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To the senate committee investigating the two-tier Medicare system for rebates for psychology services:

It is extremely concerning that recommendations have been made for psychologist session numbers under the *Better Access* scheme to be cut from 18 to ten per annum. It is further concerning that the Committee's recommendation may be to simplify the current two-tiered Medicare rebate system. Apart from psychiatry, clinical psychology is the only mental health discipline whose entire accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis and evaluated treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity. In other words, clinical psychologists are highly trained clinicians with either a Master's degree or doctorate in clinical psychology. The suggested cuts would directly minimise the distinct contribution of the clinical psychologist to specialist mental health care in Australia and directly affect those people with moderate to severe mental health problems. It was in 1989 already that the Management Advisory Service to the National Health Service (NHS) differentiated clinical psychologists from other health professionals arguing that – because of their extensive training – clinical psychologists were the only ones to be able to provide services which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. They also argued that it was only clinical psychologists who were able to provide the flexibility to adapt and combine approaches, coming from a broad, thorough and sophisticated understanding of the various psychological theories. It is obvious that the treatment of patients with moderate to severe presentations of mental health problems is only possible with the unique specialised training of the clinical psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required.

In my work as a clinical psychologist over the past decade I have seen clients with severe and complex presentations, such as comorbid eating disorders with anxiety, depression and borderline personality disorder or bipolar disorder with comorbid personality disorders. These patients have required eclectic evidence-based therapy approaches, treatment which I would have not been able to provide them with had I not undergone the extensive training that I have had. It is therefore my opinion that the two-tiered Medicare rebate system has to be maintained in order to adequately remunerate those psychologists who do clinical work and have been undergoing the according specialist training. In my practice I do bulk-bill patients

who suffer financial hardship (the majority of my clients). Having expenses still studying my PhD to even further my education and enhance my skills, and therefore also not being able to work full-time, I would not be able to provide the much needed bulk-billing service if I was being paid at the rate of a generalist psychologist. Currently the APS recommended fee for psychological services is $218.00 per hour (as of 1st July 2011) and the current generalist Medicare rebate is $81.60. Already the specialist Medicare rebate ($119.80) is only just under 55% of the APS recommended fee whereas the generalist rebate is only 37% of that fee. It is not acceptable for a clinician with at least six or more years of training to be paid 37% of the APS recommended fee.

Further, drawing from my experience in my own practice I am extremely concerned about session numbers to be cut back as it would at the minimum disadvantage people with moderate to severe mental health presentations. As ten sessions would not be sufficient to treat them successfully they may have to see a psychologist under the ATAPS scheme on top of the ten suggested sessions which in most cases would mean they have to change to a different psychologist. This would be a waste of the taxpayer's money as it takes a few sessions to build rapport with a therapist. In other cases these patients may have to be hospitalised or they may in the worst cases become incapacitated to work for lack of sufficient and effective treatment. Both of these outcomes would be much more expensive for the taxpayer than 18 sessions of treatment under the *Better Access* scheme. Further, it was argued that on average patients only use ten sessions under the *Better Access* scheme. If that was the case then cutting the session allowance from 18 to ten sessions should not provide the Government with considerable savings. If on the other hand there are significant cost savings to be had by the suggested cutbacks – and it should be noted that because psychologists have to apply for and the GP again has to approve of session numbers beyond 12 sessions the number of patients receiving 18 sessions is being monitored already – then it stands to reason that there are a significant proportion of people who are presently utilising these valuable mental health services and when it comes to the mental health of our population, the return on these investments is unquestionable.

Yours sincerely,

Astrid von Lojewski-Wilson