Article:
Brooke, RE, Killan, EC and Morrall, PA (2015) Moderate-medicalisation and an age-neutral NHS hearing aid service. British Journal of Healthcare Management, 21 (3). 117 - 121 (5). ISSN 1358-0574

10.12968/bjhc.2015.21.3.117

Moderate-medicalisation and an age-neutral NHS Hearing Aid Service

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Abstract

Age-related hearing loss is one of the most common chronic health conditions experienced by adults. However, many individuals who would benefit from a hearing aid do not seek help and many that do seek help, experience symptoms for several years prior to attending for a hearing assessment. One of the main reasons for delayed access and poor hearing aid uptake is the stigma associated with hearing loss. Recently, there have been several calls to promote earlier and easier access and recommendations, such as the de-medicalisation of NHS hearing aid services, have been suggested. In agreement with this, we argue that approaches to reduce hearing loss stigma should be prioritised. However, we propose a reduced form of medicalisation, rather than a de-medicalised, approach is required. Furthermore, in addition to what we refer to as 'moderate-medicalisation', we argue that a less 'older-age-focused' NHS hearing service will facilitate earlier access to assessment and hearing technology. We suggest some service delivery changes that will promote moderate-medicalisation and an age-neutral service.

Key points

Our propositions are:

- Reducing the stigma of hearing loss should be prioritised if easier and earlier access to NHS hearing services is to be achieved.
- A less medicalised and less 'older-age-focused' NHS hearing aid service will reduce stigma and facilitate earlier access.
- Changes to NHS hearing services that promote moderate-medicalisation and age-neutrality are recommended.

Background

A recent UK based survey reported that 10.7 % of adults aged 40-69 have substantial hearing loss, with the likelihood of hearing loss increasing with age (Dawes et al., 2014). This is consistent with reports from other developed nations (e.g. Plomp & Mimpen, 1979; Smits et al., 2006; Chia et al., 2007), making age-related hearing loss (ARHL) one of the most common chronic health conditions experienced by adults worldwide. Furthermore, research suggests it is more prevalent than such reports indicate and is increasing in younger age groups (Agrawal et al., 2008). The effects of ARHL are well known and include negative impacts on emotional, social, and physical well-being (e.g. Mulrow et al., 1990; Strawbridge et al., 2000; Arlinger, 2003; Dalton et al., 2003; Chia et al., 2007; Gopinath et al., 2009). The use of optimally fitted hearing aids (HAs) is crucial in counteracting these effects of hearing loss.

Anecdotal reports from NHS HA services indicate that the typical age of an individual presenting for assessment for first time HA fitting is 70 to 75 years old. However, many individuals who would benefit from a HA do not seek help and many that do seek help, experience symptoms for several years prior to attending for a hearing assessment (Davis, 1989). This has remained the case despite changes to service delivery, such as modernising hearing aid services, and improvements in technology (Davis, 1989; Dawes et al., 2014). There have been calls for earlier provision of HAs to individuals who are fifty to sixty years old (Wallhagen, 2010; Dawes et al., 2014) in order to provide earlier benefit, facilitate acclimatisation and HA management and, potentially, reduce the risk of developing dementia in later life (Dawes et al., 2014; Lin et al., 2014).

In support of this, and given the increasing prevalence and the wide-ranging negative consequences of hearing loss, the International Longevity Centre-UK (ILC-UK) recently published the Commission on Hearing Loss Final Report (2014), which is directed towards NHS England, the Department of Health, Public Health England and Clinical Commissioning Groups and providers, and emphasises the need to focus efforts on earlier detection of hearing loss, improving accessibility and implementing treatment-flexibility and choice. The Report discusses the realities of implementing service changes, including drawing attention to costing considerations. However, in addition to cost, a very real challenge for implementing any proposed service changes promoting earlier and increased access is the stigma associated with hearing loss. Whilst the report highlights the need to address this stigma, we argue it should be given higher priority than is implied by the Commission. The effectiveness of a screening programme for earlier detection will be limited if concerted efforts are not undertaken *first* to reduce the negative perceptions associated with hearing loss. Earlier detection and changes to service delivery models to improve access will have little impact if individuals, particularly younger adults, remain reluctant to seek help.

To this end, and following a series of workshops for audiologists, patients and members of the public during which the medicalised approach of hearing services was raised by attendees as a potential barrier to access and HA uptake, within this paper we provide an overview of the concept of medicalisation and hearing loss stigma in the context of NHS HA services. Following this we make a number of suggestions for service changes that address stigma by reducing the medicalised and old-age focused sub-culture of NHS HA services, and argue for 'moderate medicalisation' and an age-neutral environment.

The stigma of hearing loss: ageism and medicalisation

Previous research has identified real and perceived stigma as a reason for individuals with ARHL to be reluctant to seek help, be provided with and use a HA (Wallhagen, 2010; Meyer et al., 2014; Preminger & Laplante-Lévesque, 2014) (e.g. Knudsen et al., 2010; McCormack & Fortnum, 2013). Stigma is used to describe an attribute that is demeaning and can lead to experiences of rejection, isolation, prejudice, institutionalised discrimination, and what sociologist Erving Goffman (Goffman, 1963) describes as a 'spoiled identity'. Stigma can affect all aspects of the hearing loss continuum (including acceptance of hearing loss, whether to be assessed or seek treatment, the type of HA selected, and when and where HAs are worn) and is linked to three interrelated experiences: alterations in self-perception, vanity, and particularly pertinent to this article, ageism (Kochkin, 2000; Wallhagen, 2010; Hickson & Meyer, 2014; Meyer et al., 2014; Preminger & Laplante-Lévesque, 2014).

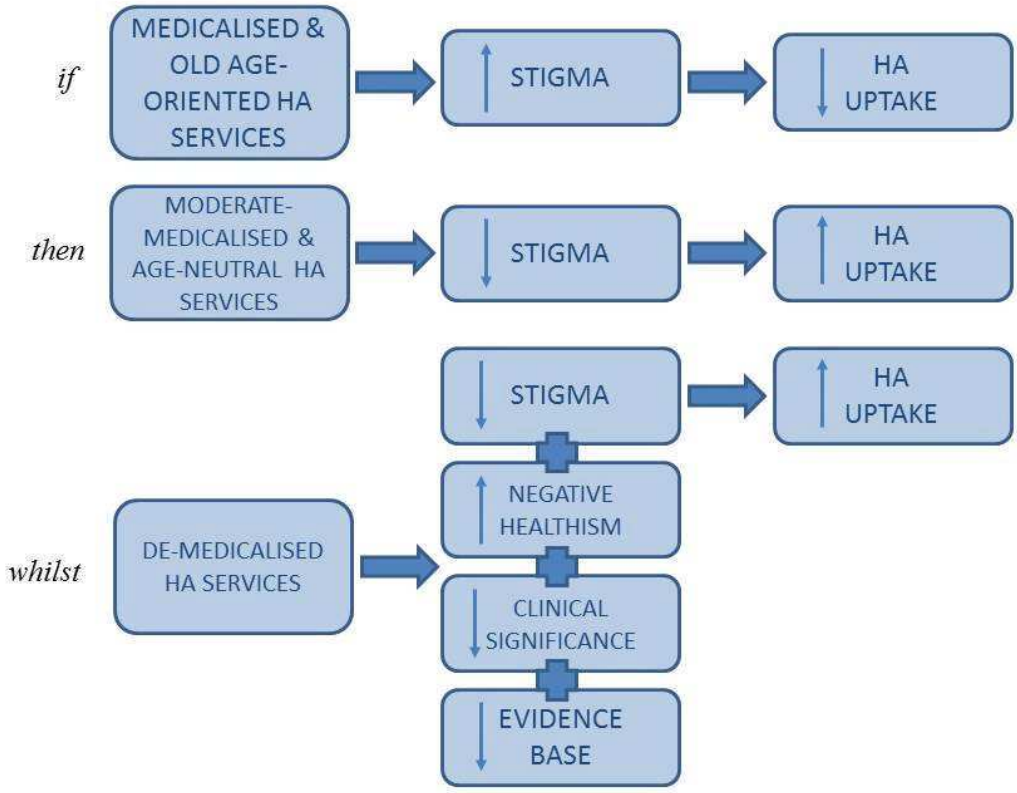
Ageism is the stereotyping and discriminating against individuals on the basis of their age and includes prejudicial attitudes towards older people, old age and the ageing process (Iversen, Larsen & Solem, 2009). Implicit ageism, the subconscious thoughts and feelings one has about older people and the ageing process (e.g. the negative associations of growing old such as cognitive decline, disability, reduced ability to function in society), will likely be felt most acutely by those younger individuals who perhaps have most benefit to gain from a hearing aid fitting. These individuals are still likely actively engaged in their work and careers and otherwise feel fit and well; they do not 'feel old' and do not wish to be perceived as 'old' and, consequently, frail and ill.

To improve access rates, HA uptake and achieve the espoused benefits linked with earlier HA use, a necessary step is therefore to identify practical strategies to breakdown the negative association between hearing loss, HAs, ageing and illness, and ultimately to reduce stigma associated with ARHL. Within the NHS setting, this association is reinforced by the medicalised culture of HA services. Medicalisation is the process by which human conditions, such as ARHL, come to be defined and treated as medical conditions (i.e. based around what is designated by the medical profession as normal and abnormal; Morrall, 2009). Because ARHL is medicalised, the typical location for a NHS HA service is within a hospital and individuals with ARHL require referral from their general practitioner to access these services. Such clinical intervention and settings can reinforce stigma (Conrad, 2007; Morrall, 2009) and medicalising ARHL potentially perpetuates the belief that 'normal' ageing and ARHL are associated with illness, and may also encourage the notion that they are full-blown disease states. Inappropriate or overzealous medicalisation can result in unnecessary labelling and poor treatment plans (Moynihan, 2002). In addition, it can increase dependency on health professionals and health services, instead of encouraging acceptance of normal aging that can be coped with either with minimal medical involvement or none at all (Illich, 1976).

An argument therefore follows that *de*-medicalisation of NHS HA services will produce positive consequences, such as normalising ARHL and reducing stigma (Munro et al., 2013; ILC-UK, 2014), and thus remove barriers to earlier access to hearing services and hearing technology. However, the process of de-medicalisation is complex, and can also have negative effects. The space left by de-medicalising a particular condition is often filled by negative aspects of "healthism" (Crawford, 1980; Morrall, 2009), i.e. a commercial and consumerist-driven obsession with health and well-being that, for example, leads to the

resurgence of non-evidence based practices such as aromatherapy or homoeopathy, and increased media attention to the ideal body and mind. De-medicalisation can also lead to a depreciation of the significance of a condition. The medicalisation of writing and reading difficulties (that is, dyslexia) resulted in an increased awareness of the condition and the creation of important educational and employment-related policies (Morrall, 2009). This might not have happened had dyslexia not been medicalised. Moreover, medical science colludes with natural and technical science to yield sophisticated diagnostic techniques and treatment regimens, so that to decouple from this store of research, knowledge, and expertise, would leave HA services and their 'clients' vulnerable to inadequate provision if not quackery.

Therefore, given the negatives as well as the positives of medicalisation (and de-medicalisation) we suggest changes to service delivery that will make NHS HA services *less* medicalised and *less* "older-age-focused", rather than totally *de*-medicalised. We call this approach "moderate-medicalisation". Figure 1 provides a simple outline of the reasoning of our moderate-medicalisation model. In making these recommendations we are not advocating privatisation of NHS HA services. Rather, we argue the approach required is *similar* to the approach undertaken by optometry services (but not the same due to important differences such as that glasses can rectify vision whereas hearing aids do not restore normal hearing) some thirty years ago wherein services were freed from the policies and protocols associated with being located in hospitals and were able to adopt high-street retail influences (Barty-King, 1986). This has seen glasses shift from being undesirable medical devices associated with old age to being fashion accessories worn by people of all ages.



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160 **Figure 1. A simple model outlining the proposed relationship between medicalisation,**
161 **stigma and HA uptake, and the potential effects of de- and moderate-medicalisation.**

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163 **Changes to create an age-neutral and a moderate-medicalised NHS HA service**

164 In the UK an individual seeking intervention for hearing loss must visit their GP in order to
165 obtain a referral to a NHS audiology service. This requirement, in addition to the subsequent
166 hospital-based audiology appointments, increases the amount of time spent within
167 medicalised environments, and may therefore reinforce the belief that having ARHL is a sign
168 of illness. To reduce the amount of time individuals are in a medical environment (and
169 overcome any barriers that occur as a result of this) shortening the patient pathway by
170 allowing direct access to audiology services could be considered (Munro et al., 2013; Dawes

et al., 2014; ILC-UK, 2014). Self-referral would also have the added benefit of making the process quicker and easier (ILC-UK, 2014).

The medical sub-culture typical of hospitals is immediately apparent to individuals in many audiology waiting areas and treatments rooms. For example, wipe clean chairs and hand cleaning gel dispensers are ubiquitous. Similarly, some departments require their audiologists to wear white tunics that are synonymous with caring for people who are ill. Whilst infection control is an important consideration and the use of hand gel is important in this regard, wipe clean chairs and tunics are arguably unnecessary given audiologists are rarely exposed to bodily fluids. The wearing of suitable but personally chosen attire would go some way to support the creation of a less medicalised environment.

Waiting areas are also often noticeably old-age-oriented with upright chairs and myriad information, on noticeboards and as leaflets, associated with growing old e.g. regarding mobility, illnesses associated with age and social support for the elderly. Whilst we recognise these are relevant and important to a large proportion of individuals, making departments more *age-neutral* might improve earlier access rates. Simple changes could include making waiting areas more contemporary with consideration to colour schemes, the addition of some stylish chairs and sofas, magazine choices appealing to both a younger and older readership, equal emphasis on information pertinent to a younger client e.g. information regarding use of HAs at work and with modern technology, and access to the internet. The latter may be particularly pertinent in promoting earlier access by a younger demographic who are still working and may wish to work whilst waiting for their consultation. HA advertisements could also be used more effectively, within waiting areas and treatments

rooms, to highlight benefits for *all* age groups and could positively reinforce HA use by presenting HAs as fashion accessories and not always stressing the discreetness of the device.

Following a case history and hearing test, individuals who would benefit from amplification are customarily shown a typical selection, or a single example of, beige, brown or grey HAs prior to their fitting. The assumption is often made that the HA should blend in with skin tone or hair colour, so that it is discreet. Currently, little or no time is available for the client to discuss or try out different colours or designs in front of a mirror. We propose that the approach to being fitted with a HA should be more individualised, in a similar way to how people with poor vision are able to choose between wearing contact lenses or glasses, and further, what model of glasses to wear. We feel it would be beneficial for prospective users to be able to view and try on a range of hearing devices and associated accessories and suggest that this is made possible in the waiting room. Clients will then be better placed to make an informed choice regarding their HAs. Future cohorts of fifty to sixty year olds will be used to the sight of futuristic designed devices clearly observable in people's ears (e.g. hands free mobile phones, personal listening devices). Thus, whilst some individuals may still choose a discrete model of HA, some may opt to make a bolder statement.

A further aspect which could easily be addressed and one which has been shown to affect attitudes is language (e.g. Young et al., 2008). Anecdotal evidence shows the language used in association with audiology services, be it written or spoken, is often unimaginative and medical. Changes which may have a positive impact would be to routinely call the 'patient case history' an 'interview' and to refer to patients as 'clients'. Although both words have similar definitions, 'patient' is *only* used in medical spheres whereas 'client' is used in other arenas and thus, may be less associated with illness and frailty. Further, when discussing

HAs an approach similar to that used when describing modern technology could be used, with HAs called by their commercial names such as “Aero”, “Spirit” or “Halo” (a relatively new device co-developed by the ultra-fashionable Apple and Starkey). These names are chosen by the manufacturers following extensive market research and are synonymous with the futuristic-sounding names given to fashionable modern technology, such as the iPad Air.

Finally, it should be noted that the negative perceptions associated with the above medical and old-age-oriented factors will be reinforced during each return visit to the department (or local health centre). Thus, it would be preferable to clients (and departments from an economic perspective) if repeat visits could be minimised. As an example, consideration should be given to alternative methods of battery dispensing such as placement of vending machines in areas that are easily accessed and not associated with health such as supermarkets and newsagents.

Conclusions

In this article we have presented some ideas aimed at changing the medical and old-age-focused sub-culture of NHS HA services. It is envisaged that moderate-medicalisation and an age-neutral service will reduce stigma associated with ARHL, facilitate earlier access and increase HA uptake. We stress that our argument is for a modified NHS HA service (in terms of its sub-culture) and *not* a call for de-medicalisation or privatisation. Many of the ideas proposed here represent small changes (e.g. the changes regarding audiologists attire, patient literature/posters in waiting rooms and language/terminology) however, we also appreciate that others would require substantial financial investment and major policy change.

However, this should not limit their inclusion in any future debates regarding improving services.

Acknowledgements

The authors report no conflicts of interest.

The workshops for audiologists, hearing impaired clients and members of the public were funded by the Higher Educatoin Innovation Fund (Brooke, R.E., Thyer, N.J., Killan, E.C., Alsharami, M., Herbert, N.C., Isherwood, S. and Shaw, P. Jan-July 2012. Enhancing public and patient awareness of the potential for poor information literacy as a barrier to rehabilitative success of hearing impaired adults and children.)

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323 **Figure 1 A simple outline of the moderate-medicalisation model**