An overview of UK Hearing Healthcare

A Provider’s Perspective

Presented by
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Founder of Audira
2 parallel routes for adults for hearing aids

- **Government Funded**
  - Family Doctor refers

- **Private/Independent**
  - **Self Funded**
  - **Patient Self-Refers**

- **Direct referral**
  - No need to see doctor
  - No need to sign waiver
What about the risk of Self-Referral?

**Referable Conditions**
- The **training** to identify
- The (enforceable) **standards to refer** onwards

**Standards of education and training**
- **Standards of proficiency**
- **Standards of conduct, performance and ethics**

**Treatable conditions**
- e.g. otitis media, cholesteatoma, acoustic neuroma…

**Outside own scope of practice**
- e.g. tinnitus, APD, abnormal tympanic membrane, balance…

**Requiring further investigations**
- e.g. asymmetry, sudden onset, dizziness…

http://www.hcpc-uk.co.uk/aboutregistration/protectedtitles/
http://www.hpc-uk.org/aboutregistration/protectedtitles/protectedfunction/
2 parallel routes for adults for hearing aids

**NHS**

Government Funded

- **Cost to purchaser:**
  - $600 for binaural
  - $452 for monaural

- **Cost to patient?**
  - “Free at point of delivery”

**Private/Independent**

- **Includes**
  - Assessment
  - Fitting of hearing aid(s)
  - Cost of hearing aid(s)
  - Follow-up
  - 3 years aftercare and 3rd year review

- **Cost to patient?**
  - Driven by market forces

  - Average approximately $1800 per ear, including ongoing support
PSAPs

Includes
- Assessment
- Fitting of hearing aid(s)
- Cost of hearing aid(s)
- Follow-up
- 3 years aftercare and 3rd year review

Not a serious contender

vs Hearing aids
- FDA Regulated
- “See doctor first before getting hearing aid”

Often more expensive than NHS hearing aid(s)
- Loses the opportunity to rule out (or monitor) referable conditions = increased risk to public (including potential fatality)
- Abdicates quality control (regulation, verification, outcome measurements…)
- Loses expertise of trained, regulated professionals
- Regulatory ambiguity/ambivalence

Using PSAPs in the US postpones addressing the real issue...
...PSAPs not suitable for moderate/severe/profound

So hearing care remains unaffordable for the more disadvantaged in society!
$588 through NHS

**Economy of Scales**
Combined purchasing power & Tendering Process
- Low training overheads
- Limited range of models
- Older technology
- Automatic referral route (family doctor)

NHS says...
We want this level of technology for this price

Manufacturer says...
“We want a seat at the table”

$3600 through Self-Funding

**Limited Economy of Scales**
Fragmented purchasing power & market driven choices
- High training overheads
- Wide range of models
- Newer technology & styles
- Marketing costs + overheads shared over fewer people

Non-NHS Providers says
It’s not fair!

Consumer says
Why is it so expensive?
In a thought out “joined up” system, could self-funding partially/wholly pay for those who cannot? Many also have NHS hearing aids! So the State has already paid out for something that is not benefiting these individuals.

“What about voucher system?”

Would pay for approx 47,000 NHS patients!

Self-funders also pay sales tax! $25m

Paying 6x as much! Because they cannot access the Government’s economy of scales.

Units Supplied Between 2010-2014

State Funded

Estimated annual cost to the State $356.3m

Self Funded

Estimated annual cost to individuals $415.5m

Please don’t increase demand too!

So the State has already paid out for something that is not benefiting these individuals.

“What about voucher system?”
“Minimum level of effective hearing aid for a guaranteed entry level cost that every US citizen has access to”

**Collective**
- Purchasing power
- = Economy of scales

**Standardized**
- Technology & fitting
  - = Level playing field
  - and quality control

**Centralised referral**
- System
  - = Creates support from profession & industry

**Minimum** (i.e. entry level) becomes **affordable** to more people
- **but without stifling for consumer choice & market forces**

It also becomes more “affordable” to **insurance companies**
- **especially when untreated compared to QALY or equivalent**

And to **Government** in supporting the more socioeconomically disadvantaged

**For example**
- **$600* for a pair over 3 years** could be paid through monthly subscription of **$17**

*Same as “his and hers” deodorant – and just as important to a healthy relationship!*

*Based on NHS tariff for binaural*
But affordability is only the beginning...

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<th>Germany</th>
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<td>“Cannot afford hearing aids”</td>
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But affordability is only the beginning...

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Is their appraisal reliable?

Hearing is the Social Sense

Prevalence vs Recognition vs Uptake

Baby Boomers at time of UK Census

Actual
Measured Thresholds (Based on Davis, 1989)

Perceived
Self-Reported (Based on EuroTrak, 2012)

Hearing Aid Owner (Based on EuroTrak, 2012)

Number of Individuals

Age Group

Note: Overlap at 45-49 due to the two sets of data used (Davis, 1989 and EuroTrak 2015) using different age banding, i.e. 41 to 50 versus 45-54.
Prevalence vs Recognition vs Uptake

40% of people left behind because they don’t perceive a reduction

59% of those who recognize it get left behind by current system

“In the drawer” 11% of people who are fitted get left behind by our current provision

Total individuals left behind by current system (assuming use of hearing aids is the correct measure)*

78%

*Currently available measures are based on “number of units”. This biases provision (e.g. rehabilitation less of a priority). Also candidacy tends to be based on “it’s up to you” type advice, rather than any “this is when you would benefit from amplification”.


Prevalence vs Recognition vs Uptake

21% of people left behind because they don’t perceive a reduction

75% of those who recognize it get left behind by current system

“In the drawer” 12.4% of people who are fitted get left behind by our current provision

Total individuals left behind by current system (assuming use of hearing aids is the correct measure)* 83%

Reduction in Hearing Range (Bilateral) A

Recognize a reduction in hearing B

Get hearing aids B

Use hearing aids C

*Currently available measures are based on “number of units”. This biases provision (e.g. rehabilitation less of a priority). Also candidacy tends to be based on “it’s up to you” type advice, rather than any “this is when you would benefit from amplification”.


Prevalence vs Recognition vs Uptake

If you could improve affordability and access?

Total individuals left behind by current system (assuming use of hearing aids is the correct measure)*

72%

Reduction in Hearing Range (Bilateral) A
Recognize a reduction in hearing B
Don’t perceive reduction
Don’t get hearing aids
Get hearing aids B
Use hearing aids C

59% of those who recognize it get left behind by current system
Don’t perceive reduction

Don’t get hearing aids

If you could improve the wear rate?

Total individuals left behind by current system (assuming use of hearing aids is the correct measure)*

68%

“In the drawer” 0% of people who are fitted get left behind by our current provision

Prevalence vs Recognition vs Uptake

Even after improving affordability and attaining a 100% wear rate we’re left with approximately 20.4 million Americans who have unsupported hearing loss.
Prevalence vs Recognition vs Uptake

This is where the **biggest unaddressed issue** lies

The answer **does not lie in audiology research**...
For a target behaviour to take place, we have to create the right conditions here.

**Capability**
Psychological/physical ability to enact behavior

**Motivation**
Mechanisms (reflective & automatic) that activate or inhibit behavior

**Opportunity**
Physical/social environment that enables the behavior

**Behavior**

The 4 Questions: A framework for creating a new social norm for hearing care

Contains **138 references and notes** from the literature regarding attitude formation and behavioral change and how it applies to hearing care. It can be downloaded from [www.audira.info/4Q](http://www.audira.info/4Q)
1. When should I have my hearing checked?

A. When I need hearing aids or my hearing changes

2. How do I perceive a change in my hearing?

A. It will be worse than it is now

3. Who uses hearing technology and is that me?

A. The deaf, the hearing impaired, the elderly, the desperate

4. When should I use hearing technology?

A. When I’m old enough, deaf enough, desperate enough

Not yet then!

I don’t notice any change!

That’s not me!

I’m not ready!

Where do these **answers** come from?

We only hear what we hear – not what we don’t! So how can we know if we’re missing anything?

Actor Observer Effect: When I can’t hear, it’s the **situation**. When you can’t hear, it’s your **shortcomings**.

Some have psychological or sensory sources.
Where do these **answers** come from?

Are you *suffering* from hearing *loss*?  
*Have your hearing checked.*

**Suffering?** It must be severe!

**Loss?** I don’t want to confirm it!

Many come from our own words, messages and associations

“Fill out this Hearing Handicap Inventory for the Elderly!”
The 4 Questions

1. When should I have my **hearing checked**?
   - A. **Routinely throughout life**, just like eyes and teeth
   - Not yet then!

2. How do I **perceive a change** in my hearing?
   - A. **I can’t** without hearing checks
   - I don’t notice any change!

3. Who uses **hearing technology** and is that me?
   - A. Anyone who wants to **hear as expected** and be themselves
   - That’s not me!

4. When should I **use** hearing technology?
   - A. Triggers: **Situational** and **Attributional**
   - I’m not ready!

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EYES checked

TEETH checked

HEARING checked?
Get the message out there

Inspiring Change
Improving Lives
The more time that passes, the more a person will...

1. Shrink their life to fit their hearing range.
2. Shift responsibility from hearing to other systems: visual, cognitive & social.
3. Stop being their true selves.

Onset of hearing loss

Time

Taking action
Thank you for your attention

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