Community Affairs, Committee (SEN)

Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services

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Author: **Jonathon Walker**
MPsych(Clinical) *Melb.*, BA(Hons) *Melb.*, BEcon(Hons) *Monash*
Member of the Australian Psychological Society, and APS College of Clinical Psychologists
Registered Medicare Clinical Psychologist Provider

Postal Address: 1 High St, Prahran, Vic, 3181

Submission addressing Terms of Reference (e) (i) <u>The two-tiered Medicare rebate system for psychologists</u>, by Senator Fierravanti-Wells.

Throughout the following document, the term 'clinical psychologist' will refer to those psychologists certified by Medicare to provide 'Psychological Therapy' services, while 'non-clinical psychologists' will refer to those psychologists providing 'Focused Psychological Strategies'.

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Section 1: Background Information

To achieve certification to provide Medicare funded 'Psychological Therapy' services, psychologists generally need to achieve a post-graduate degree (Masters or Doctorate) in Clinical Psychology from an accredited university, plus a year of clinical supervision and professional development.

Unless circumstances have changed over recent years, post-graduate clinical psychology degrees are the most competitive for students to gain entry. Specifically, entry into these degrees require exceptional academic performance over four years of undergraduate psychology studies, usually at the level of 'High-distinction/First-class Honours'.

Subsequently, clinical psychology degrees have the reputation of attracting the most dedicated and focused psychology students, and graduates of these degree programs are highly sought after in the job market.

I can attest to the validity of the above statements, and my personal experience reflects these conditions. Over 6 years of full-time psychology studies and clinical training I achieved the grade of 'High Distinction / First Class Honours' in 37 of 40 assessment units (plus three Distinctions), including 11 Certificates of Merit for highest Grade in a particular subject, plus the Brain Sciences Institute Award for Excellence in Psychology. All my colleagues in post-graduate clinical psychology degrees achieved excellent grades throughout their studies.

Upon graduation from the Masters degree in Clinical Psychology from the University of Melbourne I was only eligible for the lower-tier of Medicare rebates. However, I invested significant time and money into clinical supervision and professional development, and in 2010 I earned the right to provide clinical psychology services under Medicare. It was a long process of striving to comply with the high standards set by Medicare, a rigorous process that only a minority of psychologists are prepared to undertake.

For the past three years I have been the Director of Primary Care Psychology, a completely bulk-billed clinical psychology practice in Melbourne.

Section 2: Summary of reasons against the reduction of Medicare rebates for services provided by clinical psychologists

The following is a summary of three critical reasons why Medicare rebates for services provided by clinical psychologists should not be reduced.

1. The recent arguments for reducing Medicare rebates for clinical psychologists are based on a single research study that is flawed in many ways. The Federal Government should not be making such important decisions based on flawed research.

2. Reduction of Medicare rebates for clinical psychologists will erode the high standards for entry set by clinical psychology degrees, and the best school students will no longer have a financial incentive to study psychology. Therefore, in three to six years we may see a gradual decline in the quality and standards of services provided by psychology graduates.

3. The proposed reduction of Medicare rebates for clinical psychologists represents an overnight drop in income by approximately 32%. Under these circumstances many clinical psychologists who offer bulk-billing will be forced to close their private practices or charge an out-of-pocket fee to consumers. Very unwell consumers cannot afford out-of-pocket fees on a weekly basis and would therefore be excluded from treatment.

Section 3: Arguments against the reduction of Medicare rebates for services provided by clinical psychologists

Section 3.1 Flawed research leading to faulty conclusions

The recent arguments for reducing Medicare rebates for clinical psychologists are based on the study, "*Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative. Component A: A study of consumers and their outcomes*", by Pirkis, Ftanou, and Williamson et al. (2010).

A copy of the paper is available on the Department of Health and Ageing website (http://www.health.gov.au/internet/main/publishing.nsf/Content/6E6AF89CC56D0910CA257848000096DE/$File/A.pdf)

It is assumed the reader is familiar with the study, and so the following statements relate only to the flaws in the research methodology.

Specific Flaws in the Research:

i. The sample of psychologists is not representative, nor random.

Although invitations to participate in the study were sent randomly to 509 clinical psychologists, less than 10% (41 clinical psychologists) agreed to volunteer their time.

A very small sample of self-selected participants can significantly bias the data collected.

One must ask the question, "Why did 468 clinical psychologists (92% of the initial sample) decline to participate?".

If I was offered an invitation to participate in the study I may have also declined, as would many of my clinical psychologist colleagues, simply because our schedules are completely full. The demand for clinical psychology services is extremely high, especially for those of us who bulk-bill, and we are continually invited to participate in research studies that would potentially take time away from treating clients.

It is possible the 41 clinical psychologists recruited into the study happened to be charging very high fees in affluent areas, and therefore didn't need to see as many clients per day. Thus they would have more time and opportunity to participate in the study. If this is the case, the data collected from this unrepresentative sample would most certainly bias the results of the study.

The low recruitment rate also applied to non-clinical psychologists. Only 49 non-clinical psychologists agreed to participate (92% rejection of offers to participate).

Are these 49 non-clinical psychologists truly representative of the thousands of non-clinical psychologists across Australia?

It is well known that many non-clinical psychologists are angry with the two-tiered system of Medicare rebates. Perhaps those non-clinical psychologists who self-selected themselves to participate in the study were those who were more determined than others to demonstrate their proficiency?

In summary, both the very small clinical and non-clinical psychologist samples cannot be described as representative of all private practice psychologists across Australia, and therefore any results and conclusions drawn from the results are not valid.

2. The sample of consumers is not representative, nor random.

The small number of psychologists recruited into the study were asked to recruit 5 to 10 of their clients into the study.

When consumers decide to see a psychologist, it is usually because they have found themselves in very difficult circumstances due to debilitating psychological symptoms (such as depression, intense anxiety, substance dependence, etc). The vast majority of my clients initially present in such a distressed mental state they would not agree to actively participate in a research study. Many of them can barely get out of bed or leave the house let alone reflect on their experiences in therapy.

Occasionally I see clients who have sought a referral because they are generally well but want to prevent an escalation of mild symptoms. These types of clients are typically more motivated, have more insight, have less impediments to change, have more emotional resources to engage in a research study, and generally score below 30 on a K-10 questionnaire (the K-10 is a measure of psychological distress, where below 30 is not 'very high').

For clinical psychologists in a bulk-billed private practice, such clients are the exception.

On observation of Table 18 in Pirkis, Ftanou, and Williamson et al. (2010) , the average K-10 score reported for clients of clinical psychologists was only 28.

This average score of 28 does not have *face-validity* - which means, it simply isn't consistent with what clinical psychologists are seeing in practice. The majority of our clients present with K-10 scores significantly over 30, often in the mid-to-high 30s, which suggests **the consumers recruited into the study are not representative** of the clients that clinical psychologists see on a daily basis.

The very distressed clients we see on a daily basis would not voluntarily participate in the study.

3. The measures used to assess outcomes are not sufficient

The outcome measures used in the study to assess psychological symptoms were the K-10 and the Depression, Anxiety and Stress Scale (DASS).

The K-10 is a very brief measure of psychological distress (but the questionnaire items specifically focus on common symptoms of depression and anxiety), and the DASS is a measure of depression, anxiety and stress.

While these scales are adequate to measure depression, general anxiety and stress, psychologists are referred clients for many other reasons than depression and anxiety.

Specifically, clinical psychologists are authorised to treat the following psychological disorders under the Medicare system:

- Psychotic disorders
- Bipolar disorder
- Anxiety disorder
- Depression
- Conduct disorders
- Post-traumatic stress disorder
- Panic disorder
- Drug use disorders
- Attention deficit disorder
- Unexplained somatic complaints
- Neurasthenia
- Schizophrenia
- Phobic disorders
- Adjustment disorder
- Sexual disorders
- Bereavement disorders
- Eating disorders
- Alcohol use disorders
- Sleep problems
- Obsessive Compulsive Disorder
- Dissociative (conversion) disorder
- Enuresis (non-organic)

The DASS and K-10 are not relevant to the desired outcomes for many of the above disorders.

For example, a client with anorexia may show little improvement on the DASS and K-10, but may improve significantly on other measures such as body image evaluation, self-esteem and body weight.

As another example, a client with alcohol dependence may show little improvement on the DASS and K-10, but may improve significantly on other measures such as alcohol consumption, anger and self-control.

As a clinical psychologist I am often referred clients with diagnoses other than depression or anxiety.

Therefore, the outcome measures used in the study (the K-10 and the DASS) are not sufficient to measure outcomes across the diverse diagnoses that clinical psychologists encounter in private practice.

4. The study was not subjected to peer-review or published in a peer-reviewed, scientific journal

Peer review is a process of self-regulation by a profession, or a process of evaluation involving qualified individuals within the relevant field. Peer review methods are employed to maintain standards, improve performance and provide credibility. In academia, peer review is used to determine an academic paper's suitability for publication.

The study under scrutiny was not published in a peer-reviewed journal, nor is it stated anywhere if it was subjected to *objective* peer review procedures.

Without peer review, there is a risk the results will be published to the public without adequate consideration of methodological flaws, as has occurred in this instance.

Ultimately the results (and any conclusions drawn) are misleading to the public and I recommend the study be subjected to adequate and objective peer review or be taken offline from the Department of Health and Ageing website.

Section 3.2 Long-term erosion of service quality provided by psychologists

There is a reason why some people choose to spend many years at university to study law and medicine. Furthermore, there is a reason why law and medical students strive to achieve the highest possible grades across their assessments.

The best law and medical graduates are rewarded with very high salaries, and in general, law and medicine are associated with well-above average salaries.

This financial incentive increases demand for access to these university courses, but given a limited number of places for tertiary students each year, only the most dedicated students are accepted into these degrees. As a result, the graduates of law and medicine are held in high standing because of their ability to consistently achieve high results, academically and in the work place.

This analogy applies to clinical psychology. Clinical psychologists spend, on average, 6 to 7 years engaged in full-time study. To gain entry into a clinical psychology degree requires the achievement of consistently high results over the first four years of psychology studies.

For a psychology student, being accepted into a clinical psychology program is the equivalent of a school-leaver being accepted into medicine or law. We work hard and consistently for many years to achieve the highest standards in the profession.

I do not wish to discount the roles of other psychology specialisations - counselling, health and forensic psychology are all equally valid specialisations in their own right, and some students choose to study these specialisations over clinical psychology - but it is well known amongst psychology students that it is more difficult and competitive to attain a place in a clinical psychology degree than all other specialisations.

Thus, because of the higher Medicare rebate, clinical psychology tends to attract students who surpass their peers in terms of academic ability, as do the students who are admitted to law and medicine.

To explain my next point adequately requires a reflection on personal experience. Several years ago I spent three months living in Russia, where medical practitioners earn very low salaries. As a consequence the best school students in Russia are not applying to study medicine at university, but instead choose more lucrative disciplines, such business and marketing or information technology.

As a result, medical treatment in central Russia (outside of Moscow) can be very inconsistent, and sometimes risky. From my observations, some General Practitioners in Russia use a mix of evidence-based medicine combined with self-taught naturopathy (tinctures). Thus, there is a reason why Russia has abnormally high mortality rates.

If the Federal Government reduces Medicare rebates for clinical psychologists there will not be a financial incentive for academically-strong school students to spend 6 or 7 years at university studying clinical psychology. In this event, I predict entry scores for clinical psychology programs will fall due to decreased demand, and **strong students will choose an alternative career where the rewards are commensurate with the time and effort invested.**

Thus, in three to six years the graduates emerging from clinical psychology programs will be qualitatively different from those enrolled today. If this happens we may see a decline in the quality of service provision by new psychologists in Australia, as has occurred with some areas of medicine in Russia.

If the Federal Government is truly committed to improving the mental health of Australians they will encourage the best students into the profession by maintaining adequate financial incentives.

Section 3.3 Harmful reduction of bulk-billed psychology services

The current Medicare rebate for a 50+ minute consultation with a clinical psychologist is $119.80. Non-clinical psychologists are arguing clinical psychologists should be paid $81.60 per 50+ minute consultation. This difference represents a 32% drop in income for clinical psychologists.

With a 32% drop in income, clinical psychologists who operate bulk-billed services (such as myself) will need to close our private practices. We cannot profitably cover office rent, advertising, administration, professional development, insurance and registration fees on a 32% lower, bulk-billing revenue.

The other option for bulk-billing clinical psychologists is to increase our fees such that the consumer is $40 out-of-pocket per consultation, but this defeats the whole purpose of the Better Access to Mental Health Care initiative and just transfers the burden of out-of-pocket fees to the much less efficient ATAPS system (ATAPS is less efficient because it involves another level of red tape - Divisions of General Practice - and in many cases the Divisions refuse to even register new psychologists on their referral lists).

I see hundreds of clients each year that cannot afford out-of-pocket fees for psychology consultations. **If the Medicare rebate for clinical psychologists is reduced, most of these consumers will miss out on psychological treatment because I will no longer be able to bulk-bill.** These people will not be able to access any treatment as it is very rare to find a psychiatrist who bulk-bills.

If you would like to discuss any of these issues further I may be contacted on (03) 9553-8838 or email: jonwalker@email.com.

Sincerely,

Jonathon Walker
MPsych(Clinical) *Melb.*, BA(Hons) *Melb.*, BEcon(Hons) *Monash*
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