is not just a question of healthcare provision: it is a matter of equal rights and countries' obligations under the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD).

The European Union must take the lead by developing an ambitious European Strategy on Hearing Loss. European countries must ensure that ear and hearing care is included in Universal Health Coverage, so that access to hearing technologies and rehabilitation is based on people's needs, not their age, where they live or what they can afford.

Investing in person-centred hearing care and hearing technologies is not a cost: it is an investment in equality, independence and full participation in society.

Introduction

We are pleased to present the third edition of *State of Hearing Aids and Cochlear Implants Provision in Europe*. Building on EFHOH's previous monitoring work in [2018](#) and [2022](#), the 2026 edition expands the assessment to 26 European countries and covers hearing aids, cochlear implants and personal assistive listening devices.

EFHOH began monitoring hearing-care provision in Europe, following the adoption of the World Health Assembly [Resolution WHA70.13 on the prevention of deafness and hearing loss](#) in 2017. The Resolution called for action, urging Member States to integrate strategies for ear and hearing care within their health systems and to improve access to appropriate hearing technologies and rehabilitation.

Despite these policy commitments, the findings from the 2026 monitoring assessment reveal **persistent and concerning gaps between political commitments and the support people with hearing loss receive in practice**. Although public funding for hearing aids and cochlear implants is available across the 26 countries examined, reimbursement levels and funding arrangements do not always reflect the actual costs of hearing technologies, leaving many users with substantial out-of-pocket expenses. These barriers can undermine independence and limit opportunities for participation in education, employment and everyday life.

Investing in ear and hearing care is already proven to be an effective, sound investment. According to the [World Health Organization \(WHO\)](#), unaddressed hearing loss costs the WHO European Region approximately **€200 billion annually** through healthcare and education costs, productivity losses and wider societal impacts. Investment in ear and hearing care interventions can help reduce these costs, generating an estimated return of approximately **€30 for every €1 invested over ten years**.

The European Commission's [enhanced Strategy for the Rights of Persons with Disabilities to 2030](#), with its stronger focus on the availability and affordability of assistive technologies, provides a further opportunity to address the barriers identified in this report and improve access to hearing technologies and lifelong support.

The report concludes with **recommendations for action at national and European levels** to address these inequalities and advance affordable, equitable and lifelong hearing care across Europe.

1. Policy Context

Within the European Union, Member States retain primary responsibility for defining health policies and organising and delivering healthcare services. [Article 168 of the Treaty on the Functioning of the European Union \(TFEU\)](#) provides for EU action to complement national health policies and encourage cooperation between Member States, while Article 168(7) preserves national responsibility for the organisation and delivery of health services and medical care. Consequently, Member States largely determine hearing-care provision, including eligibility and public funding arrangements.

At EU level, hearing aids and cochlear implants are regulated under [Regulation \(EU\) 2017/745 on medical devices](#) (Medical Devices Regulation, MDR), which establishes requirements for their safety, performance and placing on the EU market. While the MDR provides a common regulatory framework for these devices, it does not determine national eligibility criteria, reimbursement levels or the hearing-care services accompanying their provision.

Beyond medical-device regulation, **Principle 16 of the [European Pillar of Social Rights](#)** establishes the principle of timely access to affordable healthcare of good quality, including prevention and treatment. This is particularly relevant to hearing care, where costs, waiting times and access to appropriate services can determine whether people receive the care they need.

Access to hearing care is a human right enshrined in the [United Nations Convention on the Rights of Persons with Disabilities \(CRPD\)](#), linked to States Parties' obligations particularly regarding health, rehabilitation and assistive technologies. **UN CRPD Article 25** recognises the right of persons with disabilities to the highest attainable standard of health without discrimination based on disability. **Paragraph 25(b)** specifically addresses health services needed because of disability, including early identification and intervention:

“Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;”

UN Convention on the Rights of Persons with Disabilities, Article 25(b) – Health

Article 26 complements this provision by requiring States Parties to organise, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in health, employment, education and social services.

These services should begin at the earliest possible stage and be based on the “*multidisciplinary assessment of individual needs and strengths.*”

The [WHO World Report on Hearing](#) provides an international public health framework specifically addressing ear and hearing care. It promotes integrated, people-centred ear and hearing care and sets out the H.E.A.R.I.N.G. package of interventions, including access to technologies and rehabilitation services, to be delivered through strengthened health systems.

The [WHO–UNICEF Global Report on Assistive Technology](#) complements this approach by addressing access to assistive technology more broadly. It highlights five interconnected elements — people, policy, products, provision and personnel — and the need for coordinated action on financing, service delivery, workforce capacity and user involvement.

Recent international commitments reinforce these principles. In 2025, [World Health Assembly Resolution WHA78.7](#) called for stronger primary prevention and integrated care for sensory impairments, including hearing loss, across the life course. On 2 September 2026, the United Nations General Assembly adopted [Resolution A/RES/80/305 on Access to assistive technology](#), calling for coordinated national action to improve access to affordable, quality assistive technologies, supported by sustainable financing, appropriate services, trained personnel and the participation of users and their representative organisations.

Taken together, these **underline that effective access to hearing care goes beyond the availability of hearing devices.** It also requires affordable provision, professional assessment and fitting, rehabilitation, maintenance and long-term support that respond to individual needs.

Access to hearing care is a longstanding focus of EFHOH’s advocacy. In 2015, EFHOH adopted the [Essen Declaration](#), “*Access to Hearing Aids Is Access to Opportunity*,” calling on European governments to ensure access to affordable, good-quality hearing aids, assistive listening devices and professional support, so that cost does not prevent hard of hearing people from living independently and participating fully in society.

Ensuring accessible, affordable and sustainable hearing care is increasingly urgent for Europe’s large and growing population of people with hearing loss. The [2024 Getting the numbers right on Hearing Loss report](#) estimates that around **59 million people** have self-reported hearing loss across the European Union, Norway, Switzerland and the United Kingdom. With Europe’s ageing population and the importance of equal opportunities in education, employment and everyday life, **ensuring timely and affordable hearing care is a public health priority**, essential to supporting independence and full participation in society.

2. Scope and Methodology

Our 2026 research examined how hearing technologies are funded and provided across European countries, focusing on eligibility criteria, reimbursement arrangements and access to hearing care. Building on previous editions, this monitoring assessment expanded the scope to include cochlear implants, recognising that people with hearing loss may use different hearing technologies, including bimodal fittings (a hearing aid in one ear and a cochlear implant in the other). In light of the EU's flagship initiative on assistive technologies from the Enhanced Disability Strategy, the report also examines access to personal assistive listening devices, which provide enhanced support in difficult listening environments.

The questionnaire was developed with the support of the [European Association of Hearing Care Professionals \(AEA\)](#). Survey submissions were reviewed across common themes and, where necessary, checked against available official information. Draft country information was also returned to contributors for verification, and subsequent corrections or clarifications were incorporated where received. The analysis is organised thematically with country examples used to illustrate specific provision mechanisms, differences and barriers identified in the evidence.

The questionnaire comprised 32 questions organised into 4 sections (see Annex III). Personal contact fields and the data-protection notice have been omitted from the published version.

2.1 Data collection and sources

The 2026 assessment covers 26 national health systems. For 23 of these, evidence was collected through submissions from EFHOH member organisations, with input where relevant from hearing-care professionals and experts with knowledge of national hearing-care provision: Austria, Belgium, Croatia, Czechia, Denmark, Estonia, the Faroe Islands, Germany, Georgia, Hungary, Iceland, Italy, Malta, the Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, Switzerland, Türkiye and the United Kingdom.

For three additional countries — Finland, France and Ireland— information was initially compiled through targeted desktop research. Finland and Ireland are based on official national sources. France is based on official sources supplemented, where current information could not be identified, by previous EFHOH research.

2.2 Approach to comparative analysis

Hearing aids and cochlear implants are analysed as separate strands, reflecting their different clinical, funding and service pathways. Personal assistive listening devices are

analysed as a third, cross-cutting strand because they may be used alongside either hearing aids or cochlear implants and often follow separate funding and provision routes. For personal assistive listening devices, the analysis focuses particularly on manufacturer-specific or compatible devices, such as remote microphones and streamers, and whether they are included in publicly funded hearing-aid or cochlear-implant provision or require separate funding or private payment. While the comparison focuses primarily on public provision through national health and statutory insurance systems, additional regional, disability, education and employment funding schemes are considered where relevant.

Quantitative findings are reported only where the available information is sufficiently comparable. Where responses were incomplete or arrangements varied by region, insurer, provider or clinical centre, the analysis uses qualified formulations such as *“reported”*, *“at least”* or *“no national information identified”*. Missing information is not interpreted as evidence that a service, benefit or entitlement does not exist.

3. European pathways for publicly funded provision of hearing care

Previous EFHOH reports distinguished two broad pathways for publicly supported hearing-aid provision: a national health model and a reimbursement-based model.

- **Direct public provision / public health-service model:** hearing aids are provided through a public health service or another publicly funded service, either directly or through contracted providers. Depending on the country, provision may be fully publicly funded or subject to a defined user contribution under national rules. Cochlear implants are fully funded through the model.

Pathway to hearing care – national health model

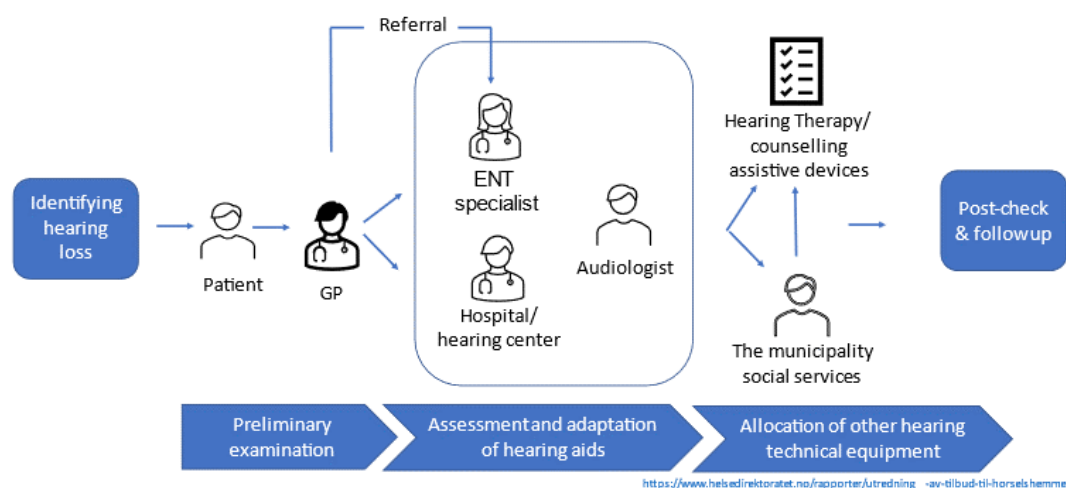


Figure 1. Illustrative pathway for hearing aid provision - national health service model (retained from the EFHOH 2022 report).

- **Insurance or reimbursement-based model:** statutory health insurance or another public financing mechanism covers all or part of the recognised cost of an eligible hearing aid provided through an approved or recognised provider. Funding may take the form of full reimbursement, a percentage of the cost, a fixed tariff or another defined contribution. Under this model, cochlear implants are fully funded as well.

Pathway to hearing care- reimbursement model

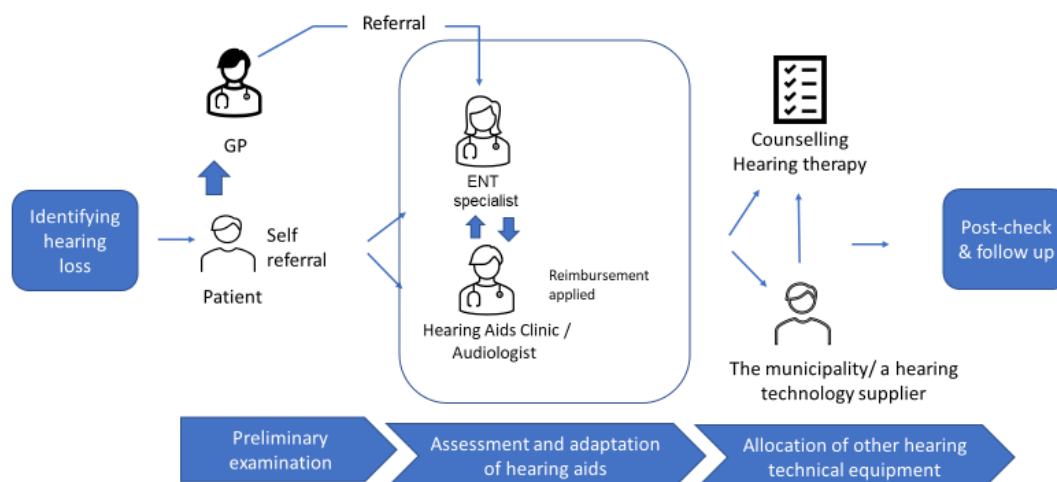


Figure 2. Illustrative pathway for hearing aid provision - reimbursement model (retained from the EFHOH 2022 report).

4. Hearing aids provision in Europe: main findings and analysis

The [World Health Organisation](#) (WHO) explicitly classifies hearing aids as a fundamental assistive technology designed to maintain or improve individual functioning and independence. Hearing Aids are fitted individually by recognised and regulated hearing care professionals who are responsible for the selection, fitting, adjustment and personalisation of hearing aids in close cooperation with the user.

4.1 Funding and eligibility

Public support for hearing aid provision exists across all 26 countries. Nevertheless, how hearing aids are funded and how much users have to pay themselves differ considerably. Only 6 countries — Denmark, Faroe Islands, Finland, Norway, Sweden, United Kingdom — provide hearing aids through the national health model, free of charge, without requiring up-front payments for users.

- **Where hearing aids are provided through reimbursement schemes, public support may cover only part of the cost, leaving users with substantial out-of-pocket expenses.** In the Netherlands, for example, adults receive 75% reimbursement, with a 25% co-payment and annual deductible.
- **Parallel funding routes create additional barriers to access.** Portugal is a clear example: hearing aids may be funded through the System for the Attribution of Assistive Products (SAPA), with support channelled through health, social security or employment services depending on the person's circumstances. Separate routes also exist through the public-sector health benefits scheme (ADSE), while others may need to pay privately. Access therefore depends on the pathway for which the individual is eligible, as well as prescription, available funding and administrative processing.

Eligibility criteria based on age and minimum hearing loss thresholds continue to limit access to publicly funded hearing aids in most European countries. In 19 of the 26 countries examined, children and young adults receive broader support than adults, especially those of working age. Key examples:

- **Italy** provides support only when an individual has 55 dB hearing loss, which is substantially above the WHO reference level of greater than 35 dB in the better-hearing ear for disabling hearing loss in adults.
- **Spain:** the national health system fully funds hearing aids only for people under 26, unequally complemented by regional subsidies.

The concern is where adult eligibility or funding restrictions prevent access to appropriate hearing care, for example, for people who have used hearing aids since childhood and for those seeking them for the first time later in life. Age alone should not determine eligibility or funding, nor be used as a measurement for a person's ability to pay privately.

Overall, these findings show that the level of public funding directly affects affordability. Public support does not necessarily make hearing aids affordable in practice. Reimbursement ceilings, co-payments, gaps between public contributions and market prices, and upfront-payment requirements can all leave substantial costs with users.

4.2 Choice, professional fitting and procurement

Users do not have the same freedom to choose their hearing-care provider or hearing aid within publicly funded hearing-aid provision. Choice of provider and hearing aid varies substantially, constrained by contracted providers, approved-device lists, reimbursement ceilings or public procurement decisions.

- **Free choice of both provider and hearing aid is explicitly reported in only 3 countries** — Austria, Belgium and Iceland. In Austria, the publicly funded amount is settled directly and users can pay the remaining balance. In Belgium, adults must be offered a hearing aid within the reimbursement tariff but may choose another device and pay the additional cost. In Iceland, adults receive partial public funding and may choose both the provider and hearing aid, paying the remaining cost themselves.
- **In 12 countries, users have some choice of provider or hearing aid, but public reimbursement is subject to specific provider, device or funding conditions:** Croatia, Czechia, Estonia, France, Germany, Hungary, Italy, the Netherlands, Poland, Slovenia, Switzerland and Türkiye. In France, providers must offer at least two Class I hearing aids, which are fully covered, while users may choose Class II devices, which can involve an additional payment. In Poland, users choose among providers contracted by the National Health Fund (NFZ). In the Netherlands, users may choose any provider, but only hearing aids listed in the national database are eligible for reimbursement.
- **In 6 countries, choice is limited to the range of providers and hearing aids available through direct public provision:** Denmark, the Faroe Islands, Finland, Norway, Sweden and the United Kingdom. Denmark uses a public product list, Norway provides choice within tender arrangements, Sweden provides hearing aids through regionally procured services, and the United Kingdom has limited provider and brand choice within the National Health Service (NHS).

- **More restrictive arrangements are reported in Georgia, Malta and Portugal.** Georgia has a single contracted supplier and no possibility to pay the difference for another hearing aid within the state pathway. Malta relies on a lowest-cost public tender, although users may purchase privately. In Portugal, choice is constrained by public procurement and the rules of the System for the Attribution of Assistive Products (SAPA), with broader choice requiring private payment.

The key issue is therefore not simply whether choice exists, but whether users can obtain a hearing aid suited to their individual needs while retaining public support. Public procurement should not reduce hearing care to the purchase of a device at the lowest price. Where it is used, tender design should preserve individual suitability, professional quality and informed choice by ensuring an adequate range of devices that respond to different user needs, rather than prioritising lowest price.

4.3 Waiting times, renewal and continuity of care

Waiting time for a first hearing aid

Long waiting times remain a significant barrier and vary considerably. In 6 of 26 countries — Denmark, Iceland, Norway, Portugal, Spain and Sweden — waiting for a first publicly supported hearing aid can reach approximately one year or more. Denmark reports public-sector waits of 10–86 weeks; Iceland reports waiting up to two years; Norway reports waiting up to 12 months; and Sweden reports regional variation from approximately one week to 1 year. By comparison, the United Kingdom reports 7–18 weeks, Czechia within one month, and Belgium and the Netherlands within a few weeks.

Prolonged waiting times can delay access to hearing care needed for communication, employment, education and everyday life. These delays may contribute to social isolation, poorer mental well-being and barriers to entering or remaining in employment, with wider social and economic consequences.

Routine renewal

22 of 26 countries report a fixed or customary hearing-aid renewal interval, with most adult intervals falling between four and seven years. Four-year periods are reported in Denmark, Estonia and France; up to five years in Belgium, Czechia, Italy, the Netherlands and Türkiye; up to six years in Norway and Slovenia; and up to seven years in Croatia as the longest reported renewal interval. Portugal reports a common reference period of around five years, with renewal requiring a new prescription and administrative approval.

Earlier replacement

Conditions for replacement of a hearing aid before the normal renewal date vary:

- **clinical deterioration or medical justification** in 8 countries — Austria, Belgium, Croatia, Finland, Germany, Slovenia, Switzerland and the United Kingdom. Belgium, for example, allows earlier reimbursement where average hearing loss worsens by at least 20 dB.
- **hearing aid becoming irreparable or no longer suitable** — France and Italy;
- **additional approval, reassessment or user contribution** — Estonia, the Netherlands, Poland and Türkiye.

Loss, damage and repair

Replacement after loss is more restrictive than clinical replacement.

- **Public or partially reimbursed replacement after loss is reported in 3 countries** — Denmark, Hungary and the United Kingdom — while at least 7 countries exclude loss from normal public coverage or rely on private insurance — Belgium, Croatia, Germany, Italy, Norway, Switzerland, Türkiye. Italy explicitly reports that accidental

hearing-aid loss is not reimbursed by the Italian National Health Service (Servizio Sanitario Nazionale, SSN).

- **Repair is more consistently supported.** Public or provider responsibility for repairs is reported in at least 6 countries — Denmark, Finland, Italy, Slovenia, Sweden and the United Kingdom — while users may face repair costs after warranty in 4 countries — Croatia, Czechia, Georgia, Poland.

Overall, routine renewal is relatively well defined, but continuity of access is less secure when needs change unexpectedly. Long waiting times, restrictive conditions for earlier replacement, limited coverage after loss and differences in repair support can leave users facing additional costs or periods without a functioning hearing aid. Continuity of care therefore depends not only on a defined renewal cycle, but also on timely and affordable access to repair and replacement when needed.

4.4 Rehabilitation and aftercare

To clarify, aftercare includes services directly related to the hearing aid, such as fine-tuning, re-fitting, verification and follow-up. Rehabilitation goes further and may include counselling, listening and communication support and guidance on adapting to hearing-aid use.

Adult rehabilitation is not consistently integrated into publicly supported hearing-aid provision. Only 4 of 26 countries — Denmark, Finland, Norway and Sweden — **clearly report adult rehabilitation as an established part of publicly supported provision.**

A further 11 countries — Czechia, Estonia, the Faroe Islands, France, Germany, Iceland, Ireland, Poland, Slovenia, Switzerland and Türkiye — partially report adult rehabilitation, but access is conditional, referral-based, or based on individual circumstances.

Aftercare is more consistently provided. 22 out of 26 countries report some form of follow-up, adjustment or servicing after fitting, although the duration and level of coverage differ. Belgium includes aftercare for three years for children and five years for adults; Denmark for four years; France provides three checks during the first year and recommends continued follow-up thereafter; Slovenia covers fitting, adjustments and an annual preventive service; and the United Kingdom provides unlimited NHS aftercare. In other countries, aftercare may instead depend on the provider, funding package or warranty period.

The findings show a clear gap between routine hearing-aid aftercare and broader adult rehabilitation. While follow-up, adjustment and servicing are widely available, structured rehabilitation — including counselling, listening and communication training, and support in adapting to hearing-aid use — is much less consistently provided to adults.

4.5 Developments since 2018 and 2022

The 2026 findings can be compared with the earlier EFHOH hearing-aid provision monitoring report for 18 of the 26 countries examined. 8 countries — Croatia, Estonia, the Faroe Islands, Georgia, Iceland, Ireland, Sweden and Türkiye — are newly included in 2026.

The comparison shows no major structural change in hearing-aid provision since 2022. The principal funding and provision models remain broadly unchanged, and most of the barriers identified in the earlier research are still present. Some specific changes have occurred:

- **Belgium** increased reimbursement and broadened eligibility, including reducing the audiometric threshold from 40 to 35 dB HL and expanding the speech-in-noise criterion.
- **Slovenia** increased public funding amounts and broadened provision through contracted providers.
- **Italy** introduced full reimbursement for two hearing aids for children under 18.
- **Spain** extended national hearing-aid funding eligibility from people up to 21 to those under 26.

Higher reimbursement amounts should not in themselves be interpreted as improved affordability. The comparison does not adjust for inflation or changes in hearing-aid prices between 2022 and 2026. A higher reimbursement amount may therefore have little or no effect on the proportion of the actual hearing-aid cost borne by the user and cannot, by itself, be considered evidence of improved access.

Overall, the main structural barriers identified in 2022 remain in place in 2026: age-related differences in eligibility and funding, gaps between public reimbursement and hearing-aid prices, limitations on provider and device choice, long waiting times, and uneven access to adult rehabilitation and personal assistive listening devices. Four years later, the evidence therefore shows no real progress in addressing the conditions that determine whether publicly supported hearing aids are affordable and accessible in practice.

5. Cochlear implants provision in Europe: main findings and analysis

Unlike hearing aids, cochlear implants bypass structures of the middle and inner ear and directly stimulate the auditory nerve. A cochlear implant system includes an external sound processor and an internally implanted component. Its provision therefore follows a substantially different pathway from hearing-aid provision, involving specialist candidacy assessment, surgery, activation and programming, rehabilitation and long-term follow-up.

5.1 Funding and eligibility

Public funding for cochlear implantation is available in all 26 countries examined for eligible candidates, although the extent of coverage and user costs differ. Examples of user contributions include Belgium, where a hospital delivery cost of around €150 is reported; Estonia, where a 10% co-payment applies to a second processor; Iceland, where public funding covers up to 90%; and Switzerland, where people receiving their first implant after retirement receive a 25% contribution towards the processor.

Cochlear-implant candidacy is determined through different combinations of audiological and clinical criteria, including hearing-loss severity, benefit from hearing aids and speech performance.

- **Minimum hearing loss thresholds:** Belgium, Hungary, Italy and the United Kingdom. Belgium includes a criterion of at least 70 dB HL for bilateral hearing loss; Hungary reports hearing loss above 60 dB HL at specified frequencies; Italy includes bilateral PTA of 75 dB HL; and the United Kingdom uses more than 80 dB HL as a typical adult/post-lingual reference.
- **Insufficient benefit from hearing aids in 14 countries:** Croatia, Czechia, the Faroe Islands, Finland, France, Germany, Hungary, Iceland, Ireland, Malta, Poland, Portugal, Slovenia and Switzerland.
- **Speech understanding or speech performance in 8 countries:** Belgium, Denmark, Finland, Germany, Poland, Slovenia, Switzerland and the United Kingdom.
- **Specialist or multidisciplinary assessment in 8 countries:** Croatia, Estonia, Germany, Ireland, Italy, Poland, Portugal and Slovenia. Türkiye follows an additional specified candidacy pathway requiring a hearing-aid trial, medical imaging and medical-board approval.

5.2 Unilateral hearing loss, bilateral implantation and waiting times

Unilateral hearing loss

Severe or profound unilateral hearing loss or single-sided deafness is explicitly included within cochlear-implant candidacy in 4 of 26 countries — Austria, Belgium, France, Italy. This should be distinguished from unilateral implantation, which may also refer to providing one implant to a person with bilateral hearing loss.

Bilateral implantation

Bilateral implantation means receiving two cochlear implants, one for each ear. **Access to two implants is not equivalent for children and adults.**

6 countries report broader publicly funded bilateral access for children than for adults — Belgium, Georgia, Malta, the Netherlands, Türkiye and the United Kingdom. Czechia differs mainly in timing: children generally receive two implants simultaneously, while adults may receive them sequentially. Other countries, including France, Hungary, Italy and Poland, report bilateral implantation according to clinical indication without the same explicit child–adult distinction.

Where children receive broader access, this is commonly linked to early listening, speech and language development. However, this should not be interpreted as meaning that bilateral implantation is less relevant for adults. [Cochlear Implant Services Matter: Cochlear Implants in Deaf and Deafened Adults: A Global Consultation on Lifelong Aftercare](#), based on a global survey of 1,076 adult cochlear-implant users in 40 countries, found that respondents with two cochlear implants were more likely to report satisfaction with both their implants and the CI services they received. The report recommends that lifelong adult cochlear-implant services provide access to bilateral cochlear implants where appropriate as part of lifelong CI services.

Waiting times

12 of 26 countries report waiting times for cochlear-implant surgery that can reach approximately one year or more (Austria, Croatia, Czechia, Denmark, Estonia, Iceland, Ireland, Netherlands, Norway, Portugal, Spain, United Kingdom). The longest reported waits are in Iceland, at up to two to three years. Ireland reports a marked age difference, with waits up to nine months for children compared with around two to two and a half years for adults.

5.3 Rehabilitation and long-term follow-up

Cochlear implantation does not end with surgery. After activation, users require processor programming and follow-up, while rehabilitation supports adaptation to the new auditory input and the development or improvement of listening and communication skills. Access to

these services over time is therefore an integral part of cochlear-implant provision, rather than an optional addition after surgery.

Access to post-implant rehabilitation is reported in 25 of the 26 countries, but its duration, amount and availability vary considerably. Limitations or unequal provision in rehabilitation are reported in at least 9 countries — Croatia, Estonia, Georgia, Poland, Portugal, Slovenia, Spain, Switzerland and Türkiye — including:

- **more restricted provision for adults or age-related differences:** for example, Slovenia provides adults with 10 auditory-verbal rehabilitation sessions, while children receive auditory-verbal rehabilitation and additional professional support; in Spain, structured public rehabilitation is available for children, while adult provision is inconsistent and often relies on private care; Switzerland reports coverage before retirement but more limited arrangements afterwards; and Türkiye provides children with up to eight hours of publicly funded rehabilitation per month but reports no equivalent adult provision;
- **limits on duration or amount:** Georgia limits rehabilitation to a maximum of 18 months and 144 hours;
- **restricted or non-standard availability:** Estonia reports limited rehabilitation, mainly through employment routes and daily support services, while provision in Croatia and Portugal may also vary by centre, region or funding pathway.

These findings show that the formal availability of post-implant rehabilitation does not necessarily ensure equivalent or sufficient access in practice, particularly for adults. Differences in age eligibility, number of sessions, duration and availability can substantially affect the level of support received after implantation.

This concern is also reflected in user evidence. In [CIICA's global consultation of adult cochlear-implant users](#), 32% reported that the rehabilitation they received was insufficient and 27% reported receiving none. The same consultation identified regular appointments, rehabilitation and easy access to technology support as important elements of lifelong cochlear-implant services.

5.4 External sound processor renewal

The external sound processor is an integral part of the cochlear-implant system and is required for the user to hear through the implant. Processor renewal should therefore be distinguished from eligibility for cochlear implantation: it concerns the continued use of an existing implant, rather than candidacy for implantation.

19 of 26 countries report a defined or customary processor-renewal interval, generally between four and seven years. Iceland reports four years; Belgium, France, Georgia, the Netherlands, Norway, Poland and Slovenia report five years; Denmark, Hungary and Switzerland report six years; and Austria, Czechia, Estonia, Malta and Türkiye report seven years. Croatia reports five to seven years, Germany four to six years, and the United Kingdom five to six years. Belgium additionally applies a three-year interval for children under eight.

7 countries do not report a single national renewal interval — the Faroe Islands, Finland, Ireland, Italy, Portugal, Spain and Sweden. Instead, renewal depends on clinical assessment, regional or specialist-centre practice, or other pathway-specific arrangements. Finland and Sweden, for example, rely on regional or cochlear-implant-team practice, while Italy requires specialist assessment and Portugal relies on specialist-centre or National Health Service arrangements.

A defined renewal interval does not guarantee timely replacement. In Austria, France, Poland, Slovenia, Switzerland and Türkiye, renewal may still require new clinical or administrative approval, including assessment of whether the existing processor continues to provide adequate technical or hearing performance. Users may therefore face additional steps or delays even after the stated renewal interval has been reached.

5.5 Repair, temporary replacement and loss

Processor failure can require support before the normal renewal date. **Continuity of access when a processor fails, is being repaired or is lost differs substantially:**

- **Repair following processor failure:** all 26 countries report some arrangement for repair or replacement, but the level of public coverage differs. Denmark, Hungary, Malta, Norway and the United Kingdom report repair without a direct user charge, while users in Czechia, Georgia, Poland and Türkiye may face costs after the warranty period. France requires a minimum five-year processor warranty and provides an immediate replacement processor in the event of failure.

- **Temporary replacement during repair:** provision is much less consistent. France, Slovenia and Türkiye explicitly report immediate replacement or loan processors. Croatia may provide a replacement processor during major repairs, but this is not guaranteed in practice; in Georgia it depends on the manufacturer, while in Portugal it varies by specialist centre and pathway.
- **Replacement after loss:** public coverage is more restricted. Denmark covers loss through the public system, while Sweden covers processors provided on loan. Croatia and Norway generally place responsibility on the user. Private insurance is reported or recommended in Austria, Belgium, Croatia, Finland, Poland, Switzerland and the United Kingdom, while no dedicated public replacement route is reported in Georgia, Iceland, Italy and Türkiye.

These gaps have direct consequences for continuity of use. As the external processor is essential for access to sound through the implant, delays in repair, lack of a temporary processor or limited replacement after loss can leave users without effective access to their cochlear implant and may shift additional costs to users.

5.6 Accessories

The external sound processor depends on accessories such as batteries, chargers, cables and coils for everyday use. Access to these accessories is therefore necessary for the continued use and functioning of the cochlear implant. However, the available evidence on coverage is not sufficiently consistent across the 26 countries to support a quantitative comparison. France reports reimbursement for specified accessories and batteries, including rechargeable batteries and a charger under defined conditions; Estonia reports coverage of several accessories and spare items; and Italy reports public coverage for maintenance, repair and replacement of external accessories.

Where essential components are not covered or cannot be obtained promptly, users may face additional costs or periods in which their cochlear-implant system cannot be used effectively.

6. Personal assistive listening devices

While hearing aids and cochlear implants are primary hearing care interventions where appropriate, they are often paired with personal assistive listening devices, such as remote microphones and Bluetooth streamers, to improve access to speech understanding and other audio. Those devices are often manufacturer-specific, yet they are almost universally treated as a luxury and excluded from basic medical reimbursement in most countries.

The findings show that their provision is considerably less consistent than the provision of hearing aids or cochlear implants themselves.

- **Only 1 of the 26 countries, Norway, provides personal assistive listening devices as part of general publicly funded provision for hearing-aid users.**
- **14 countries provide personal assistive listening devices for hearing-aid users through separate, targeted or needs-based routes:** Austria, Belgium, Croatia, Denmark, Estonia, Faroe Islands, Finland, Germany, Ireland, Poland, Portugal, Slovenia, Sweden and Switzerland.
- **At least 6 countries apply age-related conditions to provision:** Belgium, Croatia, Denmark, Poland, Slovenia and Switzerland. These include broader provision for children or younger people and more restrictive access in adulthood or after retirement. Slovenia, for example, provides a route for school-age children while adult provision is limited to specific conditions.
- **For cochlear-implant users, 12 countries provide access through restricted, separate or non-uniform routes:** Austria, Belgium, Croatia, Faroe Islands, Finland, the Netherlands, Poland, Portugal, Slovenia, Sweden, Switzerland and the United Kingdom.

Overall, personal assistive listening devices are rarely integrated into standard hearing-care provision. Access often depends on separate disability, education, employment or regional schemes, as well as age and individual assessment. This matters because hearing aids and cochlear implants alone may not provide sufficient access in all listening environments. Remote microphones, streamers and similar devices can provide additional support where distance, background noise or poor acoustics make communication difficult. When access to these devices depends on separate or restrictive funding routes, hard of hearing people still lack the technology needed for effective communication in education, employment and everyday life.

7. Emerging hearing technologies: Over-the-Counter (OTC), self-fitting and consumer-integrated solutions

While this report focuses on the public provision of hearing aids, cochlear implants and personal assistive listening devices, developments in consumer hearing technologies are also relevant to the broader question of access to hearing care.

Since [EFHOH's statement on over-the-counter hearing aids](#), the hearing-technology landscape has continued to evolve. Hearing tests, self-fitting amplification and hearing-support features are increasingly being integrated into consumer wearables, offering new possibilities for people with hearing loss.

A positive development is the inclusion of safe-listening features in some consumer technologies, reflecting the principles established in [ITU-T Recommendation H.871](#) on safe listening for personal sound amplifiers. However, consumer wearables with hearing aid features are not medical devices and should not replace the quality of hearing care provided by hearing-care professionals or transfer responsibility for hearing care from public systems to individuals.

8. Person-centred hearing care: what it is and why it matters

The report findings highlight the need to move towards a **person-centred approach to ear and hearing care**, as recommended in the WHO **“World Report on Hearing”**:

“Once hearing loss is identified, it is essential that it is addressed as early as possible and in an appropriate manner to mitigate any adverse impact. Such early intervention strategies must adopt a person-centred approach, taking into account the individual’s communication needs and preferences, as well as available resources.” [...] “Two people with the same audiogram configuration can have very different everyday hearing related difficulties and experiences.”

People with hearing loss may experience different communication barriers in everyday life. Eligibility based exclusively on a minimum level of hearing loss, measured in decibels (dB) on an audiogram, may not fully reflect difficulties experienced in education, employment, healthcare, at home or in other settings. Appropriate provision should combine clinical and audiological assessment with individual communication needs and preferences, personal circumstances, participation and informed choice.

This approach is consistent with the UN CRPD. Article 26 requires habilitation and rehabilitation services to be based on the *“multidisciplinary assessment of individual needs and strengths”* and to support participation and inclusion in the community. Article 3 identifies individual autonomy, including the freedom to make one’s own choices, among the Convention’s general principles. The meaningful involvement of hard of hearing people in decisions about their care and the technologies they use is therefore an integral part of person-centred provision.

For hearing aids, person-centred provision involves appropriate assessment, device selection, professional fitting and adjustment, counselling, rehabilitation and follow-up. The [2024 Joint EFHOH–AEA Position](#) states that hard of hearing people must have access to quality hearing care provided by a recognised and regulated health professional. It emphasises professional responsibility for the selection, fitting, adjustment and personalisation of hearing aids in close cooperation with the user. This is important because public funding for a hearing aid does not in itself ensure that the device is appropriate for the individual: effective use depends on suitable selection, professional fitting and personalisation, as well as the user’s ability to make an informed choice

Cochlear implants require a distinct clinical and rehabilitation pathway, including multidisciplinary candidacy assessment, informed decision-making, surgery, activation and programming, rehabilitation and long-term follow-up. Continued use also depends on access to the external sound processor, programming, repairs and timely replacement. Hearing aids and cochlear implants are therefore examined through separate provision pathways, while applying the same underlying principle that hearing care should respond to individual needs.

The listening environment can also affect whether hearing technology provides effective access. Hearing aids and cochlear implants may need to be complemented by personal assistive listening devices, such as remote microphones and streamers, and by environmental assistive listening systems, such as hearing loops, in classrooms, workplaces, meeting spaces and other community settings. Person-centred hearing care therefore considers not only the primary hearing technology, but also the additional technology and accessibility measures needed to support communication and participation on an equal basis with others.

From a policy perspective, person-centred provision requires the conditions surrounding the device to be considered as part of access to hearing care. These include appropriate eligibility and assessment, informed choice, professional fitting or programming, rehabilitation, complementary assistive technologies and continuity through follow-up, repair, renewal and replacement. Funding, reimbursement and procurement mechanisms matter because they can either enable or restrict access to these elements and the ability of services to respond to individual needs.

9. Conclusion

This assessment of hearing-aid and cochlear-implant provision in Europe shows a clear gap between **formal entitlement and effective access to hearing care**.

Four years after the previous edition of this report, progress remains limited, despite good practices and stronger support in some countries. European countries must take more concrete and coordinated action to address gaps in long-term support that continue to affect hard of hearing individuals and society at large.

Across Europe, hearing health policies remain mostly fragmented, contributing to unequal access to care, social exclusion, poorer health and mental well-being, isolation and wider socioeconomic disadvantages for people with hearing loss.

The consequences are real. Delays, unaffordable costs and gaps in rehabilitation, repairs or replacement mean that many hard of hearing people face barriers to living independently and participating in public life.

These inequalities are structural, rooted in how hearing-care systems determine eligibility, allocate public funding, organise services and ensure continuity of care. Addressing these inequalities therefore requires systemic changes to ensure that hearing care is affordable without undue burden on individuals and available across the life course.

The level of public financial support and the eligibility criteria applied significantly affect equal access to hearing care. The [2024 Getting the Numbers Right report](#) found that hearing-aid uptake increased from 19% where reimbursement covered around 20% of costs to 49% where hearing aids were provided free of charge. Uptake was also higher where eligibility extended to people with mild hearing loss (51%), compared with more restrictive eligibility arrangements (25%). These findings reinforce the importance of affordability and appropriate eligibility criteria in enabling effective access to hearing care.

Equitable access to hearing care requires adequate public funding and a person-centred approach, including timely assessment, professional fitting, rehabilitation and continued access to maintenance, repair and replacement.

Yet, in most countries, personal assistive listening devices, such as Bluetooth streamers, remote microphones and TV set-top boxes, are excluded from standard reimbursement schemes and treated as a luxury rather than essential support. For many people with hearing loss, these technologies are crucial for effective communication in difficult listening environments.

Translating these principles into practice requires sustained public investment, stronger action at national and European levels, and the meaningful involvement of hard of hearing people and their representative organisations in decisions affecting hearing-care provision. The following recommendations identify the priorities for making equitable, affordable and continuous access to hearing care a reality across Europe.

10. Recommendations

As stated in the [World Health Organization's World Report on Hearing \(2021\)](#), “*Ear and hearing care is an integral component of universal health coverage.*” In line with Sustainable Development Goal 3, everyone, including people with hearing loss, should have access to high-quality healthcare without experiencing financial hardship. Ensuring affordable access to hearing aids, cochlear implants and personal assistive listening devices, together with appropriate hearing-care services, is therefore essential to advancing universal health coverage and fulfilling commitments under the UN Convention on the Rights of Persons with Disabilities.

Recommendations to EU institutions and policy-makers

- Develop a **European Strategy on Hearing Loss** to coordinate national action plans on prevention, early identification, access to hearing care and hearing technologies, rehabilitation, and healthy ageing.
- **Integrate equitable access to hearing aids, cochlear implants and personal assistive listening devices** as a core priority within the EU flagship initiative “Assistive technologies and AI: from lab to market” under the Enhanced Disability Strategy, addressing affordability, rehabilitation and long-term support.
- **Ensure the meaningful participation of hard of hearing people** and their representative organisations throughout the development, implementation and evaluation of EU policies and measures affecting hearing care and hearing technology.

Recommendations to European countries

- **Develop and implement national ear and hearing care action plans** in line with WHO Resolution WHA70.13, incorporating the H.E.A.R.I.N.G. interventions framework and integrating ear and hearing care into universal health coverage (UHC). Action plans should address prevention, early identification, assessment, access to hearing technologies, rehabilitation, follow-up, repair and replacement services, and include measurable targets to monitor progress.
- **Integrate hearing care services, rehabilitation and related hearing technologies** in public health and reimbursement schemes, without unjustified restrictions, to support timely referral and continuity of care throughout the life course.

- **Establish national governance structures** to coordinate, oversee, and drive implementation of ear and hearing care policies and programmes. Where responsibilities are decentralised, equivalent coordination should be ensured between national and regional authorities.
- **Develop public awareness and early-identification programmes.** National strategies should address hearing loss across the life course, including through primary care and healthy-ageing programmes.
- **Ensure access to person-centred hearing care throughout life.** Public provision should include appropriate assessment, hearing-aid selection, individual fitting and verification, counselling, rehabilitation and follow-up according to individual need, including in adulthood and older age. Where needed, provision should also include personal assistive listening devices.
- **Base eligibility and public funding on comprehensive individual assessment** using the WHO International Classification of Functioning, Disability and Health (ICF). Assessment should consider audiological and clinical findings, speech understanding, communication needs and the impact of hearing loss on everyday activities and participation.
- **Ensure the meaningful participation of hard of hearing people and their representative organisations in ear and hearing care policy.** They should be involved in the planning, implementation, monitoring and evaluation of hearing-care policies and services, including when hearing technologies, procurement arrangements or service pathways are selected, introduced, substantially changed or withdrawn.

ANNEX I.

Comparative Tables on Hearing Aids and Cochlear Implants Provision in Europe

The comparative tables present the evidence base for the analysis presented in this report. Amounts are presented in the currencies reported and have not been converted.

Legend

Comparison with 2022: ↑ = reported increase or expansion in provision; ↔ = broadly unchanged; N/A = not applicable; information not reported or country newly included in the 2026 assessment.

Hearing aids Provision in Europe

Table 1A. Hearing aids: system, public support and eligibility (2026)

Country	Healthcare system	Reimbursement rules	Eligibility	Comparison with 2022
Austria	Statutory social insurance	Standard €792 for one Bilateral €1,425.60	No fixed audiometric criterion	↔ Standard tariff broadly unchanged
Belgium	Mandatory health insurance (RIZIV-INAMI)	Children <18: full reimbursement €1,451.56 mono €2,875.21 bilateral Adults 18 - < 65: partial reimbursement €884.59 mono / €1,751.01 bilateral. Adults > 65: partial reimbursement €859,59 mono / €1.701,46 bilateral.	35 dB HL at three frequencies between 0.25 and 4 kHz, or a 3 dB signal-to-noise ratio loss on speech-in-noise audiometry. Documented hearing-aid benefit required: improvement of 5 dB in vocal index or 5% in speech intelligibility. For bilateral fitting: improvement in localisation of 10° or 10%.	↑ Eligibility broadened. Reimbursement tariffs have increased.
Croatia	Compulsory public health insurance (HZZO); Basic and Supplementary lists of orthopaedic and other aids.	Basic list: HZZO covers the standard amount; statutory co-payment may apply. Supplementary list: HZZO covers the Basic-list equivalent; user pays the difference.	Bilateral permanent hearing loss. Children <18: ≥30 dB HL average in the better ear at 0.5, 1, 2 and 4 kHz; Adults > 18: ≥40 dB HL. ENT prescription and audiological documentation required.	N/A

Czechia	Mandatory public insurance	Children up to €800/pair Adults €300, or €600 in exceptional cases; every 5 years	Medical prescription	↔ Low fixed support remains
Denmark	Tax-funded public system	Public: free of charge Children <18: public provision only Private: about DKK 7,000/pair every 4 years; optional insurance top-up	>20 dB HL or functional/speech criteria; tinnitus/hyperacusis may qualify	↔ Coverage unchanged; waits remain highly variable
Estonia	National health system; hearing aids currently social-support benefit	90% of the maximum price; €350 for Activity Group I or €736 for Activity Group II. Children: €736. Renewal every 4 years (3 years for children). Activity Group I: users with less intensive use and simple daily communication. Activity Group II: intensive use and participation in work or education.	≥30 dB average	N/A
Faroe Islands	Tax-funded public system	Free or minimal cost	Clinical and functional assessment	N/A
Finland*	Tax-funded public healthcare / wellbeing services counties	Free public provision; hearing aids are normally issued on loan as medical rehabilitation assistive devices.	National guidance: commonly ≥30 dB adults; ≥20 dB children, with functional assessment	↔ Public provision model continues; waiting comparison limited
France**	Combination National and Additional Insurance (95% population coverage)	Mono/Stereo €950/€1900	Average loss >30 dB or a 3dB SNR loss at speech audiometry in noise	↔ Unchanged
Germany	Statutory health insurance (GKV)	€704.37 per aid; €10 statutory co-payment for adults	≥30 dB HL at ≥1 frequency (500–4000 Hz) and ≤80% speech recognition at 65 dB	↑ Fixed amount increased in April 2022; unchanged since

Georgia	Targeted state social programme	Children: 950 GEL per aid, two covered Adults: 330 GEL, one covered, disability status often required	Bilateral Grade II+ (about >40 dB); unilateral loss excluded	N/A
Hungary	National health insurance	Adults about 70% Children about 98% Some groups free; 4–6-year cycle	Average >20 dB at 0.5/1/2 kHz	↔ Adult support broadly unchanged
Iceland	Public health insurance	Children under 18: free of charge Adults: partial support every 4 years, about 10–20% of cost	≥30 dB and <70 dB by specified frequencies	N/A
Ireland*	Tax-funded HSE plus PRSI Treatment Benefit	Under 18 and medical-card adults free of charge Other eligible adults up to €500 per aid through PRSI	Clinical assessment and individual management plan	N/A
Italy	Publicly funded National Health Service (SSN)	Children under 18: two hearing aids fully reimbursed. Adults: fixed reimbursement of approximately €650–750 per ear. Implementation may still vary regionally.	Adults: >33% civil-disability status plus either (1) hearing-loss assessment >33% (≈65 dB HL PTA at 0.5–2 kHz bilaterally), or (2) bilateral PTA ≥55 dB HL in the better ear at 0.5–4 kHz with visual loss and/or cognitive decline. Separate rare-disease route: bilateral PTA ≥55 dB HL in the better ear.	↑ full reimbursement for two hearing aids for children
Malta	State healthcare; optional private insurance	Free for children under 18 and means-tested groups; for disability-card holders around €250 if privately purchased through the empowerment scheme	State aid not based on a minimum level of hearing loss	↔ Broad structure and €250 support remain
Netherlands	Mandatory regulated insurance	Children: fully covered Adults: 75% plus 25% co-pay and annual deductible	≥35 dB HL, with possible exceptions	↔ Core 75%/full-child model unchanged
Norway	Tax-funded public system	Hearing aids and assistive hearing	No fixed dB limit; medical/technical indication	↔ Universal coverage

		technology free within tender price limits		continues; waits remain
Poland	Mandatory NFZ insurance plus local disability funds	Under 26: PLN 3,000 per aid Adults: PLN 1,050 per aid; additional local top-ups possible	>30 dB under 26; >40 dB adults	↑ Nominal limits increased, but affordability gap remains
Portugal	National Health Service (SNS), with SAPA funding routes through Health, Social Security (ISS) and employment (IEFP); ADSE and private/self-funded routes.	Hearing aids are included in SAPA and may be funded through Health, Social Security (ISS) or employment (IEFP), subject to prescription, eligibility, available funding and administrative processing.	No uniform national audiometric eligibility criterion across funding pathways	↔
Slovenia	Compulsory public insurance (ZZZS)	Adults: €450 per aid Children: €850 per aid	30 dB or more at least two speech frequencies	↑ Higher amounts and broader pathway than 2022
Spain	Tax-funded National Health System (SNS), complemented by regional social grants	National Healthcare Insurance only people under 26, complemented by regional grants. Example from Catalonia Adult PUA grants: €1,500 for one hearing aid / €3,000 for two hearing aids.	Only under-26 SNS route. Permanent bilateral hearing loss greater than 40 dB in the better ear, averaged at 500, 1,000 and 2,000 Hz. Separate regional schemes may exist.	National age limit extended from 21 to under 26; adult funding remains restricted.
Sweden	Tax-funded regional system	Loan devices; regional user/fitting fees 0–1,400 SEK	Measurable disability plus functional limitation. No fixed dB limit.	N/A
Switzerland	Disability insurance (IV) / old-age insurance (AHV)	Before 65: CHF 840 one / 1,650 two every 6 years After 65: CHF 630 / 1,237.50 every 5 years	20% loss before retirement; 35% after retirement	↔ Flat-rate model and retirement gap persist
Türkiye	Universal insurance (SGK)	Fixed age-based contribution; children higher than adults; substantial market-price gaps reported	PTA ≥26 dB HL; detailed age/clinical rules	N/A

United Kingdom	Tax-funded NHS	Public: free of charge Private: no reimbursements	Permanent mild–profound loss affecting communication/quality of life	! Coverage unchanged; reported waiting longer than 2022
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Table 1B. Hearing aids: referral, payment, choice and first waiting time (2026)

Country	Referral route	Payment point / pay-up	Provider and device choice	Waiting time for first hearing aid
Austria	ENT for the first medical prescription; follow-up self-referral	Direct settlement. Pay-up: Yes; user pays balance	Free provider/product choice, but provider ranges vary	No official standard
Belgium	GP, ENT, hearing-care professional; paediatrician. Medical referral required.	Insurer approval before purchase; insurer pays directly and user pays the supplement. Pay-up: Yes. For adults: tariff option with a €55.72 unilateral / €111.48 bilateral supplement.	Free provider and device choice; adults must be offered a tariff-covered option and may choose another device with a supplement.	A few weeks
Croatia	GP → ENT prescription; audiologist assessment; HZZO confirmation.	Basic list: HZZO pays contracted provider; statutory co-payment may apply. Supplementary list: user pays the price difference, sometimes covered by voluntary insurance.	Choice among HZZO-contracted providers; device choice limited to Basic/Supplementary lists and reimbursement ceilings.	Usually a few weeks after prescription and HZZO approval; longer where ENT capacity or provider stock is limited. No national maximum.
Czechia	ENT	At purchase. Pay-up: Yes, privately outside scheme	Contracted provider; approved-device list	Within 1 month
Denmark	ENT; some professional referral	Public provision/direct deduction.	Choice of public clinic and private provider; public product list	10–86 weeks in public sector

		Pay-up: Yes in private route		
Estonia	GP to ENT; some private/self routes	Direct deduction. Pay-up: Yes	Choice of centre/device; price constrains choice	Within same day, depends on pathway
Faroe Islands	GP/clinical pathway	Direct public provision. Pay-up: Private purchase possible	Limited to public/approved pathway	Varies by capacity
Finland*	Primary/occupational care to specialised hearing service	Direct public loan. Pay-up: Private purchase possible without public reimbursement	Public specialised pathway; regional implementation	Varies regionally; official local sources report delays in some areas
France**	GP/Family doctor referral to audiologist ENT	Third-party payment after the minimum 30-day trial. Pay-up: Yes for Class II or other non-fully covered choices	Free provider choice; at least two Class I devices must be offered, with freedom to choose Class II	Mandatory 30-day trial; no national waiting time identified.
Germany	Medical/ENT prescription for first provision	Insurer/provider settlement; user pays co-payment/optional upgrade	Choice within contracted provision; additional cost for devices above covered level	No national waiting time reported; appointment delays have increased due to staff shortage.
Georgia	ENT/medical-social commission for many age groups	Direct device provision; tests often self-paid. Pay-up: No top-up within state route	Single contracted supplier; no brand/model choice	Administrative and diagnostic delays; no single national time
Hungary	GP, ENT or self-referral	At purchase. Pay-up: Yes outside list/full price	Wide approved list and provider choice	Immediate for many BTE/RIE; about 3 weeks custom
Iceland	GP	At purchase. Pay-up: Yes	Free professional and product choice	Months; reported up to 2 years
Ireland*	GP or healthcare professional to HSE audiology	HSE direct; PRSI grant route. Pay-up: Yes; user pays balance	HSE range; private choice under PRSI route	Earmould/fitting usually weeks; no national maximum identified

Italy	ENT or medical audiologist prescription	SSN reimbursement for eligible users. Pay-up: adults pay any amount above the fixed reimbursement; children under 18 fully reimbursed.	Authorised suppliers; freedom to select the hearing-aid model, with a fixed reimbursement amount for adults.	Hearing aid: days to weeks. Reimbursement: weeks to months.
Malta	GP, ENT or registered audiologist	Upfront for private/state-aid claim. Pay-up: Private purchase; upfront payment	Private choice; public tender lowest-cost stock	2 months or more depending on the availability of earmoulds
Netherlands	GP/ENT; audiological pathway	At purchase with contracted supplier; claim otherwise. Pay-up: Yes, within insurer rules	Choice, but contracted providers/database affect reimbursement	A few weeks
Norway	GP/ENT pathway	No user payment within limit. Pay-up: Private purchase outside limits	Public hospital or contracted ENT clinics; choice within tenders	Up to 12 months; regional variation
Poland	ENT/authorised specialist	NFZ deducted at purchase; local top-ups may be later. Pay-up: Yes	NFZ-contracted providers; no brand list, category/price limits	Days to a few weeks after prescription; specialist access may delay
Portugal	ENT-led prescription/clinical pathway, with audiology assessment.	Often upfront or administratively delayed. Pay-up: Yes	Public tender/SAPA cost constraints; private choice if self-funded	Public routes: months to more than one year; private provision can be immediate.
Slovenia	GP first; ENT prescribes	Direct settlement with a contracted provider. Pay-up: yes /for a higher-standard device/pay the difference.	Choice among contracted providers and approved list; trials available	The waiting time for an appointment with a specialist is approximately 6 to 7 months.
Spain	GP/ENT/audiology route	Varies by competent health authority; arrangements must allow	Authorised providers and SNS catalogue/Offer; detailed choice rules vary	Private provision can be immediate; public/grant pathways may involve substantial administrative delays to one year.

		avoidance of upfront payment in specified cases.		
Sweden	GP, ENT, audiologist or self-referral, directly without a referral in some regions	Public loan; regional fee. Pay-up: Private purchase outside range	Regionally procured range of services	Approximately 1 week to 1 year, depending on the region.
Switzerland	ENT diagnosis; user selects professional	Insurer pays provider. Pay-up: Yes	Free provider choice; approved devices; purchase abroad possible	ENT bottleneck up to about 2 months; administration fast
Türkiye	ENT and authorised audiology/medical board	SGK contribution at provision; user pays gap. Pay-up: User pays difference	Approved providers/devices under SUT rules	Usually limited by assessment/provider process; no single time reported
United Kingdom	GP/ENT; Private: self-referral	NHS direct provision. Pay-up: No	NHS clinic/provider and brand choice limited	7–18 weeks reported

Table 2A. Hearing aids: rehabilitation, aftercare and accessories (2026)

Country	Rehabilitation beyond routine fitting	Aftercare (Fine tuning, re-fitting, verification)	Accessories / remote microphones	Comparison with 2022
Austria	No social-insurance rehabilitation; some company training	Yes, 5–6 years	Not normally; workplace funding route possible	↔
Belgium	Case-dependent; reported for children and after cochlear implantation	Yes, 3 years (children) or 5 years (adults)	Regional disability-agency route for people <65 with ≥55 dB hearing loss; separate CI/company routes may apply	↔ Aftercare and renewal retained;
Croatia	Basic rehabilitation and counselling available; more systematic for children. Structured adult rehabilitation is limited and varies regionally.	Fitting, adjustments and preventive checks covered; follow-up and re-fitting through contracted providers under warranty/HZZO rules.	Batteries/accessories covered by HZZO; remote microphones and advanced ALDs not covered for adults, with limited support for school-age children.	N/A
Czechia	Partly available	Until next entitlement, often via non-profits	No	↔
Denmark	Publicly funded for children and adults	Yes, 4 years	Children included; adults can apply regionally	↔

Estonia	Inconsistent and poorly signposted	Fine-tuning free	Only by special referral	N/A
Faroe Islands	Included when clinically indicated	Included as needed	Exceptional, needs-based only	New
Finland*	Part of hearing rehabilitation; counselling and guidance included	Public follow-up and service	Needs-based medical/disability/employment routes	↔
France**	Speech and language rehabilitation for children where required; may also support adults, including lipreading.	Three checks during the first year; follow-up throughout the device's life, with two visits annually	Batteries and LPP-listed accessories reimbursed at 60%	↔ Follow-up model retained
Germany	Available where clinically indicated	Fitting, adjustment and follow-up included in provision	Transmission systems covered where individually required	↔
Georgia	N/A	Only during warranty	No	N/A
Hungary	Provider programming/checks; no separate structured package	Yes, small fee may apply after cycle	No	↔
Iceland	Subsidised with user fee	Not included	No	N/A
Ireland*	Follow-up; aural therapy may be recommended	Adult follow-up around 6 weeks; regular child reviews	Assistive devices may be recommended; separate support routes are available	N/A
Italy	N/A	N/A	N/A	N/A
Malta	Not systematic; depends on audiologist	Public yes; private provider-dependent	No	↔
Netherlands	N/A	Provider/package-dependent, often up to 2 years	No	↔
Norway	Yes	Partly included	Yes	↔
Poland	Partial; more structured for children	Provider-dependent; no national long-term category	Under 26: PLN 3,850/5 years; no national adult scheme	↑ amounts; continuity gaps persist
Portugal	Not systematically funded; adult access weak	No uniform national guarantee	Yes, through SAPA. Education and employment pathways may also apply.	!

Slovenia	Adults: Available in exceptional cases. Children: Included in auditory-verbal rehabilitation and additional professional support.	Follow-up checks, readjustments or reprogramming, up to six cleanings during the service life of the hearing aid, and tubing replacement.	Adults: not available below 80% hearing loss by the Fowler method; above 80%, available under the Disability Act, usually with a 15% co-payment. School-age children: available through the Health Insurance Institute of Slovenia with an ENT prescription.	↑
Spain	No nationally defined post-fitting rehabilitation entitlement; complete treatment and follow-up required	Follow-up included in national pathway; implementation varies	Not included in common national HA catalogue; other support may exist depending on region.	N/A
Sweden	Primary and extended rehabilitation publicly funded	Refitting/fine-tuning included; cleaning self-care	Microphones prescribed for severe hearing loss; work routes available, but prescription restrictive	N/A
Switzerland	Before retirement yes; after retirement no	Flat-rate service for 5–6 years	Work-related needs before retirement	↔/! retirement gap
Türkiye	Limited for adults; child special-education routes stronger	Provider/warranty-dependent	No	N/A
United Kingdom	No standard structured hearing-aid rehabilitation	Unlimited NHS aftercare	No	↔/! rehabilitation and choice gaps

Table 2B. Hearing aids: renewal, earlier replacement, loss and repairs (2026)

Country	Standard renewal period	Earlier replacement	Loss, damage and insurance	Repairs
Austria	5–6 years	Yes if medically documented	Loss only if privately insured; repairs covered.	Publicly covered; cost estimate may be required
Belgium	Children: 3 years; adults: 5 years	Earlier reimbursement where average hearing loss worsens by ≥ 20 dB	Replacement depends on private omnium insurance; deductible applies.	Children: 3-year warranty. Adults: minimum 2-year warranty, sometimes longer depending on provider
Croatia	5–7 years, depending on	Earlier replacement for	Loss or user-caused damage generally not	Repairs covered during warranty for faults; after

	age group and medical reassessment; new prescription required after expiry of entitlement period.	documented anatomical, physiological or functional change; HZZO approval required.	publicly replaced. Private home/device insurance may cover loss or damage. Warranty for manufacturing defects.	warranty, users usually pay. Replacement not provided.
Czechia	5 years	Yes; 2–3 months	No early free replacement Insurance: Yes, private	Warranty 2 years; user pays after
Denmark	4 years	Yes; 2–6 months	Public replacement free; private depends on insurance.	Free within 4-year period
Estonia	4 years; 3 for children	Exceptional application possible; 10% co-pay	Emergency route; loss self-funded Insurance: Home/all-risk possible	Warranty 1–2 years; loan device varies
Faroe Islands	Needs-based; no fixed published cycle	Yes after reassessment	Broken aids repaired; loss assessed individually Insurance: Private home/travel possible	Public repair/replacement where justified
Finland*	Needs-based; no national fixed interval identified	Yes by clinical reassessment	Public loan system while waiting for repair ; local rules apply Insurance: Private insurance optional	Public provider responsible for service/repair
France**	4 years	Earlier replacement may be approved if the device is irreparable or medically unsuitable.	Optional private insurance for loss or theft	Minimum 4-year manufacturer warranty covering faults during use
Germany	Adults: 6 years; children: 5 years	Possible if medically or technically necessary	No general rule reported; insurer assessment may apply	Repair/service covered; reported service flat rate covers 4 years
Georgia	2–3 years; new documentation	No fast-track; private purchase if urgent	No early replacement for loss/user damage Insurance: No	Free in warranty; self-paid after
Hungary	4 years under 9; 6 years others	Immediate new entitlement if category worsens; co-pay remains	One subsidised replacement per cycle after approval Insurance: Limited home-insurance cover	Warranty, then same subsidy percentage; negligence excluded

Iceland	4 years; no new prescription	Not free; months to a year	User responsible Insurance: not specified	Consumer warranty/provider repair
Ireland*	Clinical replacement for HSE users; PRSI frequency per scheme	Clinical replacement possible	HSE assesses lost/non-repairable aids Insurance: Private insurance may apply	Free HSE repairs for children and medical-card adults; PRSI pays half repairs
Italy	No fixed minimum period, at least 5 years. Applies to children and adults.	Possible where the existing hearing aid is no longer suitable; an ENT or medical-audiologist report may be required.	Accidental loss is not reimbursed by the SSN; private insurance is recommended for loss.	After the warranty period, repairs and replacement are reimbursed by the SSN.
Malta	Needs based	By appointment at ENT Dept. if eligible for state aid.	State-aid requires evidence if replacement Insurance: Home insurance possible	Public: free Private: free if still under warranty
Netherlands	Normally 5 years; earlier by new clinical route	Not free; new process required	Depends on warranty/insurance	Warranty/service arrangement
Norway	6 years; user initiates	Can apply after deterioration	Free for children; adults responsible for loss Insurance: Yes, private; association membership may include cover	Supplier repair obligation
Poland	3 years under 26; 5 years adults; new prescription	Earlier mainly for severe-disability certificate	No automatic early replacement Insurance: Private/device/home insurance possible	Warranty 2–3 years; user pays after
Portugal	5 years; new prescription and administrative approval; renewal not automatic.	No uniform national rule; requires clinical/prescription and administrative assessment.	Depends on pathway and provider.	Depends on public pathway, provider and warranty
Slovenia	Adults: 6 years. Children: 2 years up to age 6; 3 years	Early replacement requires a significant anatomical or functional change	The availability of loan hearing aids is limited. Insurance: Private/device/home insurance possible.	Repairs covered by the Health Insurance Institute of Slovenia. User-caused damage not covered.

	from ages 6 to 15; and 6 years from age 15. For advanced hearing aids: 5 years.			
Spain	48 months as minimum.	Difficult before cycle	Families may bear repairs/replacement; grant uncertainty Insurance: Private insurance possible	Public/private/warranty-dependent
Sweden	About 4–5 years; no new referral	Earlier if significant deterioration	Fixed fee for lost hearing aids or users pay a larger share of the cost. Insurance: Home insurance may apply	Included for duration of loan
Switzerland	6 years before retirement; 5 after; reapply	Earlier if significant deterioration	National insurance does not replace lost aids Insurance: Yes, private	Limited flat rates before retirement; none after; 2-year guarantee
Türkiye	5 years commonly for hearing aids	Administrative approval; early replacement restrictive	Loss not publicly replaced Insurance: Home/property riders sometimes	Warranty then largely self-funded; some component support
United Kingdom	3–4 years	Free as soon as clinically possible	Replacement available; possible £70–£100 charge Insurance: Home insurance for private devices	Public: free Private: insured, fix right away.

Cochlear implants Provision in Europe

Table 3A. Cochlear implants: funding, eligibility and access to surgery (2026)

Country	Public funding	Eligibility	Bilateral access	Waiting time from assessment to surgery
Austria	Yes	Severe hearing loss/deafness, including unilateral cases	Differences not reported	Up to 1 year
Belgium	Yes; patient pays about €150 hospital delivery cost	Children: bilateral loss ≥ 70 dB HL; unilateral loss ≥ 85 dB HL in the worse ear or speech intelligibility $\leq 30\%$ at 70 dB SPL, with asymmetry criteria. Adults: bilateral loss ≥ 70 dB HL; unilateral loss ≥ 70 dB HL in the worse ear or speech intelligibility $\leq 30\%$, with asymmetry criteria; reported duration criterion also applies.	Different rules: children may receive bilateral reimbursement; adults unilateral reimbursement In case of unilateral deafness: reimbursement for CI possible in children and adults.	A few months; average about 6 months
Croatia	Yes, through specialized public healthcare centers; implant surgery and device largely publicly funded for eligible users.	Severe-to-profound sensorineural hearing loss with insufficient benefit from optimally fitted hearing aids; multidisciplinary assessment (ENT, audiology, speech/functional assessment, imaging).	Children are prioritized; bilateral implantation possible based on clinical criteria and practice. Adults may receive unilateral or bilateral CI depending on indication and capacity.	Several months to over a year from completion of assessment to surgery, depending on capacity, priority (children vs adults) and waiting lists. No single national maximum waiting time is defined.
Czechia	Yes	Hearing aids no longer effective	Children: bilateral simultaneously Adults: sequential	Children: 6–9 months Adults: 9–12 months
Denmark	Yes	Public provision for all ages Audiometric, speech-discrimination and functional assessment	Same rules reported; children prioritised clinically	Children: promptly where possible Adults: 2 months to >1 year

Estonia	First processor free; second 10% co-pay reported	Committee after tests/imaging; severe loss	Children prioritised because budget limited	Adults 1–2 years; sometimes 6 months
Faroe Islands	Yes via public cooperation with Denmark	Danish specialist protocols; limited HA benefit	Paediatric and adult protocols differ	Depends on Danish centre
Finland*	Yes through specialised public care	Severe/progressive sensorineural loss with insufficient speech recognition from HAs	Children assessed early; care in five university hospitals	N/A
France**	Yes	Severe-to-profound bilateral sensorineural hearing loss with insufficient benefit from optimally fitted hearing aids; unilateral severe-to-profound loss with disabling tinnitus may also qualify under specified conditions.	Early implantation prioritised for children. Bilateral implantation is funded for specified clinical indications	N/A
Germany	Yes; medically necessary CI treatment fully covered	Severe/profound hearing loss or single-sided deafness; insufficient benefit from HAs	Bilateral implantation where clinically indicated	No national waiting time identified
Georgia	Yes, bilateral up to 4 years; unilateral for all ages, implant funded	Severe–profound bilateral SNHL; imaging and residency criteria	Children prioritised; extra readiness assessment	Up to 3–4 months
Hungary	Yes	>60 dB at key frequencies plus poor aided benefit; medical work-up	Same rules; unilateral/bilateral possible	3–6 months; urgent cases faster
Iceland	Partial, up to 90% reported	Bilateral loss and insufficient HA benefit	Same rules	Up to 2–3 years
Ireland*	Yes, national programme	Severe–profound loss and insufficient HA benefit; multidisciplinary assessment	Children prioritised; bilateral surgery described in HSE pathway	First appointment: child up to 3m, adult 9–12m; first appointment to surgery: child up to 9m, adult up to 2–2.5y
Italy	Yes; unilateral and bilateral cochlear implantation are fully covered by the SSN.	Assessment by an ENT or medical audiologist at a regional auditory-implant centre under national guidelines.	Unilateral or bilateral cochlear implantation may be fully covered. No age-based funding restriction.	Weeks to months; varies by implant centre and may depend on pre-operative imaging and other specialist assessments.

		Bilateral PTA of 75 dB HL and single-sided deafness are included within candidacy.		
Malta	Yes	Severe/profound loss and insufficient HA benefit	Children prioritized Bilateral implants not provided to adults	Waiting-list dependent, but children are prioritised
Netherlands	Yes	ENT decision based on hearing loss and benefit	Children often bilateral; adults unilateral except deafblind	Adults about 4–12 months; children sometimes weeks
Norway	Yes	Severe hearing loss	Same criteria; children prioritised	Typically 1–2 years; children prioritised
Poland	Yes	Multidisciplinary; insufficient HA speech benefit	Children prioritised; bilateral possible	Weeks to months; centre variation
Portugal	Yes, through specialist National Health Service (SNS)	Specialist multidisciplinary assessment based on hearing loss and insufficient benefit from hearing aids.	Children prioritised; bilateral practice may vary by centre and clinical situation.	Several months to more than one year, depending on specialist centre and clinical priority.
Slovenia	Yes	Severe-to-profound hearing loss with insufficient speech understanding despite appropriately fitted hearing aids.	Early identification; bilateral cochlear implantation for children and available for adults.	Up to centre capacity and priority. Adults: Waiting time for all required assessments is up to one year.
Spain	Yes through public health system	Specialist multidisciplinary assessment; severe/profound loss and poor HA benefit	Bilateral cochlear implantation covered for eligible children and adults. Children may be prioritised; varies by region.	Several months to more than one year, depending on specialist centre and clinical priority. For example, Catalonia: 8–10 months for children and 1–1.5 years for adults.
Sweden	Yes	Severe loss; audiologist and ENT assessment	Early identification; bilateral CIs for children when needed	Respondent reported no wait
Switzerland	Yes; some retired first-time users pay 25% processor	Poor speech understanding despite optimal HAs; all ages	Early paediatric assessment; adult candidacy based on benefit	About 2 months

Türkiye	Implant surgery/device broadly public; processor replacement often partial with large gap	3-month HA trial, medical board, imaging; detailed SUT criteria	Bilateral public funding strongest for children 1–4; special approval otherwise	Minimum 3-month trial plus about 4–6 months; ABI crisis longer
United Kingdom	Yes	Typical adult/post-lingual reference: >80 dB unaided and <50% word recognition	Children may receive two; adults may receive one	6–12 months

Table 3B. Cochlear implants: processor renewal, rehabilitation and continuity (2026)

Country	Processor renewal	Rehabilitation	Accessories/ remote microphones	Repairs	Loss / insurance
Austria	7 years; new prescription and trial	Some clinic follow-up; programmes mandated for development since 2025	No but workplace route possible	Publicly covered	Private insurance recommended
Belgium	Children: external processor 3 years if under 8, otherwise 5 years Adults: 5 years. Internal part: 10 years. Renewal automatic after hospital audiologist consultation.	Yes	Depends on CI company; regional agencies (VAPH, AVIQ or PHARE) may reimburse streamers	Faulty processors replaced free of charge	Private insurance recommended
Croatia	External processor renewal typically every 5–7 years, subject to specialist reassessment and HZZO approval; internal implant has a longer	Multidisciplinary rehabilitation (audiological, speech-language, educational support), for children; adult rehabilitation but intensity varies by Center and region.	Some accessories covered; remote microphones and advanced assistive devices not systematically funded for all users, with better coverage often for school children and young persons.	External-component repairs and maintenance covered under warranty/HZZO rules; replacement processors during major repairs are not guaranteed.	User responsible for loss or damage outside warranty; private CI/home insurance. Public system does not routinely replace lost processors outside warranty/contractual rules.

	expected lifetime.				
Czechia	7 years; automatic	Yes	No	1-year warranty then user pays	Yes
Denmark	6 years	Yes, free for children and adults	Yes	Free	Public system covers risk
Estonia	7 years; new referral	Limited, mainly work/daily-life coping routes	Several accessories/spares included	Warranty 3–5 years	Home insurance possible
Faroe Islands	Needs-based; CI-team approval	Yes, publicly funded	Exceptional approval only	Public repair/replacement	Private insurance possible
Finland*	Regional/centre practice; no national interval identified	Part of multidisciplinary pathway; children receive close follow-up and speech therapy	Needs-based	Public specialised care/manufacturer arrangements	Private insurance optional
France**	Minimum 5 years, not automatic	Multidisciplinary rehabilitation and specialist follow-up included	Annual maintenance, accessory and battery support; rechargeable batteries and charger covered under specified LPP conditions	Minimum 5-year processor warranty; immediate replacement processor during failure and spare parts within 48 hours	Not identified
Germany	Every 4–6 years	Intensive auditory rehabilitation fully covered	Transmission systems covered where individually required	Covered by statutory insurance	N/A
Georgia	5 years; Form 100 required (official medical certificate)	Maximum 18 months / 144 hours / 8 sessions monthly	No	3-year warranty; consumables self-paid; some loaners by brand	No
Hungary	6 years; clinic contacts user	Yes, fully funded	No	Free over six-year cycle	Limited home-insurance cover
Iceland	4 years; not automatic	Yes	Yes	Provider responsibility	No
Ireland*	Not specified	Programming and regular speech/language therapy included	Not specified	National programme/manufacturer route	N/A
Italy	Covered by the SSN with specialist assessment.	Specialist-centre follow-up; not identified	Only external CI components are covered.	Maintenance, repair and replacement of external	Accidental processor loss is not reimbursed;

				components are covered	private insurance for loss.
Malta	7 years	Yes, free	No	Free	State-provided
Netherlands	5 years; automatic	Yes	Depends on the manufacturer	Aftercare/warranty	Specific insurance available
Norway	5 years; user initiates	Yes	Yes	Free	User responsible for loss
Poland	5 years; new prescription	Yes, but adult intensity/access vary	Under 26 supported; adults limited	Warranty up to 5 years; components may cost after	Dedicated private insurance available
Portugal	Subject to specialist-centre/SNS arrangements and clinical or administrative approval	Yes, but intensity and adult availability vary	Not included, but may be available through SAPA in eligible cases.	Specialist-centre/SNS/manufacturer arrangements; national practice may vary.	Limited
Slovenia	5 years; prescription and Health Insurance Institute of Slovenia approval	Adults: 10 auditory-verbal rehabilitation sessions, depending on individual needs Children: auditory-verbal rehabilitation and additional professional support.	Adults: 85% covered under the Disability Act; 100% in eligible cases. Children: for school-age is covered 100%	Warranty/Health Insurance pathway; misuse may be charged	No standard private insurance; individual cover may be possible. Rare cases are usually managed with a loan processor.
Spain	No fixed renewal period; New prescription and clinical/technical assessment required. (example: 4-year reference in Catalonia).	Structured public rehabilitation for children; adult provision is inconsistent and often relies on private care.	No	Public/manufacturer route	Private cover varies
Sweden	Regional/CI-team practice	Yes	Needs-based; work support routes possible	Included while loaned	Yes
Switzerland	6 years; not automatic and	Covered before retirement; acquired-	Work-related support before retirement	IV pays unless gross negligence	Specific CI or home insurance available

	may be refused if functioning	rights/charity issues after			
Türkiye	7 years; new medical board and prescription	Children: up to 8 hours/month free Adult: excluded	No, beyond baseline kit	2-year warranty; partial components; loaner after long repair	No dedicated scheme; home riders sometimes
United Kingdom	5–6 years	Yes	Yes, included in some NHS processor/upgrade packages.	Free for NHS processors	Home insurance commonly used

*Source: EFHOH national submissions (2026); *Finland and Ireland: desktop research using official sources; **France: desktop research using official sources, supplemented by the 2022 EFHOH report where current national information was not identified.*

ANNEX II

WHO Grades of Hearing Loss

To standardize the way in which severity of hearing loss is reported, WHO has adopted a grading system based on audiometric measurements. The grading system is presented in Table 1.3 from Page 38 of the WHO World Report on Hearing below.

Table 1.3 Grades of hearing loss and related hearing experience*

Grade	Hearing threshold [†] in better hearing ear in decibels (dB)	Hearing experience in a quiet environment for most adults	Hearing experience in a noisy environment for most adults
Normal hearing	Less than 20 dB	No problem hearing sounds	No or minimal problem hearing sounds
Mild hearing loss	20 to < 35 dB	Does not have problems hearing conversational speech	May have difficulty hearing conversational speech
Moderate hearing loss	35 to < 50 dB	May have difficulty hearing conversational speech	Difficulty hearing and taking part in conversation
Moderately severe hearing loss	50 to < 65 dB	Difficulty hearing conversational speech; can hear raised voices without difficulty	Difficulty hearing most speech and taking part in conversation
Severe hearing loss	65 to < 80 dB	Does not hear most conversational speech; may have difficulty hearing and understanding raised voices	Extreme difficulty hearing speech and taking part in conversation
Profound hearing loss	80 to < 95 dB	Extreme difficulty hearing raised voices	Conversational speech cannot be heard
Complete or total hearing loss/deafness	95 dB or greater	Cannot hear speech and most environmental sounds	Cannot hear speech and most environmental sounds
Unilateral	< 20 dB in the better ear, 35 dB or greater in the worse ear	May not have problem unless sound is near the poorer hearing ear. May have difficulty in locating sounds	May have difficulty hearing speech and taking part in conversation, and in locating sounds

The classifications used in Table 1.3 follow the recommendations of the International Classification of Functioning, Disability and Health (ICF) proposed by WHO in 2001. The ICF defines a person's state of health along three dimensions. According to the ICF, the disability experienced is determined not only by the individual's hearing loss but also by the physical, social and attitudinal environment in which the person lives, and the possibility of accessing quality EHC services. Therefore, a person with hearing loss who does not have access to hearing care, is likely to experience far greater limitations in day-to-day functioning and thus higher degrees of disability.

ANNEX III.

EFHOH Survey on Access to Hearing Aids and Cochlear Implants in Europe 2026

The questions below reproduce the EFHOH questionnaire used for the 2026 assessment. The questions were developed with the support of the European Association of Hearing Care Professionals. Personal contact fields and the data-protection notice are omitted from this publication annex.

Section 1. General

1. Is there a health insurance system in your country that pays for healthcare treatment? Please include whether insurance is mandatory or optional.

Section 2. Access to hearing aids

2.1 Is there any support in paying for hearing aids, such as free provision, reimbursement or partial reimbursement? Please describe the different routes for children and adults.

2.2 What is the amount of reimbursement or public support? Are there different levels according to age, hearing loss or other patient characteristics?

2.3 What minimum hearing loss is required to qualify, and how is it measured and calculated?

2.4 Must a minimum improvement be documented to receive reimbursement? How is it measured?

2.5 Can clients freely choose their hearing-care professional, or must they use public, contracted or approved providers? Are there other reimbursement conditions?

2.6 Who makes the referral to the hearing-care professional: a general practitioner, ENT specialist, hearing-care professional or another route?

2.7 Where reimbursement is not used, is a medical referral still mandatory?

2.8 Is support applied at the point of purchase, or must the user pay the full cost first?

2.9 Are there restrictions on type, brand or technology level? Are there official lists or categories, and what happens if a person chooses outside them?

2.10 Is rehabilitation, including auditory training or other support after fitting, publicly funded or reimbursed?

2.11 Are branded assistive devices, such as streamers or remote microphones, included?

2.12 What happens if a person wants a hearing aid that is not covered by public support?

Can they pay the difference or reclaim part of the cost?

2.13 How long does a newly diagnosed person wait for a first hearing aid?

2.14 How long before a hearing aid can be renewed? Is renewal automatic or is a new prescription or referral required?

2.15 If hearing worsens and an upgrade is needed, how long does it take and is it free?

2.16 What happens if a hearing aid is lost or broken? Can it be replaced without full payment?

2.17 Is insurance against theft, loss or damage available, including through other policies?

2.18 Is aftercare, including cleaning, verification, fine-tuning and refitting, included? For how long?

2.19 What are the rules and costs for repairing faulty hearing aids?

Section 3. Access to cochlear implants

3.1 Are cochlear implants free to eligible patients?

3.2 Where they are not free, is partial reimbursement available?

3.3 What are the eligibility rules for cochlear implantation?

3.4 Are there different eligibility rules or pathways for children and adults?

3.5 What is the waiting time from assessment to operation?

3.6 How long before a processor can be renewed? Is renewal automatic or is a new prescription or referral required?

3.7 Is rehabilitation after cochlear implantation publicly funded or reimbursed?

3.8 Are branded accessories, such as streamers or remote microphones, included?

3.9 What are the rules and costs for repairing faulty processors?

3.10 Is insurance against theft, loss or damage available for processors, including through other policies?

Section 4. Additional information

Do you have additional comments, clarifications or relevant information regarding access to hearing aids and cochlear implants in your country?

Would you be willing to be contacted for follow-up questions, clarification or support for this project?

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