March 10, 2021

To Whom It May Concern

Dear Madam

Re: Two-Tiered Medicare System

I am a practising general psychologist who operates my own business in Brisbane and am a member of the Australian Association of Psychologists Inc (AAPi). I write to you regarding the continuing use of the 2-tier Medicare System for clinical versus other registered psychologists, Telehealth and therapies that attract a Medicare rebate.

Apparently, the APS has 24,000 members and 6000 of its members are clinical psychologists, being 25% of its membership. According to AHPRA as of July 2018 there are 36,376 registered psychologists, leaving the majority 75% (30,376) being non-clinical psychologists. In order for the diverse psychological needs of the community to be met appropriately and comprehensively, the range of psychological services available include neuropsychology, community, counselling, educational and developmental, forensic, health, organisational, and sport and exercise psychologists. General psychologists do not have a college endorsed pathway (another 2 years of supervised practice) as per the previous examples provided.

All psychologists have to complete a minimum 6 years training. Psychologists who are not college endorsed frequently have done extended study (often to PhD level) in their particular fields (for example, I have undertaken extensive post graduate study in trauma therapy). The 2-tier system discounts any extensive additional training that non-clinical psychologists undertake. Furthermore, there is no evidence that clinical psychologists produce better mental health outcomes compared to non-clinical psychologists.

As I understand it, there is an argument that clinical psychologists gained preference over other psychologists because they were well organised and politically active when the system was introduced in 2006 (I don't know if there were more clinical psychologists on the APS board at that time, which may also have led to bias towards non-clinical psychologists).

An additional affect, is the growing trend for educational institutions to offer clinical psychology courses at the exclusion of other psychology courses due to the increased demand for clinical psychology courses from students who want the better pay clinical psychologists receive when they graduate. This has led and is leading to reduced numbers of psychologists in other equally important specialities.

I believe a guiding principle is that the client should have equitable and fair access to psychological services. When there is such a disparity in Medicare rebates it can be difficult for the client to access their preferred psychologist. For example, a child with learning difficulties would be better off seeing an educational and development psychologist, not a clinical psychologist. Additionally, the disparity in rebate means it is more difficult for non-clinically registered psychologists to offer Bulk Bill services to the general population. Currently, I can only offer very limited spaces for Bulk Bill

clients as the rebate of $87.45 is a discount of 56% to my fee, and I can't afford to offer more. If the rebate was increased, then this would automatically allow me to take on more Bulk Bill clients of which there are many I have to turn away.

When the client has reduced choice of psychologist, this can also create issues related to therapeutic rapport. Therapeutic rapport is a significant part of therapy, given that it contributes to the development of trust. The right fit between client and psychologist will either assist or hinder therapy greatly. Taking a clinical or very assessment focused approach (as in the clinical psychologist approach) is generally not conducive to therapeutic rapport. It is also not unusual for clients to take some time to find the psychologist who 'gets' them, so reducing choice based on what Medicare rebate is received can be problematic.

In relation to telehealth, clients who have limited funds to travel to an in rooms session, have high anxiety using public transport (pre-Covid, but more so now with Covid), are located a significant distance away, or are so depressed that they can't leave their rooms, have found Telehealth immensely helpful. I find telehealth a real gift for clients with these issues and like to use it. A good or at least similar (to in rooms) therapeutic effect also seems to be evident, with the full range of therapies still being able to be provided via telehealth.

In relation to therapies which are covered by Medicare, I would like to see at least another evidence-based therapy added. This is Internal Family Systems (IFS). IFS has been around since 1985, and is trauma informed with many clinical studies to support it. When dealing with clients who have DID or dissociative symptoms, then often the only therapy that can be used effectively is "parts" therapy. Literally, the client is so defended by "parts" that other therapy is rejected until negotiation happens with the "parts". There are other therapies that take a "parts" approach which may be equally valid.

Many non-clinical psychologists now belong to the AAPi. I was a member of the Australian Psychological Society (APS) for 10 years, however, resigned my membership a few years ago due to my perception of bias towards non-clinical psychologists. It also is important for Government to be aware that the APS is non-representative of the majority of psychologists.

In conclusion, the Medicare system at the moment favours clinical psychologists over other psychologists with no validated research on which to base this decision. It decreases availability and choice of psychologist to the public. I urge you to consider the possible introduction of a single tier system at an increased rebate, continuance of Telehealth and inclusion of a "parts" therapy like IFS to Medicare.

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