Submission to: Australian Senate – Community Affairs References Committee

Re: Inquiry into Hearing Health

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This draws on our experience as clinical audiologists and as creators of a continuous quality improvement system for hearing aid dispensing, but is made in our role as concerned professionals.

We are prepared to give evidence before the Committee and defend our submission should it be required.

This submission concentrates on the broadest issues covering ***access to hearing services***, especially as they relate to adult onset hearing loss and provision of quality hearing care (privately and publicly funded).

This submission is based on three factors -

1. The cost of non-use of hearing aids is very large compared to the cost of provision[1]
2. The major barrier to take-up and use of hearing aids is a community perception that hearing aids don't work (well enough)[2]
3. This negative perception continues to be reinforced in the current dispensing environment[3].

These factors are examined in detail and a solution to improve the current situation is proposed.

The cost of non-use

Untreated hearing loss creates a significant financial, emotional and educational burden on the community[1,4]. People with untreated hearing loss are more likely to suffer physical and mental problems, as well as educational and vocational disadvantage[1,4]. For the elderly, the impact of non-use shows as being one step further into dependent living compared to their otherwise identical peers (matched for age, health, income, education)[4].

The extent of the problem

Despite significant improvements in hearing science, education and technology over the past fifty years, there has not been a corresponding improvement in community acceptance of hearing aids as an essential part of management of communication problems caused by hearing-loss. This problem must be addressed as the aging of the population increases the proportion of hearing impaired people in our community from one in six today, to an estimated three out of four by 2050[1].

Those who have a hearing loss sufficient to impair their communication function, but who do not use hearing aids are termed "hearing aid non-users", and are believed to be about four out of five hearing impaired people. Hearing aid non-users can be divided into two groups – those who have never tried hearing aids, and those that have acquired hearing aids but "wear their hearing aids in the drawer".[6]

It is estimated that one in five hearing impaired people in the general population use hearing aids. This proportion has increased to approximately one in three in Australia due to government subsidisation of hearing aids to eligible people (under contracts administered by the Office of Hearing Services). A leading government research scientist, Dr Harvey Dillon, has presented data showing a high rate of ineffectiveness of hearing aids fitted under the OHS program, with nearly one third of the aids fitted with little (10% used less than one hour per day) or no use (21% clients never wear their aids)[3]. This is not only a significant waste of government funding, but continues to reinforce the general community perception that "hearing aids don't work", and is a continuing barrier to seeking solutions for problems caused by hearing impairment. It also places an added burden on the community for the cost of mental, physical and educational problems caused by untreated hearing loss[1,4].

The core problem – "Hearing aids don't work"

Any member of the committee who has raised the subject of hearing aids in a social situation will have heard complaints:

"You can't use them on the phone"

"They whistle all the time"

"My voice sounds funny"

"Too fiddly"

"They don't work in groups"

"My father has tried three sets, none worked"

Rarely will there be a comment like *"I'm lucky, mine are perfect"*

If hearing care professionals are asked about these comments, they will generally agree that all these problems are avoidable, or fixable. But obviously, they have not been avoided – or fixed. Why not?

This conundrum derives from the early days of hearing aids when most of the complaints were true, and unfixable. Hearing aids have progressed to such a point that most hearing impaired people ***could*** have hearing aids that would be effective.

However, the industry has been over-promising and under-delivering for so long that consumers not only believe the historical record, but often their own experiences verify the situation has not changed. This causes them to accept sub-optimal fittings as "the norm", and their own poor experiences allow them to further reinforce the negative community perception that "hearing aids don't work". One can imagine what the one in three people fitted with aids unused aids say about their experiences in the community!

The conventional industry view is that there is a stigma associated with hearing aids that causes non-use, but research has discounted this. Kochkin's study[5] shows hearing impaired non-users are much more likely to agree with negative statements about hearing aid performance (52%) than with statements related to stigma (32%). In Australia, the OHS program has resulted in a high take up of hearing aids among the eligible hearing impaired population, but with a disappointing very high non-use rate – so even when stigma (and cost) issues are overcome and aids fitted, they are not used because of poor performance.

So the core problem can be reformulated as **consumers have strong evidence of poor hearing aid performance.** This evidence is what they have experienced themselves and/or others have told them.

It must be emphasised that an *almost perfect* fitting can still contribute to the chorus of complaints about hearing aids in the community ("I hear really well with these hearing aids, but I can't use them on the phone.")

Effects of poor expectations on public provision

Paul Newman said "Show me a good loser and I'll show you a loser". Because the community has such low expectations of hearing aid performance, consumers lose when they accept less than optimum fittings. This can lead to inappropriate device selection and fitting procedures being accepted by the client. By *accepted* we mean – *taken without complaint*. This does not mean the devices are being used (as evidenced by Dillon's data showing 30% with little or no use).

The situation is potentially worsened by a perverse incentive for dispensers. It is *financially* attractive to fit unusable hearing aids because unused hearing aids cost the dispenser less time and money (people do not come back to have physical and acoustic fit problems solved). The degree of less than optimum hearing care is unknown, but in our clinic we have seen some totally inappropriate fittings which might be an indicator of a much larger problem. OHS is in a difficult situation here – reducing

funding for each fitting merely increases the pressure for such behaviour. (WorkCover Victoria recently applied this approach, but no details of its effect have been released.)

We draw the Committee's attention to the fact that similar problems affect all third-party funded hearing aid systems – it is not unique to Australia.

Is there a solution?

Turning around a strongly held community perception will not be rapid, and cannot take place if the perception is continually reinforced by the industry's performance.

We believe that there is a role for Government (through the Office of Hearing Services) in altering this perception, and that OHS already has a desire to do so. OHS fully or partially funds nearly 80% of hearing aids fitted in Australia, so their actions will be especially influential.

As the dominant purchaser of hearing services, OHS is in a position to measure and monitor quality standards, and could apply financial pressure to force improved performance. OHS could more strongly support consumers in becoming critical consumers of hearing care if they had independent external evidence of service quality.

Our interest in this situation

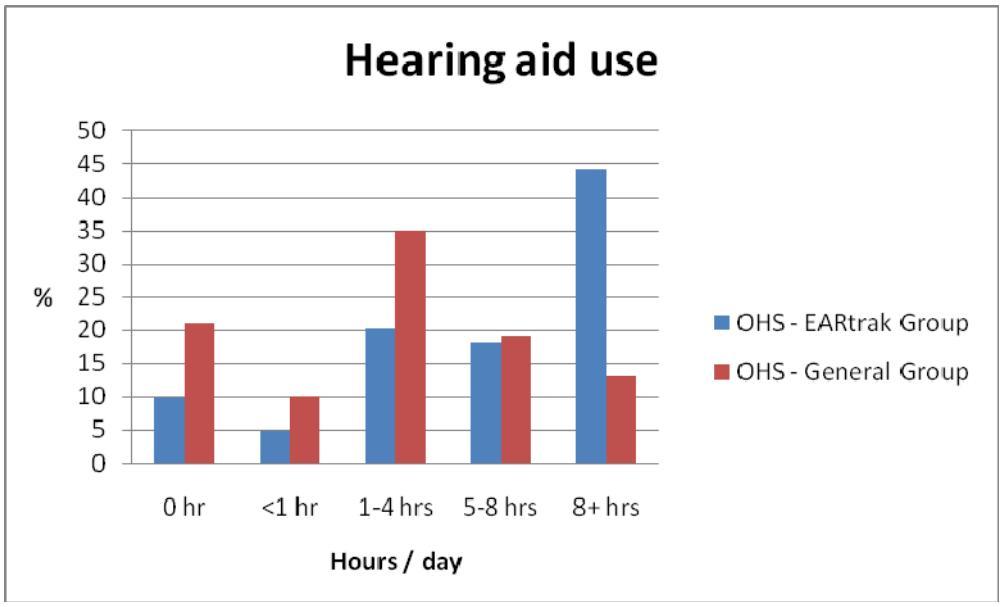
The authors have developed, over many years, a system for measuring and managing service quality based on consumer questionnaires. There was a clear need to

- strengthen the voice of consumers in securing effective service provision[7],
- provide a quality measurement system to drive service quality improvement, and
- improve hearing aid outcomes, thereby reducing a significant barrier to treatment of hearing loss.

The process is called EARtrak, and is managed by a small company (EARtrak P/L) based in Traralgon Victoria. So far, uptake by dispensers has been poor. Dispensers cannot see any point in measuring their performance while consumer complaints (to them) are low. This is a world-wide problem[5,8,9]. EARtrak is being used and its benefits have been proven for a small number of hearing care providers in Australia, New Zealand and Germany. For example, in Australia, hearing care providers who are using the process obtain dramatically different results for the outcomes of their OHS funded clients compared to the general performance of the industry[3]. (Graph 1)

The process is very cost effective (less than 1% of the OHS voucher value). The outputs of the system allow dispensers to better manage their clinical and business

performance, third-party organisations to monitor service quality, and consumers to choose dispensers based on their performance record.



Graph 1. Daily hearing aid use for OHS funded clients – Dillon survey data (OHS General Group) compared with EARtrak group.

A possible reversal, delivered economically

The 30% unused hearing aid figure can be considered a pool of funds that should be better spent. Dillon concluded that a significant part of this 30% non-use rate is due to hearing aids being fitted to clients with poor motivation to use hearing aids *before* the fitting process commences, but who proceed because of (a) family/community pressures to “do something”, and (b) it is not going to cost them anything (other than time) to try. Accepting that maybe 10% of hearing aids will be unused by these poorly motivated people still makes 20% of the overall budget availablefor improving service delivery. We agree with Dillon’s suggestion of paying the better providers a premium based on their clinic’s performance, as measured by superior client outcomes. This premium provides funding for the extra work required to achieve better results and an incentive to achieve them. The measurement system (EARtrak) can also identify clinics with an unacceptable profile of performance for appropriate discipline measures.

Potential Benefits.

Improving hearing aid outcomes through systematic use of a quality measurement system benefits all stakeholders – the hearing impaired, their families and communities, third-party funders, and the hearing care profession. It facilitates improved acceptance of hearing aids to reduce communication problems caused by

hearing loss, more effective use of private and third-party funds, and reduces the costs of associated mental, physical, educational and vocational limitations of untreated hearing-loss.

References

1. Access Economics “Listen Hear! The economic impact and cost of hearing loss in Australia. February 2006.
2. Kochkin S Marketrak III “Why 20 million in US don’t use hearing aids for their hearing loss.” *The Hearing Journal* 1993; 46(1):20-27
3. Dillon, H “Hearing Loss: The Silent Epidemic. Who, why, impact and what can we do about it” Libby Harricks Oration, Perth, Australia, May 2006
4. Kochkin S, Rogin CM. Quantifying the obvious: the impact of hearing instruments on the quality of life. Hear Rev. 2000;7:6-34.
5. Dillon, Harvey & So, M “Incentives and obstacles to the routine use of outcomes measures by clinicians” *Ear & Hearing,* 2000, 21(4):2S-6S.
6. Kochkin S. MarkeTrak V: “Why my hearing aids are in the drawer”: The consumer’s perspective. *The Hearing Journal* 2000; 53(2): 34-42.
7. Mills L. Consumer advocate urges extreme “make-over”. *The Hearing Journal* 2006; 59(2): 36-38. (P)
8. Johnson, Carole E & Danhauer, Jeffrey L “A survey of audiologists on outcomes measurement” Poster presentation, 13th Annual Convention, American Academy of Audiology, 2001 San Diego.
9. Nemes, Judith “Despite benefits of outcomes measures, advocates say they’re underused” *The Hearing Journal*, August 2003, 56(8), pp15-25.

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