The challenge of disrupting the hearing care market in the USA

BY BARRY FREEMAN

Barry Freeman, an Audiology Consultant of extensive global experience, examines the business model of hearing care service delivery in America. He discusses the challenges the profession has faced, and proposes some food for thought on learning from other health care professions who face similar dilemmas, and how they have approached it.

In the United States, 2015-16 are the years we can point to when the government and public addressed the issues of affordable and accessible hearing care. Perhaps the discussion actually began in 2009 when the NIDCD (National Institute of Deafness and Communication Disorders) convened a panel of experts from around the globe to discuss ways to increase the utilisation of hearing care services and products by adults with mild to moderate hearing loss. It was well known that the average age in the US a person first acquires a hearing aid is 70 years and only an estimated 20% of individuals with hearing loss acquire amplification. One of the outcomes from this panel was the conclusion that cost is a barrier to entry to hearing care and this perception — whether correct or not — persists today. The belief is that if only the costs of products could be reduced, more people would take advantage of them.

In 2012, the NIDCD released the results of a survey of older adults and asked them when they first noticed their hearing loss. While, on average, this group first purchased hearing aids in their 70s, a high percentage of men and women first noticed their hearing loss before age 50 (Figure 1). However, they chose not to take corrective action until they reached age 70. Similarly, Taylor (Figure 2) has suggested that 70% of all hearing loss falls into the mild-moderate category and 90% of these people do not wear amplification. In fact, only 50% of people with moderate to severe hearing loss wear amplification. Whether or not cost is the primary barrier to entry was the focus of hearings held in Washington, DC in 2015.

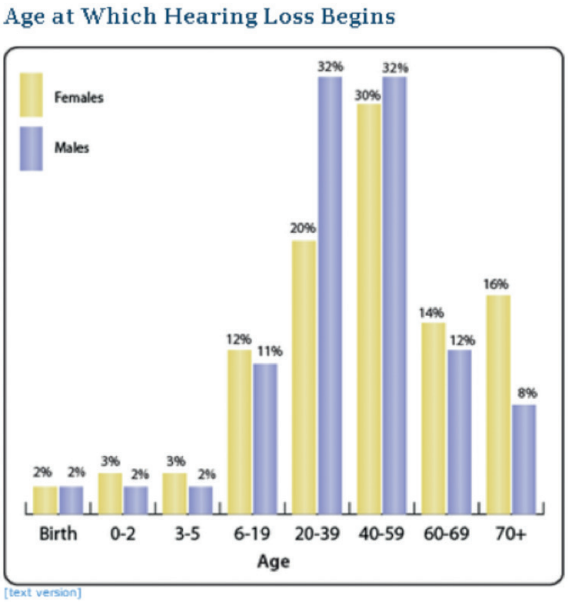

Figure 1. Age at which people first begin to notice their hearing loss [2].

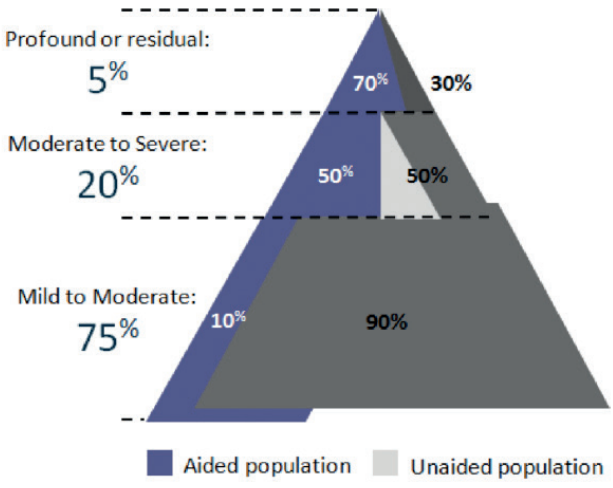

Figure 2. The unmet need of individuals with hearing loss. Of people with hearing loss, 75% have a mild-moderate loss but only 10% have done something about it. As hearing loss increases, the number of individuals that manage it increases [3].

"US audiologists now appear to be at a crossroads of deciding whether our practices are part health-care services and part retail sales, or entirely health care, where products are a part of our full scope of hearing and balance treatment services."

Government hearings on hearing care

The Institute of Medicine (IOM) at the US National Academy for Sciences formed a Committee on Affordable and Accessible Hearing Care for Adults. The committee held four public hearings in 2015 and agreed that:

- Hearing loss is a major healthcare issue.
- Hearing aids and hearing tests are underutilised.
- Federal government policies and regulations in the US affect accessibility and affordability of hearing care.

Among their conclusions was that hearing care could be more self-directed where consumers could drive decision making by accessing hearing care before engaging professionals. They considered hearing loss to be comparable to colds, joint pain, and vision loss all of which are often treated with over-the-counter medications or eyewear. The Committee explored the possible role of over-the-counter hearing instruments that could be self-selected and self-fit by patients prior to accessing professional hearing care.

Among the IOM committee members were two members of the President's Council of Advisors on Science and Technology (PCAST). The PCAST is appointed by the President to address various issues relevant to science and technology. They released a separate report on the "urgent need to improve hearing care" in the USA. The PCAST recognised hearing loss:

- As a major health and social problem
- Growing in importance with an aging population
- If untreated, as associated with higher risks of social isolation, depression, dementia, falls with injury and inability to work, travel, or be physically active
- As widely untreated as few adults with hearing loss use hearing aids.

Among the barriers to wider use of amplification cited by the PCAST were the cost of technology, the complexity of access to hearing care and hearing aids, social stigma and limited consumer awareness of the implications and ramifications of hearing loss. The PCAST committee members noted that, unlike other electronics, technical advancements have not reduced costs. The PCAST members, like their IOM counter-parts, expressed the belief that access to hearing care could be improved with self-directed care such as self-fitting hearing aid systems with online automated hearing tests. The PCAST noted: "In the near future, people could check their hearing using automated hearing tests available online[...] Interfaces[...] could allow adaptive self-fitting by devices in response to user needs. Custom earbuds and configurations could be made routinely by 3D printing. Wirelessly integrated with smartphones and other wearable electronics, hearing aids could merge with hearables."

The PCAST also expressed concern about barriers to new entrants trying to enter the hearing care market due to the vertical integration in the hearing care industry. They explained concern about six companies accounting for 98% of the global market, controlling a high percentage of the product sales, and noted the lack of influx of new innovative companies. PCAST expressed concern that developers of new technologies are inhibited from releasing products unless they establish their own dedicated dispensing channels. As these six companies have expanded into retail sales through the purchase of dispensing practices, some PCAST committee members noted that there appears to be a disincentive to selling a wide range of products which reduces consumer choice and may increase costs. In fact, PCAST expressed concern that the dispensing channel did not appear to make their own decisions about products due to the extensive influence of the manufacturers on their audiology and dispensing customers. The focus of audiologists and dispensers, PCAST noted, was on product sales and not evidenced-based practice.

Among the recommendations of PCAST was the creation of a new product category by the US FDA of a "Basic Hearing Aid" for people with bilateral, mild to moderate age-related hearing loss that would be available without accessing the professional distribution channel. This would supplement the existing category of personal sound amplification products (PSAPs) and would "augment, improve, or extend the sense of hearing in individuals." PCAST also requested that the Federal Trade Commission (FTC) require audiologists to provide a copy of their hearing test results to patients at no additional costs to the patient, thus encouraging patients to shop for their hearing aids. This is analogous to the Prescription Release Rule for optometrists passed in 1980 that required optometrists to provide patients with a copy of the test results and an eyeglass prescription. Following the implementation of this regulation, patients began to purchase eyewear at retail stores and optometrists began to focus on quality eye care, eye wear at a fair price, and annual examinations. In the USA today, 88% of consumers report having a family eye specialist whom they see for appointments regularly [1].

As with optometry, audiologists in the USA are confronted with the challenge of convincing their patients to spend discretionary dollars or disposable income for products. For hearing aids, we are unique when compared to other professions. While other professions such as optometry may sell products, they do not bundle their prices. Instead, they charge separately for the professional services associated with their products. Historically, most audiologists have tended to follow the retail sales model of bundling the costs of products and services. This has kept costs high and led to the emergence of discounted retailers like big-box stores who focus on the sale of products and not professional services. Other professions have built their brands based on the quality of their professional services and patient care, not the sale of a product. This has made them less susceptible to commoditisation and competition.

US audiologists now appear to be at a crossroads of deciding whether our practices are part health-care services and part retail sales, or entirely health care, where products are a part of our full scope of hearing and balance treatment

"Audiologists in the USA need to educate prospective patients on the value of patient-centered audiologic care and compete based on quality of care and less on coupon- and price-based product sales."

services. This is not to say that retail hearing aid sales should or will go away. That will not happen as exemplified by the recent trends of discounted direct-to-consumer sales, big-box retail sales and manufacturer-owned retail stores selling products using traditional retail price-based sales strategies. These approaches appear to be attractive to certain patients who are lured by lower prices and the commoditisation of hearing aid products. However, these patients do not understand the difference between purchasing a retail product and purchasing an audiology treatment programme that may include hearing aids. Audiologists in the USA need to educate prospective patients on the value of patient-centered audiologic care and compete based on quality of care and less on coupon- and price-based product sales.

Sometimes audiologists feel they are an island of health care, and they have issues unique to managing and treating people with hearing and balance problems. Yet audiology shares many of the same challenges of other professions, and we can learn from them if we are to survive in this changing health-care climate. As Wood (2013) recently noted, "If all you do is sell a product, differentiation is impossible because your industry can be cannibalized by corporate America" [4].

Audiologists can learn from this message; we risk becoming a commodity where patients will not understand the differences between the services we provide and those they can purchase less expensively from retail stores or online. Our learned lessons include growing the service side of our profession and delivering quality treatment plans to our patients, while taking the focus off of product sales. Let's stop making the product the center of our universe and learn the lessons of other health-care providers by delivering quality hearing care services and patient-centered treatment programmes.

References

1. Freeman BA. The Future of Hearing Care: What lessons can we learn from other professions. *Audiology Today* 2014;Mar/Apr.
2. National Health Interview Survey. *Chart created by the NIDCD Epidemiology and Statistics Program*. 2007; Updated in November 2012. Available at: http://www.cdc.gov/nchs/nhis.htm
3. Taylor B. Hearables: A business case for adopting in the practice. *Annual conference of the Academy of Doctors of Audiology*, November 2015.
4. Wood F. Lessons from Other Healthcare Professions. *Veterinary Team Brief* 2013;September/October. Available at: www.veterinaryteambrief.com/article/what-can-veterinarians-learn-other-healthcare-professions

Barry A Freeman, PhD,
Audiology Consultants, Inc,
Weston, FL, USA.

E: bfreeman.audconsult@gmail.com

Declaration of competing interests:
None declared