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THE NSW doctor

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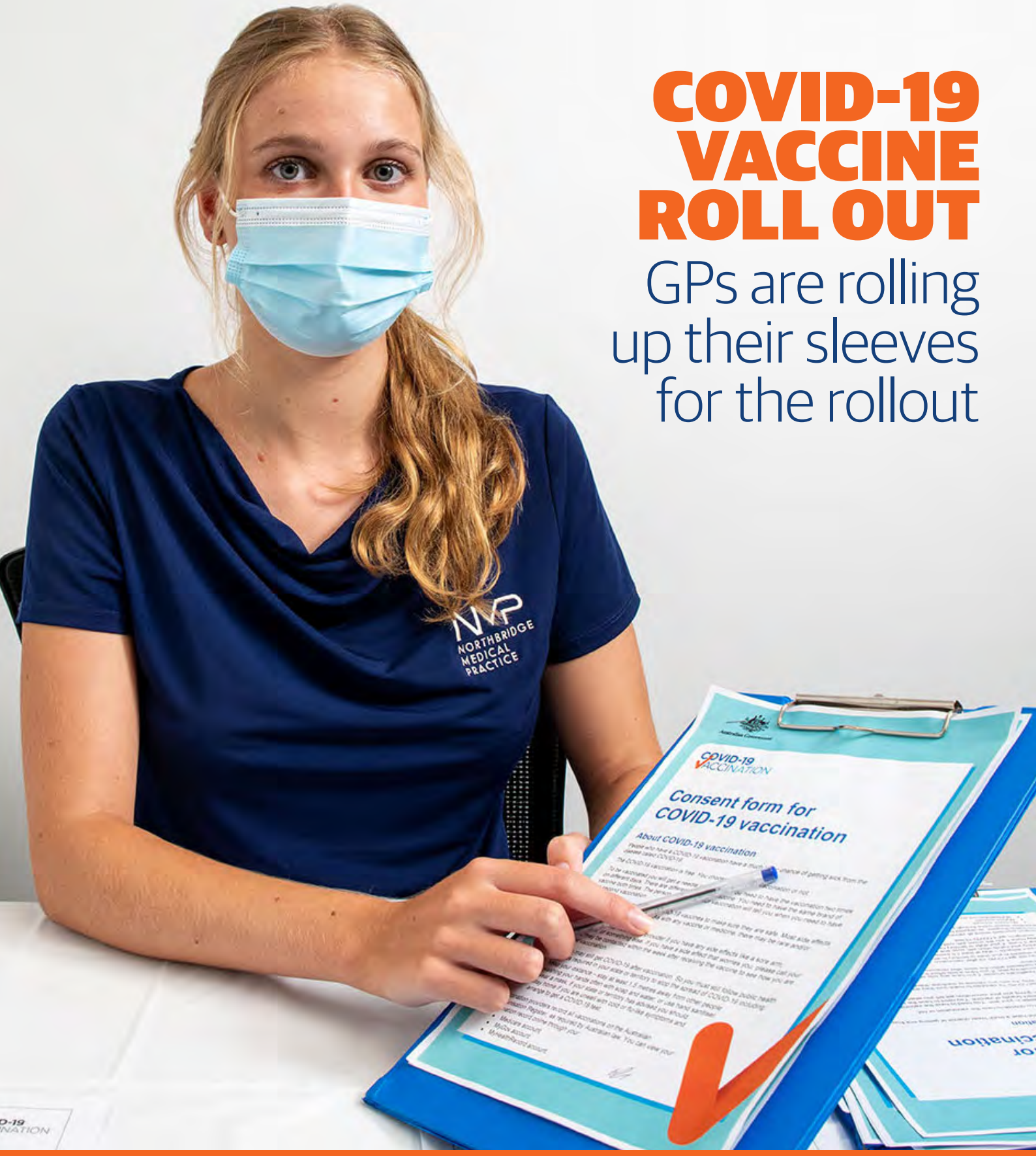

COVID-19 VACCINE ROLL OUT

GPs are rolling up their sleeves for the rollout

Vaccine hesitancy • Regional quarantine • Managed care in obstetrics

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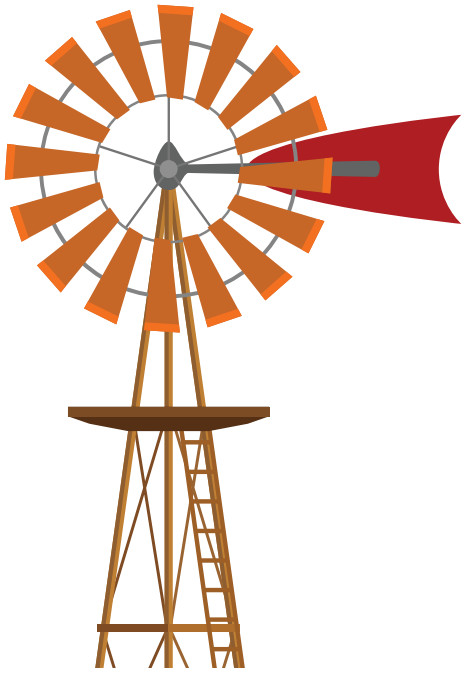

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From the Editor

Is the TGA worried about TMI? The recent warning to doctors to be careful about what they say on social media about COVID-19 vaccines caused many doctors to go WT…?

In early March, the TGA quickly worked to mollify medical professionals after it told the publication *Australian Doctor* that doctors risked contravening medical advertising rules if they discussed vaccination on their social medial accounts.

Whilst many are supportive of the rules around medical advertising, there is concern that gagging doctors leaves a vacuum in online forums that anti-vaxxers are only too happy to fill with misinformation.

The TGA subsequently released a statement clarifying its position in *The Australian*.

"The TGA accepts that not all information (including social media posts) is advertising within the meaning of the act. Distinguishing between factual, balanced and non-promotional information, and the promotion of the use or supply of therapeutic goods (ie advertising) can be difficult and needs to be assessed on a case-by-case basis."

The AMA and the RACGP have both suggested that doctors play an important role in combatting fake news about vaccines.

The TGA, AHPRA and National Boards all have a role in regulating advertising.

The National Boards and AHPRA released a Position Statement that includes guidance on COVID-19 vaccine information sharing and social media.

The guidance explains that medical professionals must ensure their social media activity is consistent with the regulatory framework and does not contradict or counter public health campaigns.

AMA (NSW) has spoken with both the TGA and the HCCC to explain the important role of all doctors in supporting vaccinations, particularly in vaccine hesitant communities, and will continue to advocate on this issue.

In Twitter-speak, that's referred to as calling out the 'bulltwit'.

Andrea Cornish,
Editor

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Letters to the Editor

Last edition, we asked readers the question, 'Should you charge your colleagues?' following Dr Michael Steiner's column that detailed the history and professional ethical arguments of this professional courtesy.

The column stirred many to respond – both for and against this practice. Members shared anecdotal stories of their own experiences, as well as the actions of their colleagues.

Here are a few responses (printed with permission and edited as little as possible for space) below.

Thank you so much for raising this issue. It is so vitally important to all medical practitioners. I am an almost completely retired specialist surgeon.

In my opinion and according to what I have done personally over 40 years of practice in NSW, I have never charged the following people: medical practitioners, nurses, paramedical personnel, ministers of religious pursuit, and many other categories of patients – and I still do not. It is only when younger medical practitioners get to my age that they realise regular visits to their GP and various specialists are a necessity of life!

The saying... "Do unto others what you would do unto yourself...." applies so very much in this context.

Thanks again for raising this important issue.

- Dr Gamani Goonetilleka

I have a contrary view. I believe that other health professionals should be treated 'professionally' which means like every other patient including paying fees. If hardship is identified, then reduction/waiving of fees is appropriate – as for every other patient. Your column writer makes the point that doctors don't see other health professionals because they don't want to be a nuisance, but surely if you know the other doctor is under some ill-defined antiquated pressure not to charge you then this only makes it worse. By behaving like all other patients (ie making proper appointments in hours, paying the appropriate fees) that allows the practice to treat you appropriately and professionally and not as some special class of patient who can then 'fall between the cracks' with results, etc. Also how far do we go with this – other doctors then, physios, nurses, pharmacists, and what about clergy? To me it's a rabbit warren not to go down.

- Associate Professor Tim Skyring

In nearly 60 years of medical practice, I have never charged a colleague or their partner or children. I believe that the compliment of one's peer to show their confidence in one's ability was reward ...

I know a lot of my colleagues charged their peers "whatever the scheme provided". Recently I have become aware of colleagues being very out of pocket from AMA fee levels charges whilst, of course, the rebate is little. The contra effect has been that when my family have not been charged, I have given a present to the doctor which leaves me well out of pocket. He (or she) receives a tax-free gift, whilst of course, no deduction is available to me. I often think I would prefer to be charged!

Thank you for taking the time to appreciate my feedback.

- Anonymous, Rural GP

I have been a GP for about 30 years. Once people become my regular patients, I do not charge a gap fee for doctors or nurses. I also used to be a nurse. If it is a one-off consultation, I would charge, as continuity of care is important to me. I still see my customers as patients rather than health consumers. I develop caring relationships with them. I do not see staff, family or friends.

I am generally bulk-billed as a GP, although I offer to pay. I've seen an old-fashioned specialist who would not even accept Medicare payments from me. It was a vulnerable time health-wise and I was very touched by this sentiment.

I'm certainly not into medicine for the money – I work part-time, do home visits (bulk billed) and see mostly pensioners and vulnerable people so charge very few gap fees anyway.

- Dr Marie Healy

Letters to the Editor

I returned to the reception after my appointment with the specialist. The room was now filling up with patients and I approached the counter ready with my credit card to pay. My doctor then approached the receptionist and confidentially mumbled something, after which the receptionist exclaimed "Oh, you're a medical student! We look after our own here!" I was taken aback by this—one, out of the sheer unexpectedness—and two, out of embarrassment given the other patients in the waiting area who might have overheard and might feel they are on the full-fee second-class track. After thanking the doctor and the receptionist for their generosity, I trotted off to class and thought more about what had just happened.

I continued to think about the privilege that comes with becoming a doctor. I would expect that my car salesperson would get a better deal than I when purchasing his/her own vehicle, but I am more uneasy with my doctor gaining advantage over his/her own and others' patients. I think that the medical profession is unlike other professions, because doctors live to serve their community and 'professional courtesy' has become a euphemism rather than a necessity. ...

I now unwittingly owe a debt toward my physician, which I now feel I must one day repay and/or pay forward. However, I would prefer that instead of a monetary or preferential gesture, I and my fellow doctors should be expected to give the literal (and priceless) gifts of professional courtesy, such as mutual respect and mentorship. I am not yet sure whether professional courtesy is a good or bad thing, but the fact I felt uncomfortable was telling.

In our futures, professional courtesy in all its forms is something we will have to be acutely aware of. It is important that a strong sense of collegiality within the medical profession be maintained; however, if professional courtesy is to continue in its traditional form, it should not be at the potential expense of our integrity, the reputation of 'the humble and selfless profession', and most importantly, our patients. While 'professional courtesy' is not yet a dusty relic of a by-gone era, redefining it may be an inevitable aspect of progress for the field.

- Tim Outhred, Medical Student (excerpted from a reflective piece produced for a university assignment)

A good philosophical question.

I never charge colleagues or retired colleagues and I try to cap costs for everyone else.

I saw a surgeon last February and was told I needed surgery very urgently. The fee was $5000. The Medicare rebate for the item number was $550.

I paid the money as it was urgent but rang my dentist as I felt unsure – he was disturbed. Two second opinions said I didn't need any surgery.

I got no refund, and I was so very cross I complained to HCCC. He did nothing illegal. He is running a business.

However, medicine is different. If we charged as other businesses do, our health system would not bear it.

We all spend huge unpaid hours in medicine helping, as we are asked: patients, committees, education, research, colleagues, colleges, students, reading – it's just endless. All would fall over if we didn't.

I see another specialist for another matter who charges nothing. That is how it should be.

- Anonymous

COVID-19 VACCINATIONS GETTING STUCK IN

DR DANIELLE MCMULLEN
PRESIDENT, AMA (NSW)

Despite the national rollout of the COVID-19 vaccine in late February, the profession is still waiting for important details. Doctors, like their patients, are being urged to exercise patience.

THE COVID-19 vaccination rollout is somewhat off and running – not winning any running races though.

At time of writing, 1a is going well in hospitals, aged care is creeping along and we're days away from launching group 1b in GP surgeries. But rather than launching with a bang, it seems it will be more of a slow trickle.

Understandably, there is high anxiety amongst medical practitioners about the rollout, particularly as the initial rollout of doses appears to be very limited.

The drip-feed of information has been painful for everyone. We often hear from health officials that 'there is much learning' to be done, which I suspect is code for 'we are flying by the seat of our pants'.

Instead of a well-developed plan, at times it feels like Government is making it up as it goes along. There is likely some truth to that cynical view – we are, after all, facing a once-in-a-lifetime pandemic.

Against the backdrop of the vaccine rollout for patients is the vaccination of healthcare workers. There has been much angst in the profession about when, where and how doctors will receive a vaccine depending on which priority group they are in and what their risk level is in terms of exposure.

A significant number of members have reached out to the AMA about the prioritisation of healthcare workers.

We have successfully advocated for medical students to be considered as healthcare workers when on clinical placements, and for the rotations of doctors-in-training to be taken into consideration.

All doctors are in group 1a or 1b.

With more vaccine doses coming into the country and being produced locally, we anticipate there will actually be a fair degree of overlap of 1a/1b and all doctors should receive their first dose soon.

We are working with NSW health to ensure healthcare workers can access either their GP or hospital hubs for their vaccine. Increasing real-world evidence as to the efficacy of the AstraZeneca vaccine is reassuring.

We acknowledge the significant role healthcare workers play in continuing to provide care to patients in this pandemic. Vaccinating our workforce is essential to making sure we can keep being there for our patients.

As doctors, it's critical we follow the evidence and base decisions on the current risk. The fastest way for all of us to return to pre-COVID activity is get as many Australians vaccinated as possible to provide as much protection as we can to the population. The primary goal of our current vaccination program, as we understand it, is to reduce the likelihood of severe disease and death when COVID inevitably reaches our shores again.

It's also important to consider the level of vaccine hesitancy that exists in the general population. If we are going to succeed in preventing people from going to hospital and dying from COVID, then it's important we don't inadvertently undermine the public's confidence in any of the TGA-approved vaccines.

Given these factors and the number of unknowns about the long-term effectiveness of any of the vaccines, we are recommending healthcare workers to follow the advice provided by the Australian Technical Advisory Group on Immunisation on priority population groups.

If this pandemic has taught us anything, it's how to adapt to an ever-evolving situation. It's also a lesson I'm learning as President of AMA (NSW) – particularly when writing this column which has been re-written three times before deadline to keep up with all the new developments.

dr.

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FIRST THEY COME FOR THE PROCEDURALISTS

FIONA DAVIES
CEO, AMA (NSW)

If there is one thing we know in health, it's that cuts don't stop with one group of doctors...

IT WAS WITH significant concern that we have been advised that SIRA will be cutting the fees payable to procedural specialists for treating workers compensation patients. For many years, procedural specialists have received 150% of the AMA fee for treating patients injured at work. This fee covers both the treatment of the patient and all of the extensive paperwork associated with obtaining approvals and battling with the scheme agents to seek to get care for patients. The justification for this decision is that fees in other states are lower. SIRA also suggests that the NSW return to work rates have not improved despite this funding. AMA (NSW) has responded to this change in the strongest possible terms and highlighted that the blame is much more appropriately placed at the feet of iCare.

Whilst SIRA is the NSW government agency responsible for regulating the workers compensation system, iCare is the state insurer.

In 2018, iCare made significant changes to their claims model. The new model reduced the number of claim agents from five to one, EML. According to Janet Dore's 2019 independent review of the nominal insurer the new claims model led to a significant deterioration in the performance of the nominal insurer, through poorer return to work rates, underwriting losses, no competition and therefore, concentration of risk.

iCare has been beset by scandal and plagued by incompetence and mismanagement. If corrections need to be made to the system, SIRA should be looking at iCare, not doctors.

The proposed change fails to consider the much more significant factors impacting on the ability of the scheme to return patients back to work. The RACP Statement on Helping People Return to Work states, "Research shows that being out of work for extended periods of time is bad for a person's health. The longer someone spends away from work, the less likely they will ever return." Despite this, barriers to accessing care are placed in front of doctors and injured workers at every turn. For patients requiring procedural specialist care, every decision is subject to review and scrutiny.

As the AMA represents all doctors, we understand that some members may question our battle to preserve 150% of AMA Fees. However, if there is one thing we know in health, it's that cuts don't stop with one group, the same logic being used to reduce the proceduralist fees could potentially come to be used for GP specialists and other non-GP specialists providing care to injured workers.

We don't need more cuts. What we need is thoughtful discussion about the challenges of caring for injured workers in the current environment and the role doctors can play in supporting their patients. We need to ensure that as many doctors as possible remain engaged with workers compensation so that patients can see their usual GP and the specialist of their GP refers them to and that the patient remains the centre of this scheme. dr.

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Overseas model shown.

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COVID-19 VACCINATIONS: MANAGING PATIENT FLOW

DR BRIAN MORTON
GENERAL PRACTITIONER

General practitioner and former AMA (NSW) President, Dr Brian Morton shares his step-by-step preparations to run COVID-19 vaccinations at his Sydney practice.

ALL OF US have been waiting for the availability of a vaccine for relief from the COVID-19 pandemic. We have been told it's the long-term solution to opening the borders and life returning to a semblance of normal. And just a little over a year since COVID hit our shores, it appears we're on the cusp of being able to immunise patients from the worst of this disease.

Australia has secured 53.8 million doses of the AstraZeneca vaccine, of which 50 million doses are to be made locally. The Commonwealth recently confirmed that the CSL facility in Melbourne was on track to deliver the first batch of doses to a limited number of general practices in the week starting on 22 March.

There seems a moral imperative as a medium size general practice to provide a vaccination clinic available to not just our practice patients but also the local community. Our practice, which is located north of Sydney, has 10 general practitioners who have amalgamated from separate practices in adjacent communities. All of the original practices have been in the area for 40 years and we have been in our current location since 2008. Given this history, we are well-established in the community and have a strong patient base.

It became obvious from the EOI process that running COVID-19 vaccinations at your practice was not going to be 'business as usual'. Hence, a considerable amount of planning has gone in to preparing our practice to accommodate the vaccine rollout.

In order to successfully incorporate COVID-19 vaccinations into our practice, we developed a strategy that would allow us to not only provide this service to our patients, but also allow us to carry on with our regular appointments.

Here is a step-by-step breakdown of our preparations to date:

Step 1: Finding space

Fortunately, our building has vacant office space, so our practice manager asked the landlord for access and we were generously given permission at no rental cost.

Step 2: Developing a plan

We held a practice meeting to reach agreement with all our staff and GPs to action a clinic. All agreed with both the principle and the functional plan. It was agreed that separation of the COVID vaccination clinic from normal daily activity would be essential.

Step 3: Ordering supplies

At the time of writing, we had just received confirmation from the Federal Government as to when we would receive our vaccines and how many doses we would be able to provide to patients. But in the weeks leading up to this, we set about ordering the supplies we would need to maintain a surgically clean environment.

Step 4: Storage capacity

We next turned our thoughts to freeing up space in our two vaccine refrigerators. We have some additional availability given that travel vaccines have not been needed, and we have been allowing routine vaccine quantities to be reduced.

Step 5: Bookings

We are also anticipating increased calls from patients who are looking for more information about COVID vaccinations and bookings. To deal with this, we put in place a telephone message, which instructs callers to go to our website for information about the clinic and for online bookings.

Step 6: Updating our website

In order to provide patients with the most up-to-date information as possible, we are putting together some unique content on our website, which will provide background information on the vaccines, the COVID-19 Vaccine Rollout strategy and patient prioritisation and booking information.

Step 7: Assessing the layout of the clinic space

This includes looking at patient flow through the clinic from the registration desk, pre-vaccine waiting area, two vaccination rooms set for privacy, post-vaccination waiting area, and then the exit desk.

Step 8: IT connectivity

We identified that we will need two laptops. One to be used for patient identification, eligibility and registration, and the other for inputting to the Australian Immunisation Register and the doctor's clinical notes.

Step 9: Staffing

To run the clinic as efficiently as possible, we determined we will require a receptionist (R), practice Nurse (N), GP 1 (D1) and GP 2 (D2).

Step 10: Rostering

Based on the staffing requirements outlined above, we developed this schedule: **See chart below**

Step 11: Bookings

Once we have received the vaccines and are ready to go, then we will need to go through our patient base and identify those who are eligible patients in Phase 1b of the COVID-19 Vaccine Rollout Strategy and create a listing for calls for attendance.

We are anticipating we will need approximately five minutes per patient for the vaccination and our bookings will be made to reflect that.

What's next?

There will be other considerations and processes that will need to be put in place, but this is a brief skeleton of our practice's logistical strategy thus far. Of course, further considerations will have to be made and we anticipate there will be some learnings along the way. dr.

	TIME	STAFF REQUIRED
Morning session	8am to 12pm	D1+D2
Lunch session	12pm to 2pm	D1
Afternoon session	2pm to 6pm	D1+D2
Evening session	6pm to 8pm	D1
Weekend session	Sat: 10am to 2pm Sun: 10am to 2pm	D1* D1*

**Schedule is subject to change according to staffing availability and demand*

Vaccine hesitancy in the age of COVID-19

**Shutterstock image - not actual image of COVID vaccine/syringe

Nearly three in four Australians have indicated they would get a vaccine, but what can you do to build trust among those who are unsure?

AFTER A YEAR of lockdowns, travel bans, and PPE shortages, it seems Australia is about to make its first steps out of the most significant pandemic in a century. With both the Pfizer and AstraZeneca vaccines now approved, we have a path back to normalcy. But with differing vaccine efficacies and uncertainty about the level of population coverage needed to reach herd immunity, an almighty effort will be required to get people vaccinated. There are clearly two sides to this coin: supply and demand. The supply debate is currently being carried out in public, with criticism being placed, rightly or wrongly, on the Federal Government's procurement strategy. But the demand side to this equation also needs to be addressed, and doctors, particularly GPs, are well placed to ensure wide vaccination coverage. One hundred and fifty million

vaccines are useless if only 150,000 people want them.

Already almost 30% of Australians are unsure about a COVID vaccine, and this level of vaccine hesitancy may rise given recent news about novel variants of COVID-19 and their variable responses to vaccines. Australia is also a victim of its own success, with relatively low amounts of cases and deaths perhaps leading to a lack of urgency in getting a vaccine. Despite the proliferation of Anti-Vaxxer sentiment on the internet, international evidence still suggests that patients see their own healthcare providers as their most trusted source of vaccine information. My own anecdotal experience supports this: I've already sat in numerous consultations where the patient has posed the question, 'Should I get the COVID vaccine?'

So how should doctors face this challenge? How should doctors engender support in the vaccine, and help build herd immunity? Luckily, there is a growing evidence base answering this very question, of battling vaccine hesitancy. Firstly, the physician should pick their battle. You can broadly group people's views towards vaccines into three groups: acceptors, who largely accept vaccines unquestionably, hesitators, who either delay vaccines or are selective, and refusers, who refuse all vaccines. While acceptors clearly do not need to be convinced, you should not spend much time on total refusers: they are unlikely to change their mind. Rather, simply a brief consultation and leaving the door open to these patients if they ever change their mind is the most suitable approach.

The bulk of persuasion and reassurance should be placed on those who are hesitant towards vaccines. The Centre for Disease Control states that a 'presumptive' stance should be taken, which should be reiterated after addressing patients' concerns. This favours language such as 'You are due for your COVID vaccine today', rather than 'What do you think about getting your COVID vaccine today?'. If the patient is still hesitant, clinicians should switch to acknowledging and empathising with the patient's concerns, while reinforcing the efficacy and safety of vaccines with short simple statistics. If any misinformation is mentioned by the patient, experts state that misinformation should only be referred to once and rebutted concisely with clear simple facts. For example, if there are concerns about severe side effects, the clinician could reply, 'This vaccine was tested in a trial with over 40,000 people, of which mild side effects like fatigue, a sore arm, and a headache were the most common. Only four serious side effects were noted.' Clear, easy to understand detail is key to conveying confidence in the vaccine.

The best way to convince vaccine hesitators is to engage in a genuine dialogue, not a monologue.

However, narratives and stories, in additional to datapoints, can further reassure patients around COVID vaccines. A survey of US primary care physicians found that personal statements around what they would do for their own family, and what personal experiences they have had, seemed to have the most effect in swaying skeptical patients. These stories and facts should take into consideration the patient's background, as patients within differing communities would have varying motivations, concerns and fears. Furthermore, referring to certain trusted spokespeople and influencers within communities can provide a unique legitimacy to a vaccine.

Finally, the best way to convince vaccine hesitators is to engage in a genuine dialogue, not a monologue. Trust is fostered through active listening, acknowledge anxieties, and addressing concerns, rather than dictating facts and dismissing worries. By building rapport, the patient will also build trust in your judgement regarding vaccines and that will help convert vaccine hesitators into acceptors.

Obviously, the COVID vaccines are different. The evidence base is emerging, there are multiple candidates with seemingly differing efficacy and tolerability. Nonetheless, the Australian medical profession is up to the challenge of ensuring that a safe and effective vaccine is widely accepted, bringing us one step closer to a post-COVID age. dr.

ABOUT THE AUTHOR

Leo Coleman is a final year medical student at Prince of Wales Hospital. For article references please email the editor at news@amansw.com.au.

BUNDLED OBSTETRICS CARE – *will managed care models work in Australia?*

Obstetricians have been the early adopters of managed care options overseas and Australian practitioners are watching closely, as Sydney obstetrician Dr Andrew Zuschmann explains.

ANAESTHETISTS work with a lot of different Medicare Benefits Schedule (MBS) item numbers. An old anaesthetist colleague once told me he was like a taxi driver – charging a flag fall and then a per-kilometre rate.

I'm not sure what analogy would best suit the complicated billing practice of obstetricians but hope the following provides insight into our long and winding road.

Much of the complication comes from the fact that our care occurs partly in the community and partly in the hospital.

In the community, we'll have the initial visits where the pregnancy is diagnosed and investigations ordered. Then there will be a number of routine antenatal appointments. Typically, this might involve eight or 10 of these episodes during a pregnancy. There will also be bloods and scans, so we will be involving pathology, ultrasound and radiology colleagues, along with GP and paediatric appointments in the postnatal period as well.

Sometimes women present at the hospital during the antenatal period, which also attracts a fee-for-service. The actual birth itself will involve the obstetrician, the anaesthetist and a number of other specialties. Typically, it will also include the paediatrician who would review the baby after birth. If the woman is unwell with something like preeclampsia, she may also have an ICU admission.

OBSTETRIC ITEMS

Before the Extended Medicare Safety Net (EMSN) came into existence in 2004, simplified gap billing was common.

Obstetricians would typically divide their fee over a number of visits during the pregnancy, and the patient would pay certain amounts per visit. The EMSN brought in item number 16590 for the 'Planning and Management of a Pregnancy' and this was basically to capture the gap payment that occurred in the community setting.

Initially, it was suggested this be split

into the gap attributed to the antenatal and birth components. So a typical pregnancy billing would look like:

- ✔ 16401 for an initial attendance;
- ✔ 16500 for each antenatal attendance;
- ✔ 16590 for planning and management of the pregnancy;
- ✔ 16519 for a simple birth;
- ✔ 16522 for a complicated birth;
- ✔ 16404 postnatal attendance (in rooms).

Note that vaginal birth and caesarean sections attract the same fee. The complicated birth numbers include things like diabetes, significant hypertension, multiple pregnancy or bleeding. An elective caesarean in somebody with diabetes might be a fairly straightforward procedure and no different in those without diabetes.

We are all familiar with the different patient rebates between the MBS and the no or known-gap procedures, but you may not be aware of the true impact of going even a little over the no-gap rebate for birth as our patients are getting significant out-of-pocket costs.

The MBS rebate versus HCF no-gap, for example, has quite a difference:

- ✔ 16519 – MBS $536 vs HCF $1,908 or;
- ✔ 16522 – MBS $1,260 vs HCF $2,315.

COMMUNITY CARE

With there being three main types of private health insurance in Australia – hospital, extras and ambulance – there is nothing that covers care in the community. This feeds into one of the major public misconceptions about why their health fund is not paying more obstetric cover.

The majority of pregnancy care, including 24/7 access to a specialist obstetrician and gynaecologist, actually occurs in the community and is outside the remit of private health insurance. So, we can see that health funds are really looking at ways of clawing this back to reduce members' out-of-pocket expenses.

With most of the care being provided in the community, the community portion tends to attract a bigger gap, with a smaller gap being apportioned to hospital services. There's a big insurer mark-up on the 16519s, which prevents the large out-of-pocket costs or large out-of-pocket gaps in hospital because many obstetricians, certainly around Sydney, will no-gap the birth based on reasonable rebates.

UPLIFT FEES

It is becoming increasingly obvious that when it comes to bundled care arrangements the provision of uplift fees is dependent on all community consultations with the obstetrician service bulk billed, which means the EMSN rebate is lost for the patient. All bloods and scans must be at a bulk bill provider already in place with the health fund. Many pathology services will bulk bill, but high-quality pregnancy ultrasound typically has a gap because ultrasound and radiology rebates have been neglected. All anaesthetic services must be provided at no out-of-pocket cost to the patient, and this includes the no-gap plus and uplift fee.

From an obstetrician's point of view, the uplift fee is significantly less than many currently charge for the package of obstetric care we provide. Although there's a wide variation of fees charged in Australia for private obstetric care, for many this would represent a significant 25% reduction in income per pregnancy.

As a busy obstetrician, I'm comfortable with the workload that I'm doing and for me to take a 25% reduction in fees with the expectation that I'm actually going to increase the workload, is really challenging. Especially in the era of safe working hours and of work-life balance in medicine, it's just not particularly acceptable.

The other challenge that bundled care can create at some hospitals is needing to run two on-call rosters.

One for the obstetricians, anaesthetists and paediatricians who want to participate in a bundled care arrangement and another for those who don't. You can imagine the issues this creates having to potentially run two anaesthetic rosters.

One of the key considerations to be taken into account is that many health funds consider women who are participating in a bundled care arrangement need to have exactly the same care arrangement from the obstetricians.

From the maternity care provision point of view, no two pregnancy journeys are the same. That the insurers are attempting to homogenise a woman having a baby speaks volumes to what their approach could be to so many other areas of healthcare. dr.

ABOUT THE AUTHOR

Dr Andrew Zuschmann is an obstetrician, gynaecologist and fertility specialist working in both public and private practice in the Sutherland Shire, Sydney. He is Head of Department at The Sutherland (public) hospital, and O&G representative MAC, Kareena Private Hospital. Andrew is also Vice-President AMA (NSW), NASOG Councillor, and Chair RANZCOG NSW/ ACT Training Accreditation Committee.

This article first appeared in Australian Anaesthetist *and is reprinted with permission. The ASA is hosting a series of webinars on managed care with information about upcoming webinars available on www.asa.org.au.*

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A GUIDE TO MEDICARE COMPLIANCE PROCESSES

DOMINIQUE EGAN

DIRECTOR OF WORKPLACE RELATIONS, AMA (NSW)

2021 is well underway, and with the new year we have seen an increase in member enquiries in relation to Medicare compliance processes.

Private Patient Billing for Out-Patients in Public Hospitals

Under the National Health Reform Agreement, patients must be given the choice to receive public hospital services free of charge as public patients, access to public hospital services is to be provided based on clinical need and within a clinically appropriate timeframe, and arrangements are to be in place that ensure equitable access to services.

Private out-patient services can be provided in public hospitals provided:

- Patients are given the choice to be treated as public or private;
- Public patients must be provided with the same access to services as private patients;
- If a patient chooses to be treated as a private patient, they must have been referred to a named medical specialist;
- Informed financial consent must be provided to patients.

Referral pathways must not be controlled so that a named referral is a pre-requisite to access out-patient services. A patient must be able to access out-patient services as a public patient.

NSW Health will be publishing a Guideline to provide guidance for NSW Health organisations when billing for privately referred non-inpatients services in NSW public hospitals. The Guideline reflects the position under the National Health Reform Agreement and the Health Insurance Act 1973.

Medical practitioners are responsible for ensuring that services billed under their provider number are billed in accordance with the requirements of the Health Insurance Act and the Commonwealth Medicare Benefits Schedule. With respect to Visiting Medical Officers and Staff Specialists, providing private patient services in public hospitals this means:

- Regularly reviewing Medicare claims submitted by the hospital on their behalf. If anomalies are identified they should be raised with the hospital and Medicare.
- Claims should only be made under a Visiting Medical Officer's or Staff Specialist's Provider Number if that person provided the service. Services provided by other practitioners should not be claimed under the Visiting Medical Officer's or Staff Specialist's Provider Number.

Visiting Medical Officers should also be aware that if a claim is submitted to Medicare for a medical service, a Visiting Medical Officer should not be paid under his or her Visiting Medical Officer Contract for the provision of that service (other than in limited circumstances where an exemption has been given by the Department of Health).

Billing for Out-Patient procedures

Some members have recently been contacted by the Department of Health in relation to the billing undertaken for out-patient procedures.

Under the provisions of the Health Insurance Act, the Medicare benefit payable for a service provided as a part of an episode of hospital treatment is 75% of the Schedule Fee.

Hospital Treatment, for the purposes of the Health Insurance Act, is treatment, inter ala, that is provided at a hospital. No distinction is made as

to whether a patient is an in-patient or an out-patient when they receive treatment.

DOH calling doctors

We understand that the Department of Health has recently begun contacting medical practitioners about how and by whom private patient billing is undertaken in public hospitals.

If you receive such a call, we would like to hear from you.

Shared Debt Recovery Process

The shared debt recovery process may be of assistance to practitioners who are formally audited by the Department of Health. It is not available to medical practitioners who complete a Voluntary Acknowledgement of Incorrect Payments after receiving correspondence from the Department of Health asking the practitioner to review his or her billings.

If you are considering making a voluntary repayment should you become aware of an inappropriate billing practice at your hospital, please contact your MDO or AMA (NSW)'s Workplace Relations Team at workplace@amansw.com.au for advice. dr.

COVID-19 VACCINES AND YOUR STAFF

LYNDALL HUMPHRIES

SENIOR WORKPLACE RELATIONS ADVISOR (EMPLOYMENT LAW), AMA (NSW)

Here are some common questions we receive from private practice employers about COVID-19 vaccines and their practice staff.

Q: I run a private practice and after a tough year business has picked up and we're now very busy. With the vaccine rollout underway, I want my practice staff to be vaccinated for COVID-19. Can I require this?
A: Generally speaking, no. Even though you run a busy practice, you cannot require that your practice staff be vaccinated for COVID-19. The State and Federal Governments have announced that the COVID-19 vaccination is voluntary and there is currently no legal requirement or authority that allows for mandatory vaccinations for staff in private practice.

Q: I have a medical condition and am immunocompromised. If my staff are vaccinated for COVID-19, I'll feel safer about working in a busy practice. Does this change things?
A: No. The fact that you (or your staff or patients) have a medical condition does not change that the COVID-19 vaccination is voluntary. To ensure your own health and safety, and the health and safety of staff, patients and others at your practice, you will need to continue to apply practical safety measures such as physical distancing, good hygiene and regular cleaning and maintenance.

Q: But I've read that an employer can issue lawful and reasonable directions to their employees. Given my medical condition, would it be lawful and reasonable for me to direct my practice staff to be vaccinated for COVID-19?
A: You're correct that an employer generally has a right to issue lawful and reasonable directions to their employees, but whether a direction is lawful and reasonable will depend on the circumstances. Currently, there is no legal requirement or authority that allows employers to mandate the COVID-19 vaccine for staff in private practice. So, a direction that practice staff be vaccinated for COVID-19 would not be lawful. This position may change in the future if new laws are made, or cases are determined by the Courts.

Q: I understand I can't direct my employees to be vaccinated for COVID-19, but I'd still really like to ask them. Is that okay?
A: Yes, you should consult with your employees about the COVID-19 vaccine and can encourage and request that they be vaccinated. In your discussions you should cover relevant factors including the nature of your practice, the risk profile of patients and individual staff members, the nature of each staff member's role and the working environment. It is up to each employee to make their own decision.

Q: One of my employees doesn't want to be vaccinated because she is pregnant/on religious grounds/on medical grounds/due to personal preference. Is there anything I can do?
A: No. As COVID-19 vaccination is voluntary you will have to respect your employee's decision. You should continue with the practical safety measures at your practice and you may need to revisit or update your risk assessment with any additional information. dr.

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RURAL QUARANTINE NEEDS RURAL LEADERSHIP

Consultation with rural and regional doctors needs to happen before new quarantine solutions are developed.

THERE HAS been much ado of late regarding Australia's hotel quarantine system. Amongst other factors, a systemic failure of the Australian Government's Infection Control Expert Group (ICEG) guidelines regarding airborne transmission has led to numerous instances of COVID-19 escaping capital city-based hotel quarantine and generating a threat to the community. In response, State and Territory governments as well as the Federal Government have proposed the setup of regional quarantine stations in areas ranging from regional towns to remote mining camps. The concept enjoys broad support, particularly amongst doctors and politicians based in cities.

As a rural doctor, what is the key to making something like this succeed? When talking about regional quarantine, many people cite the Howard Springs Quarantine facility in Darwin as a "gold standard" for how things should be done. Whilst Howard Springs has been a successful example of how quarantine should be done well, it is far from an example of "regional" quarantine. The facility is 20-30 minutes' drive from a major centre, with a nearby airport capable of handling heavy jet traffic. Sick patients (not that this occurs frequently) do not require aeromedical transfer to a larger city hospital for ongoing care, and the public health system in the NT is very capable of managing small, localised outbreaks when and if they occur.

Importantly, the process of establishing and implementing Howard Springs was driven by local doctors. As luck would have it, these local doctors were based in the decision-making centre of the Territory (i.e. Darwin) and were able to make good quality decisions in the interests of the territory.

The same cannot be said of regional quarantine proposals in other states. Proposals in Queensland and Victoria, whilst also with their merits, have been made by predominantly city-based "experts" and bureaucrats without involvement of rural doctors or the broader rural health system. The proposals ignore many issues around workforce sustainability and the management of outbreaks, both in primary care and hospitals, for the political expediency of removing the problem of quarantine from marginal seats in capital cities.

These proposals currently reflect the standard of geographic narcissism that we have come to expect from government. Rural health is a litany of capital city-based bureaucrats and managers telling rural doctors what to do without having even visited rural Australia or without any understanding of local context. This has led to a poorly designed and under resourced rural health system that ignores the needs of communities and doctors. To date, there has been no meaningful consultation with rural doctors in primary or secondary care on any of these proposals. In addition, the leadership of these sites will be from capital cities, who have not proven themselves capable of making good decisions for rural and regional Australia.

Do not mistake me, regional and rural quarantine can work under the right circumstances. These circumstances need to be managed by local doctors and doctors with significant rural expertise. These doctors are currently ignored in a very systematic and obvious way by the bureaucracy. As rural doctors we must insist on rural leadership as the centrepiece of any regional quarantine system. dr.

ABOUT THE AUTHOR

Dr Marco Giuseppin is chair of AMA Council of Rural Doctors (CRD) and a member of AMA Queensland Council. He is a practising Rural Generalist based in Queensland and a retrieval doctor with the the Royal Flying Doctors Service.

VEXATIOUS NOTIFICATIONS

While the number of vexatious complaints in Australia is small, the impact they have on practitioners' lives is significant. AMA has been working with AHPRA to develop a new framework.

THE AMA UNDERSTANDS how intensely distressing receiving a notification from the Australian Health Practitioner Regulation Agency (AHPRA) is to every medical professional. It is one of our key areas of advocacy and something we focus on each and every year.

In response to the AMA's calls, AHPRA released a framework to support the identification and management of vexatious notifications in December 2020, hopefully taking another step forward to improve their processes.

This framework has been a long time in development and stems from two Senate reports into the Medical complaints process in Australia and the Complaints mechanism administered under the Health Practitioner Regulation National Law.

One of the key issues identified in evidence to these inquiries was that of vexatious complaints. Many health practitioners argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment, including by other health practitioners.

In its submission to the second inquiry, the AMA called for the AHPRA complaints handling mechanisms to be improved by developing a system to triage and remove complaints that are clearly vexatious.

This evidence led to the Senate recommending that AHPRA and the national boards develop and publish a framework for identifying and dealing with vexatious complaints.

AHPRA published a report in 2018 'Reducing, Identifying and Managing Vexatious Complaints: Summary' which was the first international literature review of vexatious complaints in health practitioner regulation. The report found that the number of vexatious complaints dealt with in Australia and internationally is small, representing less than one per cent but concluded that these complaints have a significant impact on practitioners' lives.

The AMA continued to raise this issue with AHPRA and the Medical Board, urging further action be taken to enable vexatious complaints to be identified and managed earlier in the notification process thereby reducing harm to the practitioner.

Following detailed consultation with the AMA in the second half of 2020, AHPRA released its new framework to support the identification and management of vexatious notifications.

This framework outlines:

- principles and features of vexatious notifications;
- the significant impacts of vexatious notifications;
- potential indicators of vexatious notifications;
- how to identify vexatious notifications, and
- what to do where there is a concern that a notification is vexatious.

At the urging of the AMA, the framework also reinforces that health practitioners should not make vexatious complaints about other health practitioners. Vexatious notifications made by a registered health practitioner with the intent of harming another practitioner are taken seriously. A Board can take action against a practitioner who makes a vexatious notification about another health practitioner. This includes investigating the practitioner and, where vexatiousness is apparent, taking action that could affect the practitioner's registration. Vexatious notifications do not have good faith protections under the National Law.

It is hoped this framework will provide AHPRA with a better understanding of what a vexatious complaint might look like and how to manage one.

AHPRA CEO Martin Fletcher said the Framework was "an important milestone in more rapidly responding to concerns about the potential vexatiousness of a complaint."

In 2021, the AMA will ask AHPRA for an assessment of the implementation of this framework and looking for a demonstrable decrease in practitioner burden in their metrics. dr.

ABOUT THE AUTHOR

Dr Chris Moy is the AMA Vice President and President of AMA (SA). He has served as Chair of the Federal AMA Ethics and Medico-legal Committee. Dr Moy works as a full-time general practitioner in Parkside, South Australia.

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O WEEK 2021

AMA (NSW) visited hospitals across NSW during Orientation Week to welcome new interns to the profession.

O WEEK 2021 was an orientation like no other. This year's cohort quickly learned the art of 'smize' (smiling with their eyes) as they took in presentation after presentation in a COVID-safe way – socially-distanced and masked up.

"These junior medical officers join NSW Health at a remarkable time in our history," Richard Griffiths, Acting Deputy Secretary, NSW Health said.

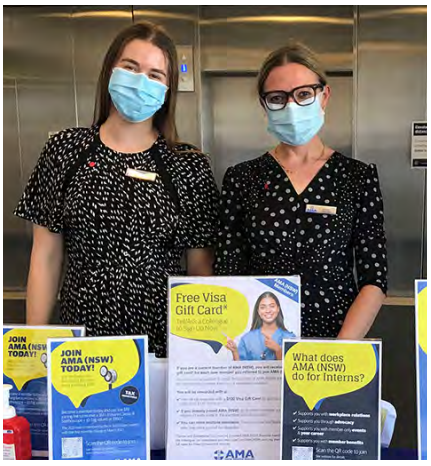
"They come to us in the middle of an unprecedented, world-wide pandemic and have the unique opportunity to play a vital role in in our extraordinary health system."

There were 1,041 interns in 2021, a 35% increase from 10 years ago.

Of the 1000-plus new doctors, 150 are taking part in the Rural Preferential Recruitment scheme, in which interns undertake the majority of their training in rural hospitals. This has doubled in number since 2012.

While AMA (NSW) wasn't able to get to all of the interns this year due to COVID restrictions, we did make an effort to visit as many as possible. And in addition to welcoming the profession's newest members, AMA (NSW) President, Dr Danielle McMullen reminded interns that AMA (NSW) exists to help them throughout their career – with workplace support, careers assistance, advocacy and more.

Last year we heard from DITs that some weren't being paid for mandatory training, but advocacy from AMA (NSW) has made a discernible improvement to this issue. There were less reports of this happening in 2021, and where it did occur, AMA (NSW) was able to assist those members get paid for any mandatory training that was completed outside of rostered hours.



We were also pleased to tell interns about other positive changes AMA (NSW) has instigated to improve the working lives of DITs. These include online claiming for unrostered overtime and callbacks. The new system makes it easier for DITs to be paid correctly and also provides a clearer picture of the actual number of hours DITs are being asked to work. This data can be used to help us push for better rostering.

If you are an intern and have a question about your employment, please contact AMA (NSW)'s Workplace Relations Team on workplace@amansw.com.au or 02 9439 8822. dr.

DIT AWARD WINNERS

THE ANNUAL DIT Awards are an opportunity for AMA (NSW) to acknowledge the great accomplishments of NSW's junior doctors and those influential to their professional development.

The awards were held late 2020 and recognised one winner and finalists in three categories: Registrar of the year, DIT of the year and Supervisor of the year. There was also an one overall winner in the JMO Unit of the year category.

All of the winners and finalists share some common attributes: dedication to patients and colleagues, a commitment to providing high quality care, a strong work ethic, professionalism and competence.

It's also exciting to honour and acknowledge those who have supported and guided our doctors-in-training as they progress through their careers. The Supervisors and JMO Units play an integral part in the development of doctors and deserve recognition.

Thank you and congratulations to all who participated in the awards.

REGISTRAR OF THE YEAR

WINNER:
Dr Anosh Sivashanmugarajah
Finalists:
Dr Cameron Gofton
Dr Timothy West
Dr Susmit Prosun Roy

DIT OF THE YEAR

WINNER:
Dr Avinesh Chelliah
Finalists:
Dr Ben Maudlin
Dr Molly Fowler
Dr Craig Coorey

SUPERVISOR OF THE YEAR

WINNER:
Dr Marion Magee
Finalists:
Dr Gregory De Moore
Dr Sophie Kavanagh

JMO UNIT OF THE YEAR

WINNER:
John Hunter Hospital JMO UNIT – Bianca Field

AUSTRALIA DAY HONOURS

Congratulations to AMA (NSW) members who received 2021 Australia Day Honours.

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MEMBER (AM) IN THE GENERAL DIVISION

Dr Tom Justin Playfair
Dr David Edward Schuster

AM (HONORARY)

Dr Alison Hilary Brand

MEDAL (OAM) IN THE GENERAL DIVISION

Dr Ruth Hope Arnold
Dr Judith Carmen Lynch
Dr Amarjit Singh More
Dr Anandhan Perumal Naidoo
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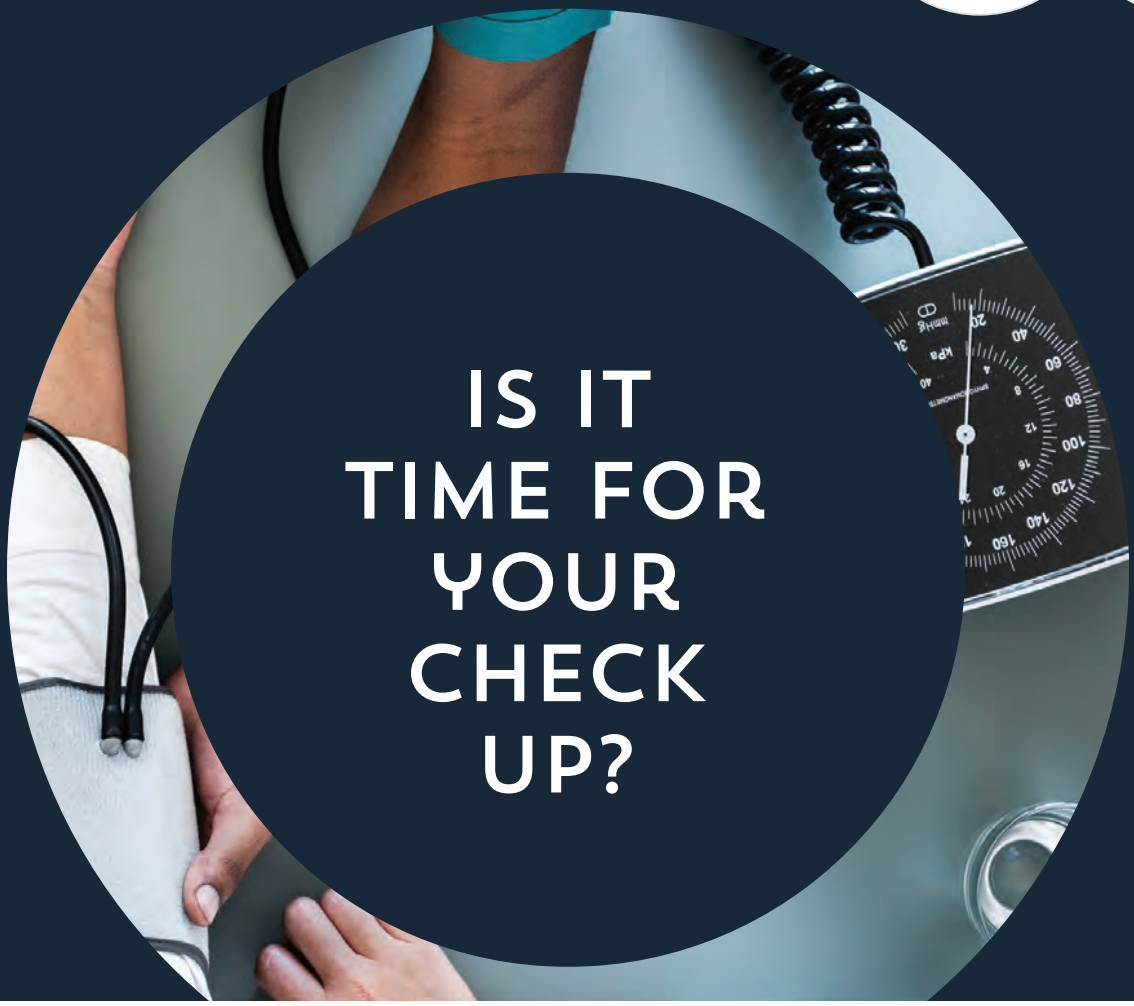

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Jessica Rankin
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Australia's largest independently- owned online bookstore. We stock over 650,000 items and have over 5 million titles for purchase online.

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AMA (NSW) membership entitles you to discounts when you fly with Emirates in Business and Economy Class.

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Free scheduled servicing for 5 years/130,000 kms, 5 Year Warranty, reduced new vehicle delivery costs, and more.

Make It Cheaper

A business energy broker, Make It Cheaper can help members save money on electricity.

Medical Staff

Medical Staff specialises in the recruitment and placement of Locum Doctors in Private and Public Hospitals, and more.

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Nespresso

Receive 10% off Nespresso Professional Zenius Machine and a accessories valued at $251. Valid ABN and business required.

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Free shipping in Australia or free polish with purchase of Comfort Craftsman, Dynamic Flex, Adelaide or Sydney boots.

Persian Rug Company

AMA (NSW) members receive a significant discount on online and in-store purchases of beautiful handwoven rugs.

Qantas Club

Make your flight experience more enjoyable with access to the Qantas Club Lounge. AMA members save on Qantas Club fees.

RendTech

We specialise in helping healthcare businesses work more efficiently by providing a range of IT solutions.

Samsung Partnership Program

Discounts on Samsung smart devices through an exclusive AMA / Samsung online portal.

Solahart

Receive 5% off Solahart systems tailored to your practice, and a $500 Coles Myer Gift Card* with a residential system purchase.

Sydney City Lexus

Preferential corporate pricing, 3 year/60,000km complimentary scheduled servicing, reduced delivery fee, and more.

Tesla Corporate Program

Complimentary 3-Year maintenance plan and waived delivery fee and energy product purchases for AMA (NSW) members.

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Our experienced staff can advise, measure, manufacture and install to suit your specific requirements.

Call AMA (NSW) membership team on 02 9439 8822 or go to amansw.com.au and ama.com.au for full list of benefits.

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Financial**Paracetamol**

March 2021

Cutcher&Neale
ACCOUNTING AND FINANCIAL SERVICES

Welcome to the March, and first edition of Financial Paracetamol for 2021.

In this edition:

Writing a business plan... Make it your business to get it right!
Starting a medical practice is by no means a small feat.

Working as a VMO or Staff Specialist? Super Guarantee Opt-Out may be worth your while...
Do you anticipate super contributions paid on your behalf to be in excess of $25,000 each year?

JobMaker hiring credit. Registrations are now open!
The JobMaker Hiring Credit is an incentive for businesses that aims to subsidise the cost of increasing your number of employees.

Top tips to establish your practice presence online.
There is an overwhelming amount of advice about how to establish and grow your medical practice online, including 'experts' that will tell you that you should spend all your limited marketing funds on online advertising.

As always, if you have any questions relating to any of the articles in this edition, please don't hesitate to get in touch.

Jarrod Bramble
PARTNER

Writing a business plan...
Make it your business to get it right!

Starting a medical practice is by no means a small feat.

Medical practitioners who decide to embark on the journey of owning a medical practice need to quickly find synergy between continuing to deliver a high level of patient care with now running a business.

Endeavours such as this typically start with the idea, countless hours of research, and planning. It is in this planning phase that a new medical practice should document its business plan.

A business plan is a roadmap for any new medical practice and should outline the day-to-day operations as well as setting goals for future growth.

So, what should be included in a business plan? Business plans should focus on the business itself, the market it is operating in, its future growth and of course the finances.

Here are just a few points to consider at each of these steps:

The Market:
You will firstly need to understand your patient demographic and potential patient numbers. You also should look at competitors in the area and consider marketing or advertising strategies you may need to implement.

An effective planning technique is the utilisation of SWOT analysis, this helps to understand the strengths, weaknesses, opportunities, and threats of a new medical practice.

The Business:
Understanding the business itself is paramount. The appropriate structure, the number of doctors required, staff, and what equipment will be needed to effectively deliver quality patient care must all be considered here.

The Future:
How do you see the practice continuing to operate into the future? This can start with a vision statement articulating what you want the medical practice to look like. It is also important to understand and identify the future and ongoing goals and objectives of the practice in this section.

The Finances:
One of the final elements in any business plan are the finances.

Initial consideration will need to be given on how to finance the practice in its infancy. Ongoing budgeting and forecasting are also required to ensure the practice continues to remain financially sustainable into the future.

Taking the time to write a business plan will no doubt increase the likelihood of the practice in reaching its overall goals and objectives.

There is considerable work involved in creating a credible business plan, it is likely you will need assistance from outside sources such as mentors and your trusted business advisor to bring it all together.

If you need help with writing your business plan, get in touch with our team today.

Working as a VMO or Staff Specialist?
Super Guarantee Opt-Out may be worth your while...

Are you a VMO or Salaried Medical Practitioner finding yourself working for multiple employers in any given financial year?

Do you anticipate super contributions paid on your behalf to be in excess of $25,000 each year?

If your answer to both questions is YES then the Super Guarantee Opt-Out for High-Income Earners regime may be worth considering.

Ordinarily employers are required to pay 9.5% superannuation guarantee on behalf of all eligible employees to their superannuation funds on a quarterly basis.

Under the Super Opt-Out provisions you may be able to elect for one or more of your employers to "opt out" of paying superannuation guarantee on your behalf (for one or more quarters

in the year). Importantly, still ensuring you receive superannuation guarantee contributions from at least one of your employers.

The 'opt out' option is designed to aid employees, such as medical practitioners avoid unintentionally breaching their concessional contributions cap of $25,000 per annum merely as a result of having multiple employers.

It is important to talk to your nominated employer about the impact an exemption might have on your overall remuneration and other entitlements, negotiation with your employer is key when it comes to how the forgone superannuation amount could be factored in so as to not be disadvantaged.

There are strict deadlines concerning the application form, employees will need to lodge the completed form with the Australian Taxation Office at least 60 days before the first day of the first quarter that the exemption certificate will apply to. Keep in mind employers can also disregard an exemption certificate should they choose to do so.

A separate application is also required for each new financial year and once a certificate is issued it cannot be varied or revoked.

If you would like to know how this might impact you or need our assistance with the application, please get in touch.

JobMaker Hiring Credit:
Registrations now open.

The JobMaker Hiring Credit is an incentive for businesses that aims to subsidise the cost of increasing your number of employees.

The JobMaker hiring credit is open to businesses that are hiring additional young staff between 7 October 2020 and 6 October 2021.

It relates to new positions filled by persons who received either JobSeeker, Parenting Payment or Youth Allowance payments for at least 28 consecutive days in the 84 days prior to commencing claiming for the employee.

The payment rates (per employee) range up to:

- $200 per week for 16-29 year olds,
- $100 per week for 30-35 year olds.

The claim period can run for up to 12 months from their employment commencement.

Claims start 1 February 2021, registration is open now via the ATO.

To find out more about the JobMaker Hiring Credit, and eligibility criteria visit our blog at **www.cutcher.com.au/insights-and-news** or scan the QR code below.

SCAN ME

Top tips to establish your **practice presence online.**

There is an overwhelming amount of advice about how to establish and grow your medical practice online, including 'experts' that will tell you that you should spend all your limited marketing funds on online advertising.

But before you take the leap into paid online advertising, it pays to make sure you have the basics right. As with every marketing tactic, nothing works in isolation and an integrated approach to your marketing is essential.

Website:
Have an easy and recognisable domain name, ensure your website is mobile friendly and have clear contact information available.

Online Directories:
Register with Google MyBusiness to ensure your practice is on Google Search and Google Maps ensuring your address, contact information and hours of opening are up to date.

Build an email database:
Capture your customers email addresses and build a list so that you can engage with your patients online.
Learn the SEO basics:
A basic understanding of search engine optimization will help you understand why it is important: get reading!

Social Media:
You don't have to register for every social media site - go where your target audience is. It's much more effective to do two social channels well, than spread yourself too thin.

Create and share content:
Provide regular updates through a blog or your social media channels. Creating simple video content is easy and can be done on your mobile device. Provide information relevant to your customers in a timely manner.

Experiment with online advertising:
Start small, and make sure you measure the outcomes to ensure your efforts are not wasted.

Finally, be patient – marketing is a long-term game.

Establishing good practices such as posting new content consistently, offering exceptional patient care and keeping up to date with online marketing trends will ensure you reap the benefits in the long-term.

Cutcher & Neale
opens new office in Brisbane

Cutcher & Neale is excited to announce that we have opened a new office in Brisbane Queensland, expanding our presence across the Eastern seaboard.

In addition to the existing offices in Sydney and Newcastle, the new Brisbane office supports Cutcher & Neale's growth strategy and strengthens our service capabilities.

To help establish and expand the Cutcher & Neale presence in Queensland, Saverio Angi and Craig Offenhauser have joined the partnership team and will be located at our Brisbane office in Fortitude Valley.

Cutcher & Neale now has twelve partners and 140 staff across its office locations.

Top Superannuation Strategies Webinar

Wednesday, 24 March 2021

In this webinar, our award-winning advisors will discuss:

- The 3 tax-free's of superannuation
- Borrowing in superannuation
- Structuring small property syndicates
- Accumulation strategies
- The $1.6 million target
- Minimising tax on your portfolio
- Segregated pension strategies
- Contribution splitting
- Catering for the next generation
- How to be cost effective in self-managed superannuation funds

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