The Economics of Hearing Healthcare in 2026

Implications for Professional Autonomy and Workforce Stability

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Audiology does not have a clinical-capability problem.

*It has an **alignment problem**: what we train audiologists to do, what patients need them to do, and what healthcare systems pay for services rendered are not yet aligned.*

Presentation Objectives

1. Describe key economic and structural forces shaping contemporary hearing healthcare delivery.

2. Explain how misalignment among training, scope, revenue structures, and reimbursement affects professional autonomy and workforce sustainability.

3. Identify clinical and structural strategies—including longitudinal functional outcomes and reimbursement reform—that may support sustainable and accessible hearing healthcare systems.

Opening Paradox: The Promise

The AuD movement was meant to elevate clinical preparation, align audiology with other doctoring professions, and secure greater professional autonomy.

Clinical Authority

Expanded preparation for diagnosis, evaluation, treatment, and management across the lifespan.

Professional Autonomy

A free-standing identity capable of practicing with clearer authority and less dependency.

Comprehensive Care

A profession positioned to provide higher-quality, coordinated hearing and balance care.

That was the promise.

The paradox is that the degree changed,
but much of the surrounding economic architecture did not.

Opening Paradox: The Proof

16.9%*

25-year workforce growth
(between 1999/2000 and 2023/2024)

$92,477**

approximate 3-year (2022-2024) mean annual audiologist salary

0

independently billable E&M pathway for doctoral-level cognitive clinical work

At nearly two decades into the AuD era, audiology still lacks the workforce scale, economic alignment, and regulatory authority typical of autonomous healthcare professions.

These are not isolated financial irritants; they are signals of how the market values the profession.

* Workforce context: occupational therapy ≈ 92.8%; optometry ≈ 83.9%, physical therapy = 94.6%; speech-language pathology = 107.9% during the same period.
**Salary context: radiation therapist (associate degree) ≈ $104,527; registered nurses (bachelor's degree) ≈ $93,973; physician assistants (master's degree) ≈ $130,887; speech-language pathologists ≈ $92,643; optometry (professional degree) ≈ $139,013 in the same 3-year comparison period.

Opening Paradox: The Question

How can a profession become more highly trained, yet remain structurally constrained?

Answer

Professional autonomy is not created by the degree alone. It emerges when training, scope, taxonomy, reimbursement, and workforce design align.

Training advanced faster than reimbursement

Scope advanced faster than taxonomy

Clinical identity advanced faster than the revenue model

The Paradox

Audiology is trained for…	Yet the field experiences…
Doctoral-level preparation	Revenue compression
Rigorous clinical and diagnostic work	Dependence on device-centered income
Longitudinal patient management	Scope asymmetry and under-recognition
Patient-centered, interprofessional care	Debt pressure and earnings compression
Complex healthcare problem solving	Workforce maldistribution and burnout

This is not a contradiction of clinical competence. It is a contradiction of system design.

Three Fundamental Misalignments

Training / Debt vs Economic Return

Doctoral preparation and debt exposure outpace the economic return available to many early-career audiologists.

Scope/Competence vs Reimbursement

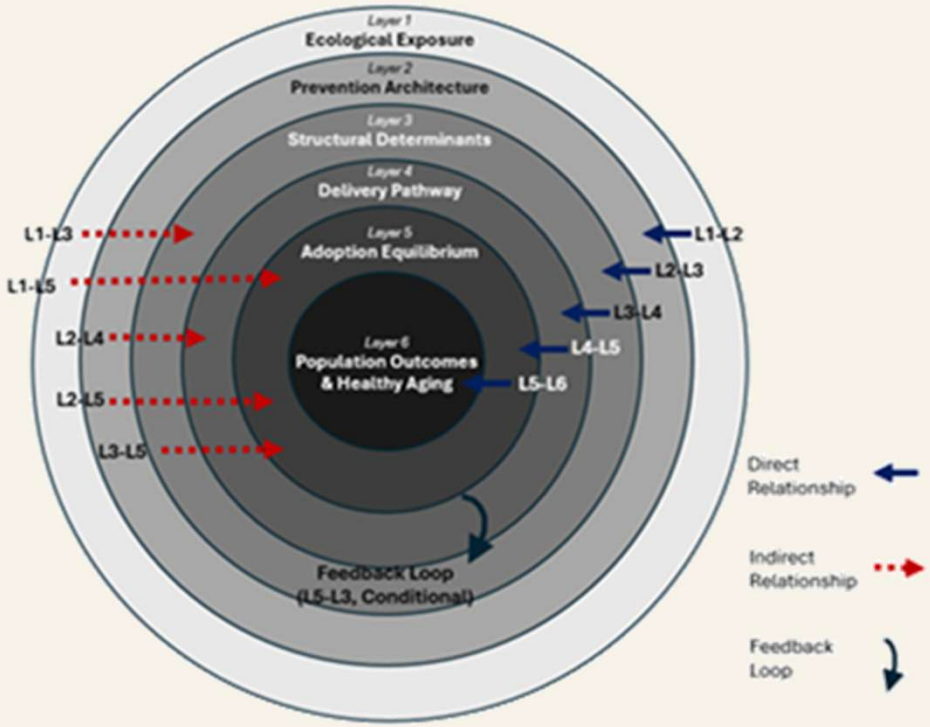
Audiologists evaluate complex conditions and plan care, but reimbursement systems continue to reward transactions more readily than cognitive clinical work.

Medical Identity vs Retail Revenue

The profession is trained as healthcare, yet financial viability often depends on product-linked margins and retail architectures.

Structural Determinants Framework of Hearing Healthcare Adoption (SDF-HHA)





(Amlani, under review)

The SDF-HHA Lens

Using SDF-HHA as a background lens: outcomes are shaped by structure, delivery design, and adoption conditions—not by clinical knowledge alone.

Layer 1–3

Upstream determinants policy, affordability, literacy, and infrastructure

Layer 4

Delivery processes what care looks like in practice

Layer 5

Adoption equilibrium whether care is sustained and used

Layer 6

Population outcomes what the system ultimately produces

This framework helps explain why obvious need, good diagnostics, and reasonable treatment options can still fail to produce sustained access or strong workforce conditions.

Roadmap for the Talk

Act I: Diagnosis

Why economic fragility persists despite doctoral preparation.

• primary ciliary dyskinesia (PCD) as clinical proof-of-concept
• over-the-counter (OTC) case
• structural misalignment

Act II: Consequences

How misalignment affects adoption, autonomy, and workforce sustainability.

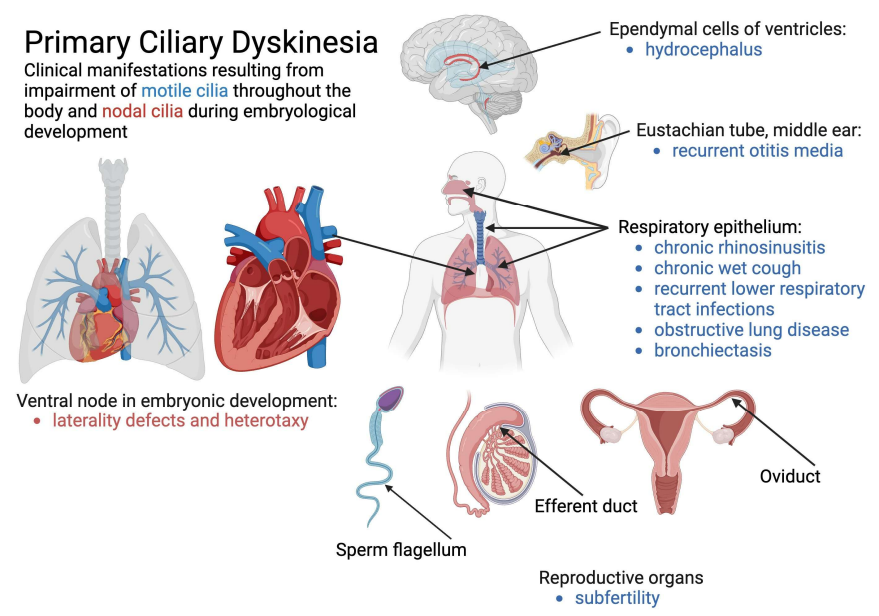
• wages and debt
• substitution risk
• burnout and distribution

Act III: Structural Futures

How the profession might realign around longitudinal value.

• cumulative auditory access
• scope and taxonomy reform
• reimbursement innovation

Act I: PCD as a Structural Access Problem



- Primary ciliary dyskinesia (PCD) is a rare motile-ciliary disorder associated with chronic middle-ear disease, fluctuating hearing loss, and lifelong surveillance needs.
- *If hearing-care adoption still fails here, the explanation is unlikely to be ambiguity of need.*

PCD is not a detour from the economics talk.
It is the clinical proof-of-concept that the system is misaligned.

Act I: The Adoption Gap in PCD

89.6%

Caregivers reported at least one social or access-related challenge

Common Challenges

- Housing instability
- Food insecurity
- Financial hardship
- Healthcare access barriers
- Health literacy

Interpretation

When 9 in 10 caregivers face upstream challenges, clinical intervention alone cannot deliver consistent population outcomes.

The key point is not merely that PCD families struggle. It is that unmet adoption reflects the cumulative effect of social constraints, care design, and treatment burden.

Act I: The Tympanostomy Tube Paradox in PCD

- Short-term: tympanostomy tubes can improve hearing and temporarily reduce conductive loss.
- Long-term: the underlying ciliary dysfunction does not resolve, effusion recurs, and children may cycle through repeated procedures.
- Complications and treatment burden—otorrhea, scarring, repeated interventions, care fatigue—can reduce net functional benefit over time.

The system typically judges success cross-sectionally: what happened to the audiogram at that visit. It rarely asks about cumulative functional access.

A clinically reasonable choice can still produce a weak longitudinal outcome if the system is designed around episodes rather than trajectories.

Act I:
The Treatment Paradox: When Clinical Action Does Not Solve the Problem

77.5%

underwent tympanostomy tube placement

Median = 2

tube sets per patient

65%

still had documented hearing loss despite treatment

This is the core systems insight: appropriate clinical care did occur, but the system was not organized around proactive surveillance, functional outcomes, coordination, or longitudinal accountability.

Act I: What PCD Reveals About Hearing Healthcare

Need is clear

Families generally want hearing care and the clinical need is not ambiguous.

Intervention exists

There are valid clinical tools: surveillance, amplification, counseling, and middle-ear management.

Adoption still fails

The system is organized around episodic encounters rather than longitudinal access.

If structural barriers can suppress adoption in a population with obvious need, they can suppress adoption anywhere.

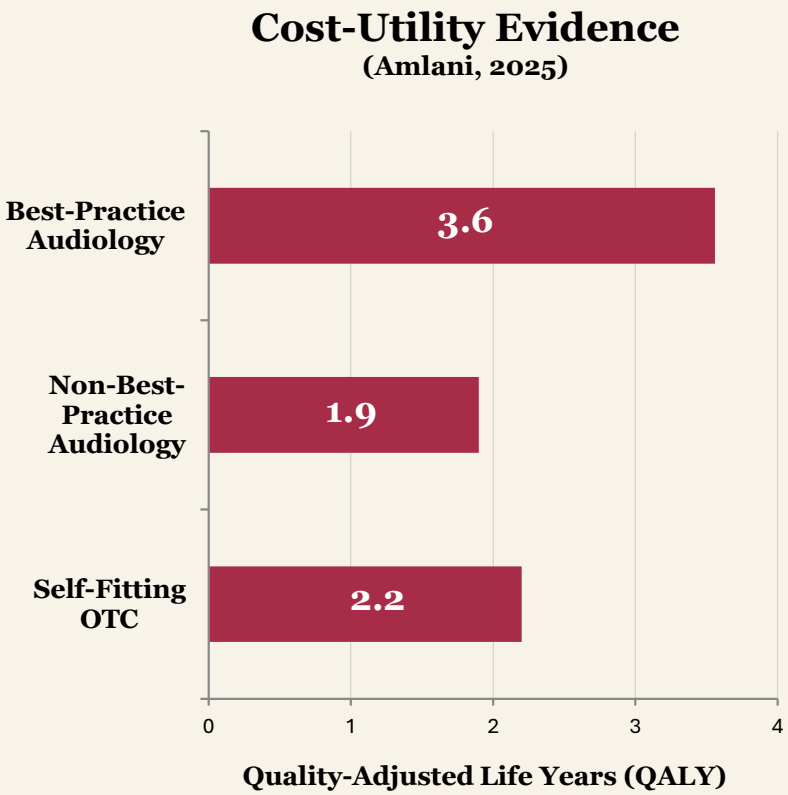
Act I: The OTC Story: Market Structure Over Outcome Quality

- The OTC rule changed market access by permitting self-fitting hearing aids.
- Regulatory change expanded access, but the market still optimized around existing incentives.*
- The critical question is not whether OTC exists; it is whether the market competes on clinically meaningful outcomes or simply segments by convenience, volume, and margin.

The OTC story is less about innovation than about what the market architecture chooses to reward.

*higher margins; greater sales volume; delivery costs; control of distribution; reimbursement rules

Act I: OTC Case Study: Outcome Difference



Key result

Best-practice audiology (3.56 QALY) produced about a 60% QALY advantage over self-fitting OTC devices (2.2 QALY).

Interpretation

System design—not access expansion—determines quality.

The outcome gap isn't about touchpoint—it's about incentive alignment (functional outcomes).

- Non-best-practice audiology - professional care that did not measure or reward functional outcomes
- OTC/direct-to-consumer - expanding OTC without fixing the incentive architecture will replicate structural failure at scale

Act I: The Market Response to OTC Regulation

- Regulatory change opened a new category.
- Incumbents did not necessarily respond by competing most aggressively on outcome quality.
- Instead, the system incentivized segmentation, engineered positioning, and protection of volume-based channels.
- The lesson is broader than OTC: markets drift toward what payment and classification structures reward.

If the reimbursement system privileges transactions,
the market will optimize for transactions.

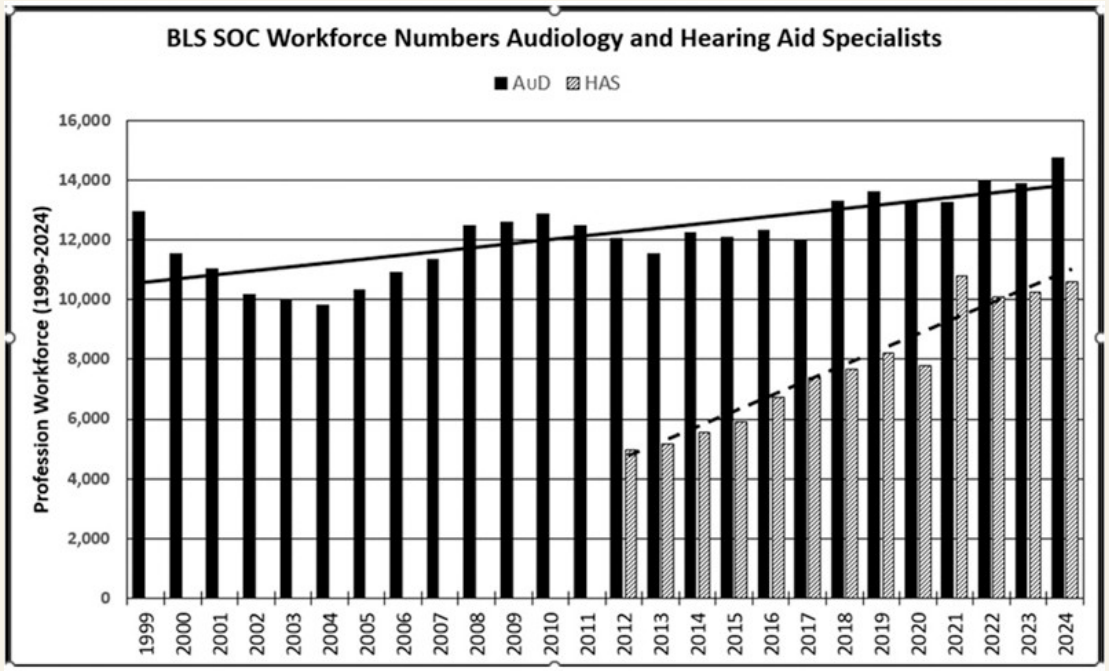
Act II: From Adoption Failure to Workforce Consequence

What the clinical system needs	What the economic system rewards
Longitudinal responsibility	Episodic encounters
Diagnostic reasoning	Volume throughput
Functional outcome tracking	Product-linked margin
Care coordination	Limited reimbursement recognition
Population access	Retail geography and substitution pressure

When those two columns diverge, the workforce feels the strain first.

Act II: The Workforce Is Rebalancing

(Bray & Amlani, 2026)



Audiologists

Slow workforce growth despite doctoral-level preparation

Hearing Instrument Specialists

Rapid workforce expansion → projected to reach parity with audiology around **2036**

When the market expands faster in the lower-cost delivery workforce than in the doctoral workforce, that is an economic signal—not simply a pipeline problem.

Act II:
Workforce Consequences: Highly Trained, Structurally Marginalized

Audiologists are trained for…	But the system often positions them for…
Longitudinal thinking	Transactional work
Complex diagnostics	Threshold-centered encounters
Functional outcome measurement	Volume-based productivity
Patient-centered care	Retail compliance
Interprofessional collaboration	Revenue dependence on devices

Mismatch, not incompetence, is the core workforce stressor.

Act II: Economic Return: Debt, Wages, and Early-Career Pressure

>$120,000

common doctoral debt load referenced in the special issue

19%

gross income retained as discretionary income for a median-salary early-career AuD graduate

25%

comparable discretionary income estimate for an SLP graduate

- The student-debt problem is not simply a salary problem.
- It is a revenue-architecture problem: audiologists lack the fully recognized, independently billable diagnostic identity that helps peer professions translate advanced training into stronger earnings.

Act II: Professional Taxonomy and Reimbursement Recognition

- Audiology's federal and statutory classification remains a major structural constraint.
- Exclusion from E&M codes means doctoral-level cognitive labor—assessment, interpretation, clinical reasoning, and care planning—often lacks independent reimbursement recognition.
- That exclusion reinforces a cycle: limited billing authority drives product-dependent revenue; product dependence reinforces retail perception; retail perception makes classification reform harder.

*Correcting taxonomy is not just a regulatory goal.**
It is the mechanism for interrupting the cycle.

**Legislation = Medicare Audiology Access Improvement Act (MAAIA; H.R.2757/S. 1996)*

Act III: The Audiogram Does Not Fully Describe Functional Hearing

Among people who **report recurrent difficulty in noise**, how many have PTA ≤20 dB HL?

63.7%

Functional-difficulty group → Audiometric status

Among people who **have PTA ≤20 dB HL**, how many report recurrent difficulty in noise?

34.2%

Preserved-threshold group → Functional status

Threshold sensitivity and functional hearing describe related—but different—dimensions of hearing health.

Act III: Cumulative Auditory Access: A Unifying Outcome

Cumulative Auditory Access (CAA) = the degree to which an individual maintains functional access to speech and meaningful acoustic information over time.

Traditional question

Did we normalize the audiogram at this visit?

CAA question

How much of this person's life was spent with adequate functional hearing?

CAA does not replace clinical outcomes.
It integrates them into a more meaningful longitudinal frame.

Act III:
From Functional Need to Proportionate Care: CAA + Minimum Clinical Need

CAA defines the outcome worth purchasing.
MCN defines the clinical reasoning required to prescribe care proportionately.

1. **Identify risk / need**
   screening, case history, communication demands
2. **Characterize CAA**
   functional access over time, not one audiogram
3. **Determine MCN**
   least intensive intervention sufficient to meet need
4. **Intervene**
   technology, counseling, accommodations, coordination
5. **Reassess CAA**
   validate function; escalate only when needed

CAA — Outcome target

How much functional auditory access is being maintained over time?

MCN — Clinical decision rule

What is the minimum level of care sufficient to meet demonstrated functional needs and goals?

A value-based hearing-care system should pay for the reasoning that connects functional need to proportionate intervention.

Act III: From Episodes to Trajectories

Current model	Future model
Episode-based	Longitudinal
Threshold-focused	Function-focused
Reactive	Proactive
Transaction-driven	Outcome-driven
Device-centric	Patient-centric
Primary endpoint: audiogram	Primary endpoint: CAA

Strategic Lever 1: Scope Modernization

- Recognize preventive work, diagnostic complexity, and longitudinal management as core audiology functions.
- Clarify practice authority across settings and reduce ambiguity where overlapping disciplines affect care access.
- Align formal scope with contemporary training, evidence, and public health need.

Scope modernization is not about prestige.
It is about enabling the work the profession is already trained to perform.

Strategic Lever 2: Taxonomy Reform

Unbundle complex assessment

Separate diagnostic complexity from routine testing and device fitting.

Create care-coordination codes

Reimburse longitudinal counseling, education, family support, and cross-setting coordination.

Establish preventive-service codes

Support screening, identification, follow-up, and health-literacy work as recognized healthcare activity.

Taxonomy reform* makes the profession legible to the payment system.

**Medicare Audiology Access Improvement Act (MAAIA; H.R.2757/S. 1996)*

Strategic Lever 3: Reimbursement Innovation

Episode-based bundling

One bundled payment for diagnosis, fitting, and follow-up over a defined period.

Incentive: quality over volume.

Capitated payment

An annual per-patient fee for hearing-related care.

Incentive: prevention and continuity.

Outcome-based payment

Base payment plus incentive tied to sustained functional hearing.

Incentive: benefit, not transaction count.

All three models better support CAA than a purely transactional encounter-by-encounter system.

Strategic Lever 4: Population Accountability and Canadian Relevance

Population accountability

Measure system success by aggregate functional benefit across populations—not simply by device volume. Track educational, occupational, and quality-of-life consequences of sustained auditory access.

Why this matters in Canada

Provincial variation demonstrates that structure matters. Different scope definitions, reimbursement models, and access architectures create natural experiments that can inform reform.

The advocacy frame should be public health, access, and outcome accountability—not simply income protection.

Lead the Change

Scope modernization • Taxonomy reform • Reimbursement innovation

The future of audiology will be determined by how well the profession aligns training, scope, payment, clinical reasoning, and longitudinal outcomes.

Old question

Did we normalize the audiogram today?

Better question

Did we preserve adequate functional hearing across this person's lifespan?

Closing Reframe

Questions?

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