



## Executive Summary

Neurosensory strongly supports private health insurance reform which aims to: simplify Private Health Insurance (PHI) for consumers; increase membership rates; and ensures a sustainable PHI industry.

Neurosensory strongly opposes the sub classification of ENT conditions and services. Further, Neurosensory strongly opposes the proposed hospital product redesign based on a sub classification system, for the following reasons:

- Sub classifying ENT conditions and services is confusing for consumers, and further reduces transparency of PHI coverage.
- Hearing loss impacted over 3.6M Australians in 2017, yet PHI paid only 6% of the total hearing health expenditure. A reduction in benefits through ENT sub classification may lead to further disengagement with PHI, and ultimately reduction in membership.
- Currently, ENT conditions and services is 2 % of total medical benefits paid and 1% of total prostheses paid; therefore ENT sub classification will not have any material impact on the sustainability of PHI.
- Hearing loss treatment is effective and economically efficient and supports workplace participation. The yield on investment is substantial.

Further, Neurosensory seeks clarification as to what criterion is being used to determine what a “hearing loss surgery” is. Many ENT surgeries have a direct impact on hearing.

Neurosensory strongly supports one category for ENT, being *ENT conditions and services*, and strongly recommends that ENT conditions and services are available at bronze, silver and gold PHI classifications.

## **About Neurosensory**

Neurosensory has been a leading provider of comprehensive hearing, implant and balance services in Australia for over 35 years. We help over 25,000 Australians every year with their auditory needs. Neurosensory is owned by 65 of Australia's leading Ear, Nose and Throat surgeons who are committed to the highest standards of clinical outcomes. Please refer to appendix A for our Surgeon members.

The Company has 24 clinics in Queensland, New South Wales and Victoria, providing an extensive scope of audiological assessment and rehabilitation services. Our services include:

- Hearing assessments for babies, children and adults.
- Balance assessments.
- Auditory processing assessments.
- Electrophysiological assessments.
- Hearing aid rehabilitation programs.
- Hearing implant rehabilitation programs (cochlear implants, bone conduction implants and middle ear implants).
- Tinnitus management programs.
- Assistive listening devices.
- Hearing protection.
- Vestibular physiotherapy.
- Psychological counselling services.

Neurosensory believes that undertaking preventative measures, wherever possible, to diagnose early-stage diseases and disorders, and provide the most appropriate, clinically-validated intervention, is the key to ensuring all Australians have the best chance of ageing healthily and continuing to contribute to the community well into their later lives. Neurosensory's mission is to improve how people interact with the world around them.

## **The Importance of Healthy Hearing for Australians**

It is estimated that in 2017 3.6M Australians had a hearing loss. This prevalence is expected to double by 2060 to be over 7.8M Australians<sup>i</sup>. The annual financial cost of hearing loss is estimated to be over \$33.3B, however, the direct medical costs were estimated to be \$881M in 2017<sup>i</sup>. In 2017, the overall health spend on hearing loss was \$245 per person, with only \$9 of this spend attributable to cochlear implants. Further, Australia has a good balance of hearing funding with contributions from Federal Government (Hearing Services Program, NDIS, DVA), State Government (health budget allocations) and Private Health Insurance (PHI). PHI contributed only 6% or \$55.1M to the overall hearing health expenditure in 2017<sup>i</sup>.

Intervention to habilitate and rehabilitate hearing loss is effective and cost effective. A yield of \$5.20 for every dollar spent is estimated<sup>i</sup>. The downstream impacts or comorbidities of untreated hearing loss are social isolation and mental health issues, musculoskeletal problems, cardiovascular disease including hypertension, and cognitive functioning. There is also a link between untreated

hearing loss and dementia, although the link is not established as causal, there is a correlation, and common sense would indicate that if facing cognitive decline, it is paramount to ensure that sensory inputs are optimal. A preventative approach to this risk is preferable, in that, it is preferable to treat hearing loss to prevent and / or reduce the risk of a cognitive decline.

Persons with treated hearing loss have higher employment and participation rates than persons with untreated hearing loss<sup>ii</sup>.

### **Response to the Proposed Clinical Definitions**

Neurosensory is extremely concerned with the sub categorisation approach which is proposed for ENT therapeutic group. The approach is flawed as it fails to take into consideration the fundamental premise of the PHI reforms which is to simplify PHI for the consumer. A consumer will not be expecting sub categorisation for ENT treatments. In addition, many ENT interventions treat hearing loss. As an example, the insertion of grommets is quite possibly the most effective treatment of childhood hearing loss, however this procedure is not categorised as hearing loss surgery in the draft reforms.

Further, Neurosensory is seeking clarification as to the criteria used to classify which surgeries will be deemed “hearing loss surgery”. In particular, how will grommet insertion, stapedectomy, myringotomy, ossiculoplasty and tympanoplasty be classified, and what is the consistent methodology being employed behind this classification?

The ENT category represents 2% of all medical benefits paid and only 1% of all benefits paid for prostheses<sup>iii</sup>. The small overall impact the ENT category has on the broader PHI benefits payable does not require a sub categorisation approach.

It is noted that other therapeutic groups, which are a lot larger in size and impact on PHI than ENT, such as cardiac / cardiothoracic therapeutic are not sub categorised. Cardiac and cardiothoracic is sensibly proposed to be combined into Heart and heart related conditions and services.

Therefore it is proposed that in the interests of ease of understanding for consumers and the relative small impact sub categorisation will make to PHI benefits, that ENT is not sub categorised and instead, is one category.

### **Response to the Proposed Hospital Redesign**

Neurosensory is extremely concerned with the proposed hospital redesign which recommends that only those with gold cover are able to access hearing loss surgery. The reasons for this concern are as follows:

- Consumers will not decipher between different surgeries for hearing loss. Consumers will assume that all medical / surgical interventions to manage and improve hearing will be included under ENT coverage. This lack of differentiation by consumers is extremely salient for a range of surgeries which treat hearing loss, such examples of this are grommet

insertion, myringotomy, stapedectomy, mastoidectomy, and ossiculoplasty. These surgeries all have the goal of treating hearing loss.

- The small population who would benefit from cochlear implants are those with more severe hearing losses and worse speech discrimination functioning, which makes their workforce participation more challenging<sup>i</sup>. Further, these individuals are less likely to have the same earning capacity as a hearing person<sup>i</sup>, and therefore the affordability of gold level insurance is questionable.
- The impact of sub categorisation of ENT and in particular implant surgery will have a negligible impact on total benefits paid by PHI. It will have a large impact on a small number of consumers, but insignificant impact on the sustainability of PHI. It is noted that only 6% of total hearing health expenditure is borne by PHI.

Therefore it is proposed that ENT is not sub categorised, and thus ENT is one category, *ENT conditions and services*. Further, it is recommended that ENT conditions and services are provided in bronze, silver and gold PHI classifications, as this will reduce consumer confusion and have negligible impact on PHI sustainability.

#### **Additional Points of Note for the Committee**

Neurosensory's review of the proposal raises the following questions and would appreciate greater clarity on the committee's position of these items, as follows:

- The issue of replacement speech processors is not clearly addressed in the recommendations. Would the committee please indicate how replacements and ongoing care of privately health insured implanted individuals is able to be assured? The committee should note that once an ear is implanted, the ability to return to conventional hearing technology, such as hearing aids, is negated. Therefore these consumers need to be able to access replacement technology when their processors are no longer functioning or optimal for their outcomes through their PHI.
- The issue of hearing aid technology and how this technology is also only available to gold level classified PHI is also of enormous concern to Neurosensory. Again, the total hearing health expenditure for PHI is only 6% of the total spend. For PHI to further reduce this small contribution for privately insured Australians is unacceptable. Further reduction of benefits to consumers increases the risk of them exiting PHI.

Neurosensory would like to note our support of Cochlear Ltd's submission to the committee.

Neurosensory welcomes the opportunity to participate in the consultation process and is available to assist the committee in their role.

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<sup>i</sup> Access Economics (2017) The Social and Economic Cost of Hearing Loss. Deloitte.

<sup>ii</sup> Hogan A, O'Loughlin K, Davis A, Kendig H (2009), 'Hearing loss and paid employment: Australian population survey findings', *International Journal of Audiology*, 48:117-122.

<sup>iii</sup> APRA (2017) Private Health Insurance Quarterly Statistics.

**Appendix A: Neurosensory ENT Surgeon Partners.**

Dr P Allison	Assoc Prof B Lyons
Dr A Ananda	Dr M Magarey
Mr T Baker	Dr S Mahendran
Dr R Barr	Dr D McCormick
Assoc Prof N Biggs	Dr D McCrystal
Dr A Blond	Dr B McMonagle
Assoc Prof R Bova	Dr P Michael
Dr J Bowman	Dr D Morrissey
Mr R Briggs	Assoc Prof P Mukherjee
Dr H Burns	Dr J O'Neill
Dr M Busby	Prof B Panizza
Dr P Canty	Dr F Panizza
Mr S Chan	Dr A Parker
Dr A Chang	Assoc Prof C Perry
Dr S Conman	Dr E Perry
Prof W Coman	Dr N Potter
Mr T Connolly	Dr S Prince
Mr B Cook	Dr C Que Hee
Mr B Costello	Dr A Richards
Dr M Courtney	Dr D Robinson
Dr M Cronin	Mr G Sherman
Dr B Dixon	Dr N Slee
Mr M Dobson	Dr A Sprague
Dr S Dowthwaite	Mr M Taylor
Dr G Fitzgerald	Mr R Taylor
Dr S Flanagan	Mr R Thomas
Dr R Grigg	Dr P Titoria
Mr P Guiney	Dr S Wagstaff
Dr R Gundelach	Dr B Wallwork
Dr J Hallam	Dr S Withers
Dr R Harrington	Dr L Wun
Dr S Kelly	Mr Y Zhao