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27 March 2026

Rural and Regional Affairs and Transport References Committee
Parliament of Australia
PO Box 6100
Parliament House
Canberra ACT 2600

Submitted online:
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Rural_and_Regional_Affairs_and_Transport/Medicareaccess

Dear Committee Members,

APS response to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding

The Australian Psychological Society (APS) welcomes the opportunity to respond to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding (the Inquiry). The APS commends the Committee for establishing this Inquiry to explore the impact of recent legislative changes on Medicare access and funding as it is imperative that people living in rural, regional and remote areas experience equitable and quality healthcare services.

The APS is the largest and longest-standing professional association for psychologists in Australia. We advance the science, ethical practice and application of psychology to promote health and wellbeing across the lifespan, enabling individuals, organisations and communities to reach their potential. We advocate for psychologists as a critical workforce in health. Psychologists bring expertise in assessment, intervention, prevention, health promotion, research and evaluation, and are uniquely placed to provide evidence-based supports that promote resilience, prevent mental health difficulties from escalating, and respond effectively to complex mental health needs. Through our policy, advocacy and partnerships, the APS seeks to ensure psychologists are recognised, supported and deployed where they can have the greatest impact on the wellbeing of all Australians.

In making this submission, the APS has consulted members who provide services to people living in rural and remote areas. We have responded to selected Inquiry Terms of Reference and consent to our submission being made publicly available. If any further information is required from the APS, I can be contacted through the National Office on (03) 8662 3300 or by email at [redacted].

Yours sincerely

Dr Zena Burgess FAPS FAICD
Chief Executive Officer

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APS Response to the Senate Inquiry into Rural, Regional and Remote Medicare Access and Funding

In this submission, the APS responds to the following Terms of Reference (ToRs) concerning the Federal Government's changes to Medicare access and funding and the impacts on people living in rural, regional and remote Australia.

ToR a. The impact of the 1 November 2025 Medicare changes on access to primary care, including telehealth, for rural, regional and remote Australians

The Better Access Initiative legislative changes, which were implemented on 1 November 2025, included:

- *Mental Health Treatment Plan (MHTP) preparation, referrals for psychological therapy services or focussed psychological strategies services, and reviews of a patient's MHTP will be provided by either:*
    - *a General Practitioner (GP) or Prescribed Medical Practitioner (PMP) at the general practice in which the patient is enrolled in MyMedicare, or*
    - *regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner.*
- *GPs and PMPs can only provide telehealth services for new MHTPs if they are the patient's MyMedicare registered practice or usual medical practitioner and have an established clinical relationship with the patient.*
- *Removal of GP and PMP MHTP review items and ongoing mental health consultation items, allowing GPs and PMPs to use time-tiered professional (general) attendance items to review, refer and/or provide ongoing mental health consultation for a patient's mental health* [1,2].

MHTP requirements for a usual GP and an established clinical relationship for telehealth services

The APS understands that these legislative changes were intended to facilitate continuity of care and foster holistic, longer-lasting relationships between patients and their GPs, with the aim of improving health outcomes. However, prior to implementation we anticipated that these changes were likely to have unintended and potentially serious consequences, particularly for vulnerable populations who do not have a usual GP and have not enrolled in MyMedicare. In June 2025, we wrote to the Hon Mark Butler MP, Minister for Health and Ageing and Minister for Disability and the NDIS, following our meeting regarding complex mental health management issues and the wellbeing of children and young people. In this correspondence, we requested reconsideration of this aspect of the proposed legislation to ensure it would not inadvertently restrict access to timely mental health care.

Our concerns regarding potential unintended consequences have, unfortunately, been realised, particularly impacting Australians living in rural, regional and remote areas. APS members who provide services to these communities report that their patients were already experiencing significant barriers to accessing GPs prior to 1 November 2025. The maldistribution of the GP workforce between metropolitan and rural, regional and remote regions is well documented[3,4]. Barriers include longstanding challenges recruiting and retaining GPs in these regions (with subsequent reliance on locums), and some GP practices closing their books for extended periods when demand services exceeds available supply.

In the context of pre-existing GP workforce shortages and access constraints in rural, regional and remote communities, the introduction of the 1 November 2025 Medicare changes has further reduced patients' ability to obtain timely mental healthcare via a MHTP under Better Access.

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The requirement to attend their MyMedicare practice or secure an appointment with their 'usual' practitioner has become an additional obstacle layered onto already limited primary care access in rural, regional and remote communities.

Members also report that some people living in small and close-knit rural and remote communities prefer not to see their usual GP for mental health referrals due to privacy and confidentiality concerns.

The additional requirement for in-person GP attendance for new MHTPs (unless there is an established clinical relationship) has further constrained access, including for children and people with disabilities, and people in rural, regional and remote communities who must travel long distances to attend appointments.

APS members report that delays in securing GP appointments for a new MHTP or a review have resulted in some patients missing out on much needed psychology services or paying full fees without access to the Medicare rebate. While psychologists encourage patients to book their MHTP reviews well in advance, this level of forward planning can be difficult for vulnerable individuals experiencing significant mental health challenges and who are often unaware of Medicare changes adding further confusion to an already complex system.

In our previous advocacy the APS has highlighted that there are particularly vulnerable groups who are impacted negatively by the "usual GP" requirement, and in particular emphasised the potential inequities for people living in rural, regional and remote areas. The APS recommends that the Federal Government reconsider these legislative changes to ensure that they do not compound existing inequities in access to mental health services for people living in these locations. This could include introducing appropriate exemptions for people unable to access a usual GP in a timely manner and removing the requirement for an in-person GP consultation for a new MHTP (for those people who do not have an established clinical relationship).

Removal of Medicare items for MHTP review

The removal of Medicare item numbers for MHTP reviews by GPs has also caused some confusion in practice. APS members report that some GPs have refused to undertake MHTP reviews, mistakenly interpreting the removal of the specificitem as meaning that MHTP reviews are no longer required. Some GPs have incorrectly interpreted the changes to mean that they can make a referral for 10 sessions upfront, rather than the six initial sessions permitted under Better Access. These misunderstandings have impacted both psychologists and patients, resulting in unnecessary delays for patients and reduced access to timely psychological care. In rural, regional and remote communities, where access to GPs and psychologists is already constrained, such confusion can have a disproportionate impact, compounding existing workforce shortages and further limiting access to essential mental health services.

An additional administrative burden is placed on psychologists due to Referral Requirements for Better Access Treatment Services; outlined in MBS note – MN6.3[5].

> *If, in their referral, the referring practitioner:*
>
> - *Does not specify the number of services*
> - *Specifies a number of services above the maximum allowed for the course of treatment*
> - *Specifies a number of services above the maximum allowed for the calendar year (including any services the patient has already received that year),*
>
> *The eligible allied health professional must contact the referring practitioner to determine the required number of services required.*

In practice, this requirement introduces further delays, particularly for patients in rural, regional and remote communities where contacting the referring practitioner may be difficult and alternative providers are limited. Psychologists must attempt to resolve administrative discrepancies before commencing services, which can postpone access to clinically indicated and timely treatment.

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The APS recommends that the Federal Government reconsider this requirement, which places the administrative and compliance onus on allied health practitioners when referring medical practitioners have provided insufficient or incorrect details in their referral. Further, we recommend targeted education for medical practitioners to ensure clarity regarding their referral obligations.

ToR c. The extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions in rural, regional and remote areas.

Currently, there is a limit of up to 10 individual Better Access mental health sessions per calendar year. This means that eligible patients who have utilised all their MBS subsidised sessions and cannot afford to pay for additional non-subsidised sessions may need to wait months to access further mental health treatment. Unfortunately, this is an outcome that is particularly likely for patients with complex mental health needs and increases the burden of care on the public system and families – especially in rural, regional and remote settings where alternative services are few and far between.

In addition, people presenting at emergency departments with a mental health condition are more likely to experience socioeconomic disadvantage[6]. The APS contends that the current Better Access individual session limits, together with the in-person and 'usual GP' requirements discussed earlier, contribute to avoidable emergency department presentations and preventable hospital admissions, particularly for patients with complex mental health needs.

Further to the recommendations outlined above, the APS recommends that the Federal Government amend Better Access to enable psychologists to determine the clinically necessary number of sessions for each patient[1]. This change would facilitate psychologists' delivery of evidence-based treatment aligned with best practice and patient need, potentially reducing relapse risk and preventable presentations to emergency and hospital admissions.

Specifically, we recommend enabling psychologists to:

- Determine up to 20 sessions per calendar year for patients with complex mental health conditions.
- Determine up to 40 sessions per calendar year for chronic, high-impact, lower prevalence conditions (to be specified in the MBS and reviewed periodically with input from the APS).

Expected outcomes include:

- Improved treatment effectiveness by aligning treatment planning with clinical evidence and individual patient need, leading to better outcomes and reduced symptom persistence.
- Reduced relapse by ensuring adequate treatment length to prevent recurrence and/or deterioration
- Improved system efficiency through higher recovery rates that reduce reliance on GPs, emergency services and hospital admissions.
- Enhanced workforce sustainability by enabling psychologists to practice in accordance with evidence-based standards and remain engaged in Medicare-funded service delivery.

[1] As per Initiative 6 outlined in the APS Pre-Budget Submission 2026-27

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ToR d. The adequacy of Medicare support for the mixed-team models of care required in rural, regional and remote communities, including the roles of general practitioners, nurse practitioners, nurses, allied health professionals and visiting specialists

Psychologists working collaboratively with GPs and other health professionals, including those supporting rural, regional and remote patients, report undertaking a significant proportion of non-billable care coordination, consultation and liaison.

This raises concerns about the sustainability of allied health professionals accepting and supporting patients with complex mental health needs, who require the most intense interdisciplinary input.

While the APS acknowledges the introduction of MBS mental health case conferencing items intended to promote interdisciplinary communication and optimise patient care[7], current arrangements are limited in scope and accessibility, particularly for patients in rural, regional and remote settings.

Given the well documented shortage of health practitioners in rural, regional and remote areas[4], the requirement that a minimum of three practitioners attend a case conference (which must be initiated by a GP or other medical practitioner) disproportionately impacts these patients' ability to access integrated mental healthcare services, facilitated by case conferencing.

The APS recommends[2] that the Federal Government enable psychologists to initiate MBS-funded mental health case conferencing. Restricting initiation to GPs or other medical practitioners does not reflect contemporary models of collaborative mental health care, where mental health professionals such as psychologists may identify the need to convene case discussions to address emerging clinical risks or coordination issues.

Further, we recommend that case conferencing arrangements allow for a minimum of two practitioners, not three, for example, a psychologist and GP, to constitute a valid case conference. In many settings, and especially in rural, regional and remote contexts, a third practitioner may not be involved or readily available. This requirement unnecessarily restricts access to better coordinated patient care in resource-constrained environments.

ToR f. Reforms needed to ensure Medicare is fair, workable and sustainably funding for rural, regional and remote Australians, including the requirement for rural stress-testing of future changes

Bulk billing incentives for psychologists

The APS commends the Federal Government for expanding bulk billing incentives for GPs which has increased the bulk billing rate[8,9]. Psychologists currently lack similar incentives, discouraging and limiting bulk billing availability, particularly for patients living in rural, regional and remote communities and those experiencing socioeconomic disadvantage. This contributes to affordability barriers for patients and constrains equitable access to psychology services. Without equivalent incentives, many psychologists who encounter rising practice costs must raise their fees or limit the number of bulk-billed patients, effectively excluding those who are unable to afford private fees or out-of-pocket expenses.

Introducing targeted bulk billing incentives would make MBS-funded psychology services more financially sustainable, particularly for socioeconomically disadvantaged or geographically isolated populations. The APS therefore recommends that the Federal Government introduce bulk billing incentives for psychologists, modelled on existing GP structures and adjusted for consultation length. These incentives should mirror the GP bulk billing framework, including scaled rural, regional and remote loadings under the Modified Monash Model (MMM)[10]. This change would increase the proportion of psychology services delivered under bulk billing arrangements, remove out-of-pocket costs for patients, and improve service continuity.

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[2] As per the APS Response to Unleashing the Potential of our Health Workforce: Scope of Practice Review – Issues Paper 1

Expected outcomes of introducing bulk billing incentives for psychologists include:

- Expanded access to psychology services for low-income, rural, regional and remote Australians.
- Reduced financial barriers and more equitable access.
- Psychologists retained in Medicare-funded service delivery, reducing reliance on cross-subsidisation from private patients

Increase and index Medicare rebates for psychology services

To complement bulk billing incentives, the APS recommends that the Federal Government increase and index Medicare rebates for psychology services[11].

Introducing higher rebates for Better Access services, indexed annually in line with the consumer price index (CPI), would ensure that rebate values reflect true service-delivery costs, including the unbillable administrative time involved in Better Access work, and correct the below-CPI indexation of schedule fees since 2018–2019[12].

The cumulative effect of lower than CPI increases to Better Access rebates means that the gap between running costs and relevant rebates has steadily grown over time. Without appropriate indexation, psychologists are placed in the position of needing to either absorb cost increases or raise their fees, which in turn reduces service availability and affordability, particularly for disadvantaged patient groups such as those living in geographically isolated areas.

Expected outcomes of this recommendation include:

- Improved affordability and access to psychology services for low-income, rural, regional and remote Australians by reducing out-of-pocket costs.
- Greater workforce participation, with more psychologists remaining engaged in Better Access service delivery.
- Stronger service sustainability, ensuring rebate values keep pace with actual delivery costs
- Reduced pressure on GPs, emergency departments and crisis services through earlier access to psychology services.

ToR g. Any other related matters

There are several changes that the Federal Government could make to facilitate timely access to mental health services, including for patients based in geographically isolated locations. The first three recommendations outlined below relate to improvements that the Federal Government could make to the operation of the Better Access initiative to support psychologists to work to their full scope of practice[13]. The fourth recommendation, to extend the Commonwealth Prac Payment to postgraduate psychology students, would provide financial support for psychology students completing their mandatory placements and include an additional loading for students in rural and remote locations[11], leading to improved workforce numbers, and service provision, in these areas.

Facilitating direct access to psychologists

Psychologists are aware of their scope of practice and are ethically bound to work within their competence[14]. The requirement for patients to obtain a GP referral to access Medicare-subsidised psychology services can delay timely access to care and limit psychologists' ability to work to their full scope of practice. While collaboration and continuity of GP care is essential, including mental health services, mandating an initial GP referral does not reflect psychologists' recognised competency as autonomous primary healthcare providers. Psychologists are trained and authorised to undertake assessment, diagnosis and treatment planning for mental health disorders, and to determine when medical review or broader multidisciplinary involvement is required.

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In rural, regional and remote communities, where GP availability is often limited and wait times for appointments can be prolonged, the referral requirement can represent a significant structural barrier to care. Enabling more direct pathways to psychology services would reduce unnecessary delays, ease pressure on the overstretched GP workforce, and better support equitable access to evidence-based mental health care for people living outside metropolitan areas.

Enabling psychologists to refer directly to medical specialists

Consistent with being ethically bound to work within their competence[14], psychologists can also recognise when a patient requires specialist diagnosis, assessment, and care from other health professionals, particularly psychiatrists. We recommend psychologists be able to refer directly to psychiatrists in these cases while ensuring that the patient's GP remains informed.

Enabling direct referral would support timely access to specialist input, strengthen multidisciplinary coordination and improve system efficiency, particularly in rural, regional and remote areas where GP availability is constrained and delays can have significant clinical consequences.

Removing the administrative burden of GP review

The MBS requirement for GPs to review a patient's progress part way through their treatment with a psychologist is costly and interrupts the flow of treatment. Psychologists, as experts in supporting mental health and wellbeing are best placed to determine when a patient requires a GP review and when treatment should end. In addition to enabling psychologists to work to their full scope of practice, changing the requirement for GP reviews to either the end of 10 sessions or end of treatment (whichever occurs first) would create a cost-saving to both patients and the MBS – potentially improving treatment outcomes and certainly improving efficiencies within the Better Access initiative.

In rural, regional and remote communities, where access to GPs may be limited and appointments can involve significant travel and waiting times, the current mid-treatment review requirement can pose a substantial barrier. Greater flexibility would reduce avoidable disruption to care, ease pressure on the constrained GP workforce, and support more equitable access to continuous psychological treatment for people living outside metropolitan areas.

Extend Commonwealth Prac Payment to postgraduate psychology students

The APS reiterates its recommendation from our 2026-27 Pre-Budget Submission[11] to extend the Commonwealth Prac Payment to postgraduate psychology students, including the introduction of an additional rural and remote loading to better support students undertaking placements in these locations.

Specifically, extending the Commonwealth Prac Payment to postgraduate psychology students would:

- Reduce the financial burden on postgraduate psychology students associated with undertaking unpaid placements while completing their studies.
- Achieve greater alignment with policy intention underpinning the initial scope of the Commonwealth Prac Payment, as psychology students experience similar placement-related financial pressures as students studying to be a nurse, midwife, social worker or teacher while also sometimes incurring an additional cost of paying the hourly rate of their supervisor.
- Support approximately 2,000 students commencing a professional program of study in psychology across Australia each year.
- Provide an additional loading of $150 per week to postgraduate psychology students who are based in rural and remote locations for their placements to assist with travel and associated costs.

Expected outcomes of this recommendation include:

- Removal of financial barriers to psychology students completing their studies, contributing to filling critical workforce gaps and ensuring an adequate pipeline of future psychologists.
- Improved attraction and retention of psychologists working in rural and remote locations, through increased numbers of students choosing to undertake placements and then continuing to work in these locations.

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- Improved equity of access to support for training for psychology students, contributing to the development and sustainability of the psychology workforce.
- Greater policy alignment with recommendations from the National Mental Health Workforce Strategy, Universities Accord and Women's Economic Equality Taskforce.
- Improved economic security for a female-dominated profession.

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time, knowledge, experience and evidence-based research to the development of this submission.

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