A WINTER WONDERLAND
Life lessons in Lapland

Medical Billing Winter 2018 Update
What you need to be aware of

eHealth
The affect on your bottom line

Postcards From Practice
Reflecting on 15 years as a Rheumatologist
CONTENTS

4  The Editor’s Welcome
5  Events
6  eHealth
   Is eHealth the Key to a Healthier Practice?
8  Marketing
   Marketing Tips for Medical Business Growth
12  Biotech
   Why Drug Reimbursement is about Science, Politics and Art
14  Postcards from Practice
   Rheumatology is a Journey, not a Destination
18  Escape
   A Winter Wonderland
26  Financial Advice
   Paris and London or Geelong and Lithgow?
28  Medical Billing
   Update in a Nutshell
36  Investment
   Understanding Negative Gearing

40  Superannuation Accounting
   The never-ending Complications of Superannuation
46  Marketing
   Using Referral Marketing Data for Sustained Practice Growth
48  Practice Design
   Special Needs Healthcare Design
54  Luxury Cars
   Collectable, Classic and Prestigious
56  Medico Legal
   Testing times – Let the doctor decide
62  Career Advice
   Keeping up with your Immunisations
64  Capacity and Guardianship
   QCAT: What is it and how can it help adults with impaired capacity
68  Property
   Losing sight of reality

Learn more

theprivatepractice.com.au/2018courses
f/ThePrivatePractice
in/the-private-practice

Published by The Fintuition Institute
Editor:  Steven Macarounas
Art Director:  Lisa Reidy
Advertising:  Steven Macarounas / editor@theprivatepractice.com.au / Tel. 02 9229 9731

This magazine has been prepared by the Fintuition Institute Pty Limited ABN 89 139 869 426 (Fintuition). The information in this publication is general information only and is not intended to provide you with any financial advice or take into account your objectives, financial situation or needs. You should consider, with a financial adviser or other professional adviser, whether the information is suitable for your circumstances. To the extent permitted by law, no liability is accepted for any loss or damage as a result of any reliance on this information. The information is believed to be accurate at the time of compilation and is provided in good faith. This publication contains information contributed by third parties. Fintuition does not warrant the accuracy or completeness of any information contributed by a third party. Any views expressed in this publication are opinions of the author at the time of writing and are not the opinions of Fintuition, unless stated otherwise. The views expressed in this publication do not constitute a recommendation by Fintuition to act. Information in this publication is current as at August 2018 and may be subject to change. No part of this publication may be reproduced in any manner without prior written permission from the publishers.
Everyone in your practice can get more back with our increased Extras benefits.

As an employee, in any capacity, of a medical or health practitioner you too are eligible to join and we would be delighted to welcome you. And once you’ve been a member of Doctors’ Health Fund, you can remain a member even if your employment changes.

We’re dedicated to delivering you outstanding choice, value and service.

We keep out-of-pockets and rate rises to a minimum. In 2018 Doctors’ Health Fund announced the lowest published rate increase of all the health funds, and in fact it’s our sixth consecutive year of below industry average increases*.

Plus increased extras benefits:

> $600 optical limit over any 2 consecutive calendar years when you choose Total Extras Cover

> $1,600 combined dental limit when you choose Essential Extras Cover.

Call 1800 226 126 and speak to one of our experts today or visit doctorshealthfund.com.au to get a quick quote.

Dr Dominic Barnes, GP,
Doctors’ Health Fund Member since 1993


Private health insurance products are issued by The Doctors’ Health Fund Pty Limited, ABN 68 001 417 527 (Doctors’ Health Fund), a member of the Avant Mutual Group. Cover is subject to the terms and conditions (including waiting periods, limitations and exclusions) of the individual policy.
EDITORS MESSAGE

Risk & Reward

Identifying, quantifying and managing risk has become a big and important theme in The Private Practice mantra.

The climb up the mountain of success is fraught with danger, and if we don't want our dreams and goals to be dashed on the rocks below, we should make sure we have done our homework, chosen the right route and have safety nets in place.

And yet...

Is playing it safe all it’s cracked up to be?
Do we really get the most out of life by sticking to the ‘tried and true’? Is doing things the way they’ve always been done, going to yield anything exciting, revolutionary, disruptive, transformational?

My Escape article on page 18 addresses this notion of risk and reward as it relates to holidays and shared family experience, but of course, the same is true of our business models and our financial lives.

Risk taking, need not be foolhardy or devoid of research and planning.

Risk taking can start with challenging the status quo - simply accepting that there could be should be, must be, a better way of doings things that better meets the needs of our patients, clients, colleagues, family and ourselves.

Follow this notion with action – structured experimentation with guidance and a framework for measurement, revision and re-setting.

But, at the heart of this kind of thinking remains ‘risk’ – the risk of failure, but also the risk of success.

Whilst slow and steady does win the race – where’s the fun in that? AND, what’s beyond the finish line?

To quote the Philosopher and Song Writer Criss Jami from his book Killosophy.

“Most men either compromise or drop their greatest talents and start running after, what they perceive to be, a more reasonable success, and somewhere in between they end up with a discontented settlement. Safety is indeed stability, but it is not progression”.

I hope the articles in this Winter 2018 edition of The Private Practice inspire you to challenge the status quo, take some calculated risks and strive for unreasonable success.

Happy Reading.

Steven Macarounas, Managing Editor
editor@theprivatepractice.com.au
EVENTS

1-3 June 2018, Sydney, Personal and Practice Growth Strategies

15-17 June 2018, Melbourne, Practice and Personal Growth Strategies and Transition to Retirement Workshop
Is eHealth the key to a healthier practice?

An ‘e’ prefix tends to indicate a technological leap forward, and that’s certainly the case for ‘eHealth’. eHealth is helping patients manage their own health and changing their relationship with healthcare providers.

So, where does that leave your bottom line? NAB’s Cameron Fuller examines the impact of technology and contemplates potentially profitable new business models.

DIFFERENT RELATIONSHIPS

We’ve seen healthcare providers using digital technology to streamline their systems and processes for some time now.

Cameron Fuller, NAB’s Customer Executive, Growth Sectors, points out that electronic record-keeping is replacing scanners, printers and faxes in health practices up and down the country.

“Electronic records can save time and money because they’re so much easier to access, update, store and share,” he says. “And, by the end of this year, every Australian who doesn’t opt out will have an electronic My Health Record, so doctors and other healthcare professionals who have the right technology in place will be able to share health information and collaborate online.”

Patients could also contribute to the pool of information in the future.

“Most people are familiar with the way wearables such as Fitbits and Apple watches can provide feedback on things like activity levels, nutrition and even the quality of our sleep to help people adopt a healthier lifestyle,” Fuller says. “Now we’re seeing moves towards sharing that information with medical professionals. In the US, for example, Fitbit just joined forces with Google with the intention of using Google’s new Cloud Healthcare API to connect user data with electronic medical records.”

INVESTING IN PREVENTION

Fuller predicts that a more preventative approach to healthcare will create new income streams for providers.

“In health, revenue is moving towards prevention,” he says. “Both the government and private health insurers are keen to keep people out of hospital so it’s possible that, in future, they’ll incentivise practitioners to take a more proactive approach.”

New technologies are already helping some people manage chronic illnesses at home.

“Most private health insurers in the US now provide cover for apps that enable people with diabetes to monitor their blood glucose and insulin levels,” Fuller explains. “This can help them make adjustments before they need medical intervention.”

Those patients requiring fewer face-to-face consultations will still need to work in collaboration with medical professionals.

“Doctors and other providers might stay in close touch electronically and play a more consultative role,” Fuller says. “Clearly we’re going to need new business models to ensure there’s a fair and profitable fee structure for anyone who offers this kind of online eHealth service.”
PATIENTS DRIVING CHANGE

Technology is also changing consumer expectations.

“Patients used to be seen but not heard… people are [now] more likely to be active participants in every aspect of their healthcare,” Fuller says.

He also believes that it’s the patients themselves driving the uptake of technology.

“Booking online used to be a cool option, now it’s what people expect,” he says. “They might also expect a text to remind them about their appointment and another if there’s going to be a delay. This could be an important business opportunity if you listen to your patients and respond to what they want.”

An appropriate response could include greater transparency.

“People in need of a particular service want to know where they can find it and how much it will cost,” Fuller says. “The HICAPS Go app now lets them source a service, check their health fund rebate and see their out-of-pocket costs, book an appointment and then swipe to pay. As other apps come along, we can expect to see even more transparency in the system. Consumers will be able to make more informed choices and I imagine some providers will feel threatened by that. But I think the majority will see it as an opportunity to build their practice by winning confidence and trust.”

EDUCATION AND PREPARATION

Fuller suggests that, when change is happening so rapidly, education and preparation go hand in hand.

“The more you know about new developments the easier it will be to incorporate them into your business as they become available,” he says. “It’s also important to stay in touch with the government and private health insurers so you understand how new revenue models will likely evolve. When you’re on the front foot, you’ll be ready to take advantage of opportunities as they arise.”

Need help relating to profitable business models?

If you would like more information in relation to this article, please contact us for an introduction to Cameron Fuller.

Important information: While care has been taken in preparing this material, National Australia Bank Limited ABN 12 004 044 937 (NAB) does not warrant or represent that the information, recommendations, opinions or conclusions contained in this publication are accurate, reliable, complete or current. This publication does not purport to contain all relevant information and any statement as to any future matter is a present prediction of a possible future outcome, the accuracy of which cannot be guaranteed. Past performance is not a guide to future performance. In all cases, anyone proposing to rely on or use the information should independently verify and check the accuracy, completeness, reliability and suitability of the information and should obtain independent and specific advice from appropriate professionals or experts. The information is not intended as an offer or solicitation for the purchase or sale of any financial instrument or service. To the extent permissible by law, NAB shall not be liable for any errors, omissions, defects or misrepresentations in the information or for any loss or damage suffered by persons who use or rely on such information (including by reasons of negligence, negligent misstatement or otherwise). If any law prohibits the exclusion of such liability, NAB limits its liability to the re-supply of the information, provided that such limitation is permitted by law and is fair and reasonable. Publication of non-NAB related products or advertisements do not imply NAB endorsement of the products or services. NAB is not a registered tax agent. If you wish to rely on the general tax information contained in this document to determine your personal tax obligations, we recommend that you seek professional advice from a registered tax agent. © Copyright 2018 National Australia Bank Limited ABN 12 004 044 937. Article first published by NAB in June 2018 on Business Research and Insights.
Caroline Ucherek shares some tips on how to make 2018/19 a better year for your medical business.
TIP 1:
DATA CAPTURE

This is one of the simplest things we can do as a business – but surprisingly, very few medical businesses are doing it. If you can include this as one of your front desk’s key practices you will find yourself ahead of the game.

For all medical practices, clinics, hospitals, service providers, include a field of “How did you hear about us” in your new patient history forms.

If you have a medical website, include a downloadable item that requires a data capture field such as name and email address.

If you are a medical specialist, clinic or hospital, regularly review your referrer data through your practice management software. Be aware of who your top referrers are, who is increasing and who is dropping off.

Why is data capture important? Analysis of this data will provide you with valuable insights on how your clients found you and allow you to develop marketing strategies based on results.

Once you have the data captured, be sure to track it against different criteria including time periods and geography and correlate it back to different marketing activities, ie Google, AdWords, social media posts, newspaper article, education seminar; so you have a consistent easy to read record of new patient acquisition based against activities. This analysis will then help you to determine what activity is delivering results and where to spend your time and marketing money in the future.

TIP 2:
IMPLEMENT SURVEYS

Surveys can be a powerful tool and results are often very surprising. A well constructed survey can be used to dig deep into what your patient is actually experiencing at the coal face of your business and most importantly; can identify necessary changes.

Quantitative research is quite a science and data is easy to skew, so survey questions need to be well considered.

Survey questions should be balanced to highlight the negative and positive sections of your business. If the survey just tells you the negative things that can’t be changed it won’t be valuable to you. Carefully work through your survey questions to ensure you are able to use the results found as a basis to identify areas of strength, weaknesses and opportunity and implement any necessary changes.

TIP 3:
CONDUCT ONLINE AUDITS

There is so much information online now, but are you sure your online information is accurate?

Conduct an online audit on Yellow pages, White pages, True Local and other directory listings to check if your online details are correct. Check your practice details as well as each individual doctor’s details. Look for and check address, phone numbers, spelling errors.

What is being said about you online? Check Google+, Rate MD, Facebook and see if there are comments online. It might be time for you to consider a digital media program.

TIP 4:
REVIEW RECEPTION AREA AND STAFF

The very first face to face experience your patient has of you is your reception. Take the time to look at your reception area through their eyes and ask what impression are you creating?

There are some really basic things you can do to improve the look and feel of your reception.

De-clutter: Remove old torn magazines, pamphlet “forests”, hand written sticky taped signs. Replace with fresh new magazines, a specified pamphlet zone and make sure signs are professionally produced and hung.

What impression do your staff create? Do they need a name tag or a uniform refresh? Do they greet patients and smile? A smile is one of the most powerful tools in your practice sales force arsenal and can set a positive impression and experience before any clinical interaction. If your patient is treated well at your reception, it will help to ensure you experience a more relaxed consultation; that they will want to come back and will recommend your practice to their friends and family.
TIP 5: CONDUCT MYSTERY SHOPS
Mystery shops are one of the best ways to uncover the strengths and weaknesses of your practice. Ideally, they should be conducted in person, via phone and online every 6 months to benchmark results and improvements.

Mystery shops should look at uncovering:
- Call answer times in peak periods
- On-hold procedures
- Quality and correctness of information given
- Accessibility
- Caller/visitor experience

TIP 6: VALUE RELATIONSHIPS
Remember that strong relationships are the most important part of a service based business. What are you doing to strengthen your relationships with your patients and/or referrers? Implement some basic outreaches such as a practice newsletter to keep in touch and include clinical updates as well as some fun items to break down barriers.

TIP 7: MONTHLY REVIEWS
Monthly reviews of your practice will ensure you are keeping on track and achieving your goals. Look at your data capture, surveys, mystery shops, reviews and benchmark month to month against a checklist that highlights declines, status quo or improvement.

Understanding your business, your referrers and your patients will allow you to see your business improve and grow in 2018/19.

---

Marketing solutions for medical practices
If you’d like to discuss these marketing tips further, please contact us for an introduction to Caroline Ucherek.

---

Disclaimer: While this document is based on information from sources which are considered reliable, CJU Specialist Medical Marketing, its officers, employees, independent bloggers and consultants do not represent, warrant or guarantee, expressly or impliedly, that the information contained in this article or blog is complete or accurate. CJU Specialist Medical Marketing does not accept any responsibility to inform you of any matter that subsequently comes to its notice, which may affect any of the information contained in this document. To the extent permitted by law, CJU Specialist Medical Marketing excludes any liability, including any liability for negligence, for any loss, including indirect or consequential damages arising from or in relation to the use of any of the information on this website or associated pages.
Benefit from our 25 years of experience and the expertise that comes from being part of NAB Health.

Call Medfin on 1300 36 11 22 or visit medfin.com.au
Why drug reimbursement is about science, politics and art

Athena Kolivos, Head, Medical Affairs, Clinical Research Corporation (part of The IQ Group Global) discusses the three crucial factors to consider in supporting reimbursement and minimise the time it takes for PBS (Pharmaceutical Benefit Scheme) listing.

Drug reimbursement in Australia has become particularly challenging in recent years as an increasing number of high-cost yet innovative drug therapies face both health technology assessment as well as PBS budget hurdles.

Even when marketing approval is expedited for a particular biotechnology advance with high potential for patient outcomes, the road to reimbursement and patient access can be long and complicated with the intense focus on therapy value (improved outcomes relative to cost) and PBS (payer) affordability.

So, what can we do to support reimbursement and minimise the time it takes for PBS listing? At the Clinical Research Corporation, which specialises in medical and government affairs for the healthcare industry, here are three crucial factors we consider:

1) The science – have the evidence right first time to support clinical and economic claims

The clinical trial program ideally should include evidence needed to support both regulatory and reimbursement outcomes.

Yet this rarely happens with the focus instead on registration, i.e. approval to sell based on efficacy, safety and quality. Meanwhile, reimbursement (comparative effectiveness and safety, therapy value, budget impact) usually makes do with whatever evidence exists to show therapy value and support the ‘buy’.

However, if the data is insufficient to show therapy value, it will be difficult to support reimbursement. This means a therapy without a buyer and hence out of reach to patients who cannot afford to pay.

The more the evidence is lacking to support reimbursement, the greater the reliance on a more complex economic model built on alternative inputs and assumptions. This, in turn, increases uncertainty for the PBAC and government (payer) about the new drug’s effectiveness and value.

It’s crucial that a submission gets it right first time with studies containing clinical efficacy and other endpoints (e.g. quality of life, healthcare resource utilisation) and an economic model to show cost-effectiveness or therapy value in the intended patient population.

2) The politics – understand the healthcare environment

Reimbursement decisions are not made in a vacuum. While an evidence-based submission is pivotal to the funding decision, it is not all about the data.

The politics of reimbursement is very
Why drug reimbursement is about science, politics and art

If you would like more information about drug reimbursement in Australia, please contact us for an introduction to Athena Kolivos.

This article is published by Clinical Research Corporation Pty Ltd (ACN 167 749 233) (CRC) is a wholly owned subsidiary of iQnovate Ltd, a globally listed life science organisation and member of The iQ Group Global. CRC is an organisation that provides strategic medical affairs services to the pharmaceutical industry throughout the entire drug development life cycle, from preclinical to clinical through to registration, reimbursement and commercialisation.

Acknowledgement of original article when published
This article first appeared in the Australian Doctor Group online publication “Inside Healthcare” May 30, 2018.
Rheumatology is a journey, not a destination

Reflecting on 15 years as a Rheumatologist

Dr Irwin Lim is editor of Rheumatology Republic, an offshoot of The Medical Republic, and Practice Principal BJC Health.
Dr Irwin Lim took on a role as an editor for a publication called Rheumatology Republic, an offshoot of The Medical Republic. The inaugural issue of Rheumatology Republic launched at the start of June. Here, he reproduced the piece he wrote for it.

February 2004. That’s when I escaped the confines of hospital to set up private practice as a rheumatologist. There was a mixture of fear and excitement. I was unknown among potential referrers and unloved at that stage. I saw 2 or 3 patients that entire 1st week. My start was slow but it allowed time to learn a raft of skills to develop as a private practice rheumatologist.

Now, in my 15th year in practice, this publication gives me an excuse to reflect.

The following are a few personal observations, noting that I practise in a well-resourced, metropolitan environment.

**Hospital training just does not prepare you for private rheumatology practice**

Hospital-based rheumatology with sicker patients on the wards and under-resourced, busy outpatient clinics with excessive waiting lists did not ready me for the type of rheumatology I would see in private practice.

As those of you based in the community know, the people coming to private rooms are different, the expectations are different, the pathology presented is different.

Unfortunately, I am not aware of any sustained progress made in training our future rheumatologists in the private sector.

When freshly-minted rheumatologists join our practice, it’s very clear they need help adjusting to the new settings and the different types of problems they have to manage. It’s also very clear that most really have little experience in managing soft tissue rheumatism and the many problems caused by poor biomechanics and movement patterns. Few have the experience or tools to effectively deal with the regular presentations of chronic pain.

This of course matters. Especially when we are trying to care for people, aiming to help them understand their problems and finding ways to reduce the loss of productivity and the negative social impact of their rheumatic disease.

Surely, rheumatology training needs to be broadened.

In addition, my entire medical training did not include any teaching about small business. Given the vast majority of rheumatology is practiced out in the community in Australia, learning to run a viable, small business is vital for the rheumatologist’s peace of mind and efficiency. Fortunately, things have changed in this space. There are financial firms and private practice educators helping to bridge this knowledge gap.

**Private practice rheumatology can be invigorating**

As a registrar, I was told by senior colleagues how private practice can be isolating and over time, the drudgery of attending to patient complaints and problems day-in and day-out can be draining.

This can of course be managed, in some settings better than others.

The traditional model of rheumatology practice with one consultant, 1-2 consulting rooms, a little waiting room and 1-2 administrative staff may follow that script. However, there is a shift to a few consultants working together with all the benefits that brings. Gen X and Gen Y rheumatologists are unlikely to be working the same number of weekly sessions, so group practice makes sense.

I’m lucky enough to work in a collaborative group practice with enthusiastic rheumatology colleagues and many rheumatology-aligned allied health colleagues. We teach and we learn from each other. We hold educational meetings, run preceptorships, mentor, provide cover for each other and share.

**The scope of my practice has shrunk**

The longer I’ve been in rheumatology practice, the more general physician skills I’ve lost. For example, I have not prescribed an anti-hypertensive for blood pressure since I left hospital. This is generally the GP’s domain and I have avoided stepping on any toes. Working in a city practice, there are also lots of other specialists, all tending to look after their own part of the body.

The mix of patients I see is also more limited. I definitely don’t get to see acute vasculitis very often, or sick lupus patients with threatened internal organs. They get referred to the hospital. Phew!

I tend to see people my age or younger with spondyloarthritis and rheumatoid. Lately, there’s been a run of 2nd and 3rd opinions, which is harder work. Come to think of it, there’s also been quite a few diagnoses of fibromyalgia and chronic pain secondary to really poor biomechanics.

As I tend to blog about inflammatory arthritides and as I’ve been involved in a number of awareness initiatives, I’ve had the good fortune to engage in person and online with patients and rheumatology
colleagues on these issues. This increased exposure allows me to learn from people far more expert than I am. People living with these chronic diseases require regular follow-up and over the years, they’ve filled up a larger and larger percentage of my available appointments. I’ve completed my 10,000 hours in these areas and have some insight and expertise in the clinical management of these. And that’s good for the ego and my professional development.

Again, I’ve worked out that I don’t mind a limited scope of practice. I do enjoy thinking of ways to improve the experience and health journey for the people who consult me, both while they are in my consultation room, and increasingly, even in the time between in-room consultations.

**The rise of the Patient**

During my training, I would never have guessed that I would have utilised the internet for rheumatology practice. Twitter and Facebook didn’t even exist.

In 2010, I started to dabble with social media, starting a blog. Through this, I’ve been exposed to a range of patients’ comments. Some of this has been eye-opening and it has made me far more aware of what those who have chronic rheumatic disease experience: uncertainty, frustration, various side effects, misunderstanding, and also importantly, hope.

When we truly try to place the patient in the centre of what we are doing, rheumatologists can very much provide that hope. There are so many ways we can engage to improve awareness and to educate.

I’m not just talking about an on-line presence.

Many of you understand the need for thoughtful design of our consultations, our workplace, and the supports we build for those who need our care.

**As our treatments become more potent, rheumatologists need to raise their profile**

In 2004, a few months into my 1st year, PBS-subsidised biologic DMARD therapy became available for rheumatologists to prescribe. We now have access to an increasing armamentarium to treat inflammatory disease. You know there has been quite an explosion of knowledge and scientific trial data in the last two decades with more to come.

Rheumatologists have become more useful to their patients (at least a cohort of them), and it is imperative that our traditionally low profile improves.

If general practitioners and the general public don’t even know what a rheumatologist is, and what we can do, how will people with the rheumatic conditions we treat well, ever come in contact with us?

It’s great to keep highlighting the “window of opportunity”, but what measures are we taking to remove the range of blocks affecting this, such as:

- the time for a person in the community to attend a GP or an allied health professional (AHP),
- the flow of knowledge to help our GP and AHP colleagues recognise the potentially vague, early presentations,
- the pathway for GP and AHP colleagues to access rheumatologists in different parts of this country,
- the waiting times and costs to access rheumatologists?

There are not easy answers of course. I however think that raising the profile of rheumatology would point us in the right direction.

To date, I’ve not regretted the decision to be a rheumatologist. My professional career has been fulfilling and varied. I’ve had to learn a far broader set of life skills in developing the practice I want to work at. I’m still excited about our specialty and the difference rheumatologists can make, and hope to continue to harness this feeling to explore all the various things brewing and sprouting in my head. 😊
CJU Medical Marketing are leaders in providing a comprehensive range of marketing services and business development programs, designed to grow your medical business. We work across all sectors of the health care industry.

CJU Medical Marketing services include:

- Strategy Development
- Brand Consultation and Development
- Website Development
- Digital Marketing
- Medical Referral Services
- Integrated Marketing Campaigns
- Sales Training
- Marketing Consultation
- Social Media Marketing and Engagement
- Public Relations
- Creative Services
- Event Management
- Lean 6 Sigma

Enquire now about how we can help grow your medical business

1300 941 250 www.cju.net.au

Providing specialised medical marketing services Australia wide
A Winter Wonderland
The words ‘anxiety’ and ‘holiday’ should not belong in the same sentence.

Certainly it is incongruous that I should find myself, the self-proclaimed evangelist of family holidays, feeling rather anxious and filled with trepidation during the planning of, and leading up to our last vacation.

This lead-up to a holiday is usually characterised by excitement and anticipation of the mental, physical, social and emotional rejuvenation to come.

Not so, this time around, as we tried to wrap our heads around the prospect of -30 degree temperatures, 3 hours of sunlight per day and having to wrestle with 5-7 layers of clothing – which, when multiplied by four, would need a small shipping container to cart around.

Thankfully, our pre-holiday unease was also mixed with curiosity and wonder, for our destination promised a true adventure and an opportunity for incredibly concentrated bonding between my wife and I and twelve years old twins – a truly alluring, if not somewhat challenging experience.

We went to Lapland.

If you haven’t guessed already, I’m not a fan of cold weather, I could quite comfortably delete Winter from my life altogether, however following incessant pleading as well as environmental arguments from my daughter around the gradual disappearance of the Northern lights we took the leap, way over my comfort zone, and landed in a place of unexpected beauty and tranquility.

Specifically, we spent Christmas in the Finnish Lapland Arctic Resort of Kakslauttanen.

Yes, Arctic Resort – another two words that don’t belong together.

Just 250 kilometres from the Arctic Circle, a four-hour drive to the Arctic Ocean, this iconic family-run hotel is slap bang in the middle of pristine Arctic wilderness.

Have I made it clear we holidayed in the Arctic?!

What was special about this trip falls under three categories:

The soul soothing, harmonious concentration of exotic, pure, unadulterated nature.

This land is so mind-blowingly stunning that it feels like some virtual reality; from the mysteriously beautiful Northern Lights, to the gloriously scented fairy tale pine forest, to the crunchy under foot snow blanket surrounding us.

The water is so pure that you can drink straight from the gently flowing, bucolic streams, the atmosphere deafening in its silence, the air so fresh that you can feel its purifying qualities deep down in your lungs.

The experience is quite spiritual. I can’t help but feel embraced within a cathedral of nature.
A unique family bonding experience
Any decent amount of time on holiday with your family, particularly if it includes young kids, offers a great opportunity for busy professionals to re-connect with the most important people in their lives.

When you throw in log cabins, half hour snow treks to breakfast, lunch and dinner, reindeer and husky sled rides, ice fishing, tobogganing and cross-country skiing, all under an Aurora Borealis glow, you’ve got the makings of an unforgettable family adventure that I know we will reminisce over for the rest of our lives.

Life lessons in the importance of being daring and breaking with routine
Most of us fall into routine, we follow the familiar, the tried and tested. We know what we know and despite an inkling that there could be a better way, we go out of our way to not go out of our way and continue to do things the way we’ve always done them.

This goes for holidays as well as for our business lives, our financial lives and our lifestyle in general.

There can, however, be tremendous rewards from breaking out of our comfort zone, from taking calculated risks, for considering and trialling new models, for being curious and on a never-ending journey of improvement.

In the context of our Lapland family holiday, we did suffer (or at least I did) the ‘pain’ of change (-30 degrees is no picnic) but the discomfort we felt re-kindled my adventurous self and has made me reconsider lots of things in my life, not least of which is holiday destinations.

Whilst I still swear by my formula for optimal rejuvenation that includes liberal amounts of sun, bottomless cocktails, fine dining and mind-reading service surrounded by five-star architectural excellence, the Kakslauttanen experience has reminded me of the joys of raw nature and value of celebrating difference.

Next stop, India.
When people planning their retirement talk to us about managing their finances, their eyes light up when the conversation turns to travel. After years of hard work and family commitments, people want the freedom to jump on a plane and see the world, but the devil is in the finances. Will it be a tour of Paris and London or Geelong and Lithgow?

Australians’ favourite overseas holiday destinations

Because travel is such a priority for retirees, we wanted to find out more about the travel habits of Australians. So, we asked 2,700 people as part of Perpetual’s How Do You Feel project. By far the most popular travel destination was Asia, accounting for 47% of overseas holidays over the last 12 months.

Then we asked where people would go if they could choose anywhere in the world. The destination of choice was Europe at 35%, followed by North America at 13%. Asia dropped to 9%.

It’s little surprise that travel destinations are determined by budget – Australians would prefer to travel to Europe but choose Asia because it is less expensive.

In much the same way, the size of your nest egg in retirement will determine the stamps you have on your passport.

How healthy is your travel budget?

When people seek financial advice in preparation for their retirement, the conversation is often about protecting their wealth, rather than building it. The size of their retirement income has already been determined. People want advice on the best way to manage and access their money:

• How can I receive regular retirement income to meet my monthly living expenses?
• What about my superannuation – should I take it as a lump sum?
• I don’t want to use credit cards to pay for travel – how can I have access to cash for discretionary spending?
• Should I keep my self-managed super fund?
• Should I sell an investment property to fund my lifestyle?
Croissants or chicken parma?

We know the conversation shouldn’t stop there. Important considerations such as planning for rising health costs later in life and options to help your children financially, if overlooked, could mean the amount of discretionary spend you have for travel may be a lot less than anticipated. It can be a sobering conversation as people tend to overestimate their level of retirement income and underestimate how long the money will need to last.

Are we telling you to swap your plans for croissants in Paris with chicken parma in Patonga?

Quite the opposite, provided you seek financial advice sooner in life.

The best holidays are planned in advance

Let’s return to our research for some inspiration.

When we asked people what makes a great travel experience, 34% said researching where you’re going and 32% said planning in advance.

Now there’s an analogy for achieving financial freedom in retirement – early planning with a clear destination in mind.

Here are some of the reasons why an earlier conversation can help you generate more retirement pocket money for things like travel:

- **Superannuation** – Super is a tax effective way to fund your retirement but recently introduced caps make it harder to top up before you retire. You need to plan contributions over a longer period.

- **Growth** – You can take more investment risk for greater potential gain when you are younger because time is on your side – you can ride out periods of market volatility rather than being forced to sell your investments for retirement income.

- **Diversification** – Australian retirees can sometimes concentrate their investments in a single asset class – like the perennial favourite residential property. This increases risk because they are more exposed to a downturn in the property market – most of their eggs are in one basket. An experienced adviser can help people diversify – by investing in a broader range of areas. This could include shares in a variety of industry sectors both domestically and around the world.

You may delay, but time will not.

*Benjamin Franklin*

The right financial advice can be life changing. By seeking advice earlier in life, you will have more time to build your wealth and achieve financial freedom in retirement. That’s more pocket money for the finer things in life – like travel. 😊
UPDATE IN A NUTSHELL

Medical Billing
Winter 2018

Winter 2018 has brought a number of changes that doctors, and medical administrators need be aware of. As these changes are likely to directly or indirectly affect the entire industry, Loryn Einstein dives in with the update.

“CONTRACTED FACILITY” REINS TIGHTENED BY BUPA

Perhaps the largest recent shift on the health fund landscape has been the publication of the revised Bupa benefits commencing 1 August 2018.

In February, Bupa faced concerns voiced by industry bodies after announcing that their gap cover scheme would only pay benefits if patients were treated at a Bupa-contracted facility. In the first iteration of the change which is scheduled to take effect on 1 August 2018, Bupa also announced that private patients who are treated in a public hospital would not be covered by their Bupa Medical Gap Scheme as no public hospitals are Bupa-contracted facilities.

After fierce opposition to this plan, Bupa reviewed their proposed 1 August 2018 change to provider benefits which prevented patients admitted to public hospitals on an emergency or unplanned basis from accessing their Bupa Medical Gap Scheme.
As a large proportion of admissions to public hospitals are on an emergency basis, the debate on this particular issue continued until July.

After an information release to providers in mid-July, Bupa rolled out a further modified policy change which came into effect on 1 August 2018. The 1 August 2018 changes included:

- Bupa Scheme benefits were increased for most operation and anaesthetic items from 1 August 2018.
- The higher Scheme benefits apply to patients being treated in a Bupa Members First, Network or Fee agreement Hospital or Day Hospital.
- Bupa will only pay benefits up to 100% of the MBS Schedule fee for patients treated in facilities that do not have an agreement with Bupa (including registered Second Tier facilities).
- Bupa implemented a new **Public Hospital Medical Gap Scheme** starting 1 August 2018 which provides the following benefits to gap scheme providers:
  - When a patient is admitted on an emergency or unplanned basis, the Public Hospital Medical Gap Scheme applies on a **No Gap** basis only.
  - When a patient is admitted for a planned or pre-booked admission (defined as an admission where the Hospital performs an electronic eligibility check to Bupa at least 2 days prior to the admission), the Public Hospital Medical Gap Scheme allows for either a **No Gap** or **Known Gap** option for providers.
- To be eligible for **Known Gap** cover under the Public Hospital Medical Gap Scheme, doctors must be registered for the Public Hospital Known Gap Scheme.
- After 1 August 2018, Bupa requires that all Eclipse and Manual claims to include both the Facility ID and name of the facility of where the treatment took place. Failure to provide this information will result in rejection of your claim.
- From 1 August 2018, Bupa Scheme providers will no longer be able to opt out of being promoted to Bupa customers.

In Bupa’s 19 July 2018 emails and letters to providers, Bupa stated that it has automatically enrolled doctors in the Public Hospital Medical Gap Scheme based on their current enrolment in the existing Bupa Scheme (i.e. based on each doctors’ registration as either a No Gap or Known Gap provider under the current Bupa Scheme).

As of the third week of July 2018 Bupa has not published the new fee schedules, batch headers or an updated Medical Gap Scheme Practitioner’s Guide on their website. The list of Bupa Member’s First, Network and Fixed Fee facilities is available [online](#).

**What this means for your billing**

If Bupa commences this change on 1st August 2018 without further revisions, doctors working in day hospitals (many of which do not have a Bupa contract will experience a large reduction in their income. The Bupa benefit for these patients (including the Medicare contribution) will be 100% of schedule fee instead of the Bupa Medical Gap Scheme amount.

Recommended actions to take to ensure Bupa billing is in line with the new Schemes:

- Ensure that Bupa pricing in your software is updated on 1 August 2018
- Check the Bupa Hospital Listing to see if the facilities where you practice are to be billed at Scheme rates or at 100% of the MBS Schedule fee
- Check your current enrolment with Bupa and if needed, adjust your registration as a No Gap or a Known Gap provider
- Ensure that all Bupa billing after 1 August 2018 includes the Facility Id and the name of the facility where the service took place
- As all Scheme providers will be promoted on the Bupa website, check your details [HERE](#) and lodge a Change of Details form if any of the information needs updating
HBF CHANGES:
WHAT YOU NEED TO KNOW
West Australian based HBF and East Australian based HCF not-for-profit insurers have announced that their planned merger will not be proceeding. In a joint statement in early June 2018, HBF and HCF said that “it would not be in the best interests of our members to proceed”.

As HBF was seeking to position itself as a major competitor for Bupa and Medibank through its merger with HCF, it is likely that HBF will be seeking an alternative to the failed HCF merger.

In an unrelated move, HBF updated their Medical Gap Agreement on 1 July 2018. The updated agreement is available on their website at www.hbf.com.au/about-hbf/for-providers. The key change to the Medical Gap Agreement is regarding the HBF privacy collection policy regarding how HBF may use and disclose doctors’ personal information when they participate in the medical gap arrangement. This means that doctors’ correspondence and/or billing address may be disclosed.

Also noteworthy are a number of cuts to patient cover for some HBF policies that took effect on 1 July 2018. The HBF policies impacted where:

- Young Saver Hospital cover no longer covers obesity surgery, dialysis, insulin pumps, cochlear implants or sterilility reversal
- Mid Hospital cover no longer covers obesity surgery or dialysis and psychiatric care is only covered in public hospitals
- Young Singles Saver Twin Pack cover no longer covers obesity surgery, dialysis, insulin pumps, sterilility reversal or cochlear implants
- Smart Saver Twin Pack cover no longer covers obesity surgery, dialysis, insulin pumps or cochlear implants
- Mid Family Cover no longer covers dialysis and psychiatric care is only covered in public hospitals.

What this means for your billing
Whilst HBF and HCF have cancelled their merger, keep an eye on HBF as they seek to identify an alternative fund to merge with as this may result in future changes to benefits schedules or fund rules.

With increased policy restrictions which commenced on 1 July, review your HBF rejections carefully and encourage your patients to check if upcoming procedures are covered by their policy.
PRIVATE HEALTH INSURANCE REFORMS – GOLD/SILVER/BRONZE/ BASIC PRODUCT TIERS

The Turnbull government passed legislation in June 2018 requiring a four-tier health cover rollout by all health funds in 2019. To remain compliant, health funds will be restricted to offering a maximum of four levels of cover, marketed as ‘Gold, Silver, Bronze or Basic’. The minimum cover requirements in each category were finalised recently with the new product categorization taking effect from April 2019.

**What this means for your billing**

The new Hospital Treatment Product Tiers will simplify your administrative processes by providing an easy way to identify what treatments patient’s health fund cover includes.

**Hospital Treatment Product Tiers – Gold, Silver, Bronze and Basic**

<table>
<thead>
<tr>
<th>Hospital treatments by clinical category</th>
<th>Basic</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Hospital psychiatric services</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Palliative care</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Brain</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Eye</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Ear, nose and throat</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Tonsils, adenoids and grommets</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Bones, joint and muscle</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Joint reconstructions</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Kidney and bladder</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Male reproductive system</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Digestive system</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Hernia and appendix</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Gastrointestinal endoscopy</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Miscarriage and termination of pregnancy</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Chemotherapy, radiotherapy and immunotherapy for cancer</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Skin</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Breast surgery (medically necessary)</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Diabetes</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Heart, lung and vascular system</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Blood</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Back, neck and spine</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Plastic and reconstructive surgery (medically necessary)</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Dental surgery</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Podiatric surgery (provided by an accredited podiatric surgeon)</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Implantation of hearing devices</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Cataracts</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Joint replacements and spinal fusion</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Dialysis for chronic kidney disease</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Pregnancy, birth and miscarates</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Assisted reproductive services</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Weight loss surgery</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Insulin pumps</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>RCP</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
<td>✓✓✓✓</td>
</tr>
</tbody>
</table>
PRIVATE HEALTH INSURANCE REFORMS – OUT-OF-POCKET COSTS

In early 2018, the Minister for Health announced the establishment of a Ministerial Advisory Committee on Out-of-Pocket Costs. This Advisory Committee has been tasked with:

- Developing the best way to make information regarding out-of-pocket costs more transparent to consumers
- Identifying and resolving legislative and regulatory barriers to consumer transparency of out-of-pocket medical costs
- Implementation of best practice models

It is expected that the Committee will meet four times in 2017-18 and twice in 2018-19.

What this means for your billing

To date there are no noteworthy outcomes from the Committee. Information regarding the outcomes of the work performed by this Committee will be included in future articles when relevant information becomes available.

MEDICARE REBATES TO BE REDUCED FOR NON-VR DOCTORS

As part of the Stronger Rural Health Strategy announced in the 2018-19 Budget, a new Medicare fee structure will commence on 1 July 2018 for standard and non-standard attendances performed by medical practitioners who are not vocationally-recognised and who are new entrants to general practice after 1 July 2018. The resulting changes include:

- New medical practitioners providing services in a metropolitan area who are not vocationally-recognised will be paid at a rate that is 80% of the benefit for most equivalent GP items
- New medical practitioners providing services in a regional or remote area who are not vocationally-recognised will be paid at a rate that is 80% of the benefit for the equivalent GP items for all types of services
- Items for general consultations and attendances associated with PIP incentive payments performed by new non-VR medical practitioners in metropolitan areas will be paid the equivalent other medical practitioner (OMP) items for these services (Group A2 and A19 of the Medicare Benefits Schedule)
- Urgent after-hours items in Medicare Benefits Schedule Group A11 are not impacted by this change

The changes for currently practicing non-VR doctors will be phased in over the next five years. Medical practitioners currently participating in an OMP Program will be able to claim the higher specialist GP rates until 1 July 2023. Access to the OMP Programs will be closed to new applicants as of late 2018. The OMP programs impacted include:

- The Rural Other Medical Practitioners Program
- The Outer-Metropolitan Other Medical Practitioners Program
- The MedicarePlus for Other Medical Practitioners Program
- The After-Hours Other Medical Practitioners Program

A range of existing GP items were amended as at 1 July 2018 to restrict their use by new entrant non-VR practitioners. The items that were amended are: 160, 161, 163, 164, 170, 171, 172, 701, 703, 705, 707, 715, 721, 723, 729, 731, 732, 735, 739, 743, 747, 750, 758, 871, 872, 900, 903, 2125, 2138, 2179, 2220, 2700, 2701, 2712, 2713, 2715, 2717, 2721, 2723, 2725, 2727, and 4001.
First impressions last.  
8/10 new patients will visit your website before they visit you. What does your website say about you?

Easy to navigate
Drive patient bookings
Mobile and device responsive
Easy to access phone number or click to call
Visually appealing
Google friendly and relevant content

I want a complimentary web health check

Click Here  1300 84 84 38

*vividus

vividus.com.au/webaudit
As at 1 July 2018, a number of item numbers were added to the Medicare Benefits Schedule to reflect the changes in benefits for non-VR practitioners. The new items are all in Group A7 and are:
Subgroup 2: 179, 181, 183, 185, 187, 188, 189, 191, 202, 203, 206, 212
Subgroup 3: 214, 215, 218, 219, 220
Subgroup 4: 221, 222, 223
Subgroup 5: 224, 225, 226, 227, 228
Subgroup 6: 229, 230, 231, 232, 233, 235, 236, 237, 238, 239, 240, 243, 244
Subgroup 7: 245, 249
Subgroup 9: 272, 276, 277, 279, 281, 282, 283, 285, 286, 287
Subgroup 10: 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789
Subgroup 11: 792
Subgroup 12: 812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892

What this means for your billing
With these changes to benefits, GP's should ensure that they are listed as a “specialist” in general practice on the AHPRA register as this will now have an impact on their billing.

AND LAST BUT NOT LEAST... AN IMPORTANT UPDATE ON MEDICARE COMPLIANCE AUDITS

Many providers have received urgent action requests from Medicare over the last few months to justify initial items billed over the last few years. These audits have been caused by numerous billing errors including:
• Billing more than one initial consultation under the same referral
• Billing more than one initial consultation under and indefinite referral
• Billing more than one initial consultation for a single course of treatment
• Billing frequency of initial consultation for individual patients

If you are not clear on the rules surrounding initial versus subsequent consultations, it is critical that you update your knowledge immediately. The Government has budgeted a further $9.5 million to continue to improve Medicare compliance and debt recovery. Just because items that you billed in the past were paid to you does not mean that they were billed properly AND does not mean that the billing performed will not be audited and “clawed back” in future.

Keep an eye out for the next Medical Billing Experts article to make sure that you stay up to date with medical billing news and updates.

Stay on top of medical billing
Keep an eye out for the next Medical Billing Experts article to make sure that you stay up to date with new insurance regulations, medical billing news and updates, and if you have questions about your medical billing, contact us for an introduction to Loryn Einstein.

Medical Billing advice and services are provided by Medical Billing Experts Pty Ltd (ABN 58 135 003 002). This article has been prepared by Medical Billing Experts Pty Ltd and may contain information contributed by third parties. It contains general information only and is not intended to provide advice or take into account personal objectives or situations, practice objectives, practice situations or medical billing situations or scenarios. The information is believed to be accurate at the time of compilation and is provided by Medical Billing Experts in good faith. To the extent permitted by law, no liability is accepted for any loss or damage as a result of any reliance on this information.
EST 1911

DUTTON
Garage

“MAKE MINE RARE”

41 MADDEN GROVE
RICHMOND, 3121

+ 61 3 9419 8080

DUTTONGARAGE.COM
Understanding Negative Gearing

Simon Connolly is Manager, Strategic Advice at Perpetual Private.

Catherine Chivers – National Manager – Strategic Advice, Perpetual Private.
Let’s take a look at negative gearing, one of the most popular ways in which to leverage your investment portfolio through borrowing (a method in which you use other people’s money) to build your retirement savings.

**An introduction to gearing**

Gearing means borrowing to invest in an asset, such as property, shares or managed funds, to increase your investment exposure and accelerate your potential investment returns.

You can use two approaches to borrow to invest – recourse and non-recourse loans.

Recourse loans, usually used to buy investment properties, require you to pay back the full loan amount, even if there is still money owing after the property is sold.

A non-recourse loan, also called a margin loan, is often used to invest in shares or managed funds, the difference being that the amount at risk is limited only to the value of the shares acquired using the loan.

However, if the value of your share or managed fund portfolio falls, you may be required to put in further money, called a margin call, to ensure your non-recourse loan remains at the agreed Loan-to-Value ratio (The Loan-to-Value ratio is a financial term used by lenders to express the ratio of a loan to the value of an asset purchased. The term is commonly used to represent the ratio of the borrowings as a percentage of the total appraised value of the asset).

**What is negative gearing?**

The amount of income you earn from an investment, relative to the costs of investing, determines if it is positively geared or negatively geared.

A negatively geared investment is one where the income received from the investment is less than the costs of investing.

For an investment property, this means that the rental income is less than the costs associated with maintaining the property, such as loan interest, council and water rates, body corporate fees, insurance and repairs.

A portfolio of shares or managed funds is negatively geared when the dividend income or distributions received are less than the loan interest.

**What are the benefits of negative gearing?**

Using negative gearing to invest offers many long-term benefits, as it can help you to:

- **Build your wealth faster.** Negative gearing allows you to invest using a mix of your own money and borrowed money, giving you much larger investment exposure. This means you can potentially accelerate your investment returns, relative to investing only with your own money.

- **Diversify your portfolio.** Having more money to invest through borrowing gives you access to a wider choice of investments, which can help to broaden your investment portfolio and can make it less risky. Within property, you can select from residential, commercial and industrial sectors, while an investment in shares or managed funds allows you to spread your portfolio across many different countries, sectors and individual companies.

- **Build your wealth tax effectively.** Negative gearing can be a tax effective way to invest, especially if you’re in a high-income tax bracket. Being able to offset the ‘losses’ from your investment against your taxable income may allow you to reduce the overall tax that you pay, while also building wealth.

However, it’s not all about tax. For example, a negatively geared investment property only makes sense where there is the potential for sound capital gains over the long term. It’s also important to remember that your rental income could increase at a higher rate than your associated costs, which means the property may become neutrally or even positively geared over time.

**A tax effective strategy**

To calculate the tax benefit of negative gearing, you simply take the tax loss on your investment, and then multiply that by your marginal tax rate (plus Medicare levy). For example, if the deductible expenses on your investment property are $95,000pa and you receive rental income of $70,000pa, then the annual tax loss on your property is $25,000. If your taxable income is $250,000pa, the annual tax benefit that you would receive is $11,750pa ($25,000 x 47.0%)*.

*This is a simplistic scenario that may not capture all the complexities of a real-life gearing strategy. Personalised tax advice should always be sought before embarking on a gearing strategy.
What you need to consider before getting started

While negative gearing could help you to generate higher investment returns through borrowing, it’s not a free lunch.

Here are some questions that you should ask yourself before thinking about borrowing to invest:

- **Am I comfortable with the level of debt and risks involved?** Gearing can be an effective strategy when the assets acquired with the borrowed funds are increasing in value, because you are being exposed to greater gains.

However, the opposite is also true – you become exposed to larger losses when the assets fall in value. That’s why gearing may be considered a higher risk strategy. If you’re not comfortable with this risk or the level of debt required to gear an asset, you should think very carefully before proceeding.

- **What if there is a change in legislation?** There is a potential risk that legislation could change to limit the tax benefits associated with negative gearing. As we said earlier, it’s not all about tax, but it is always important to consider how legislative change could impact your investment strategy.

- **Do I have a long-term investment horizon?** With a negative gearing strategy, you’re essentially banking on future capital growth to generate an investment return, given your investment costs are higher than the income received.

This capital growth may take time to eventuate, perhaps five to seven years (or more!), and so this timing needs to be something to which you can commit. The ability to have a long-term investment outlook is a key aspect when considering if a gearing strategy is appropriate for you.

- **Will I have sufficient cashflow to maintain the investment?** All geared investments have ongoing costs that need to be met before you potentially receive any tax refund or capital growth. For shares or managed funds, this is the interest on your margin loan, while for an investment property, this is loan interest as well as maintenance costs, utilities and insurance.

While interest rates are currently at record lows, a long-term investment horizon also increases the likelihood of higher interest rates during your investment period. That’s why it’s important to ensure you can absorb increased costs over this time period.

You should also review your personal insurance to make sure any additional costs associated with your geared investment are covered, should you be unable to work for an extended period due to injury or illness.

Getting started with gearing

If you’re thinking about borrowing to invest to grow your wealth, one way to ‘dip your toe in’ is through an internally-geared managed fund.

All the borrowing is done within the fund, often at wholesale rates, which means you’re not personally responsible for any ongoing borrowing costs. This allows you to receive additional exposure for every dollar that you invest, relative to what you would have received using an ungeared fund.

While you won’t receive a personal tax deduction for investing into an internally-geared fund, they do offer an easy and relatively low-cost way for you to determine if building wealth through gearing is right for you.
As a health professional, your patients are your primary focus. They rely on your specialist knowledge to thrive and grow.

Building a streamlined, efficient medical business development plan also takes a special kind of expertise. It takes time to learn how to strategise, develop and grow your business effectively.

We can help.

Health Business Network designs agile business strategies and procedures for medical professionals who want to explore actionable options, understand potential pathways for development and achieve demonstrable growth.

We only work within the medical and health industries, so we know what’s needed to transform your business and propel it to the next stage.

Focus on your patients while we help build your business.

As a healthcare consulting company, we help you create measurable health business development and growth with bespoke, scalable and targeted strategies designed to:

• Give you more business clarity
• Create a practical, actionable plan for the future
• Streamline your business practices
• Support and manage your team to do their best work
• Take you to the next level

We’re facilitators, managers and problem solvers who believe the best medical business solutions start by understanding your business inside out and exactly where you want to be.

EMAIL: office@healthbusinessnetwork.com.au
WEB: Healthbusinessnetwork.com.au

Call us on 1300 998 770 to learn how we can support your business.
The never-ending complications of superannuation

Angela Stavropoulos and Kristy Baxter are Associate Directors and co-head the medical division at Pilot Partners Chartered Accountants.
Kristy Baxter and Angela Stavropoulos who co-head the medical division at Pilot Partners, demystify complicated superannuation topics that may impact on your super balance in the coming year.

Superannuation is always a complicated topic and one that many Australians avoid thinking about, until they are close to retirement. While you may not be knocking on the door of retirement, it is important that you understand and comply with the super changes in the near future to avoid unnecessary tax being paid or even a penalty imposed by the ATO.

As medical practitioners we understand that your time is limited so we have demystified some of the significant superannuation changes that occurred since 1 July 2018 which may impact on your super balance in the coming year.

$1.6 MILLION TRANSFER BALANCE CAP

One of the main outcomes of the reforms from 1 July 2018 was the introduction of a $1.6 million cap on the total amount of superannuation that a member can hold in retirement phase. Confused already? Let’s look at it simply.

Retirement phase is the period that you start to be paid an income stream or pension from your superannuation fund. This generally happens at the age of 65 years old. Prior to either the transition to retirement phase or retirement phase, we refer to the superannuation fund being an accumulation phase – when you and/or your employer are paying into superannuation and accumulating the balance rather than drawing out.

What the new laws do is limit the amount that you can transfer into retirement phase to support your income stream from super. This is now set to a limit of $1.6m.

In order to track the movement of amounts in and out of your retirement phase accounts, the Australian Tax Office (‘ATO’) has developed what is known as a Transfer Balance Account (‘TBA’). The balance of the member’s TBA determines the space available under the cap at any given time. TBAs must be maintained by the trustees of superannuation funds on behalf of each member receiving a retirement income stream.

Commencing from 1 July 2018, self-managed superannuation funds will be required to report events to the Australian Tax Office (‘ATO’) that impact a member’s TBA.

Reportable Events

The most common events that need to be reported (by the trustee) are:

- Where there is a pre-existing income stream in retirement phase just before 1 July 2017;
- Any new retirement income streams commencing on or after 1 July 2017; and
- Income stream commutations that occur (which is when you convert your income stream into a lump sum).

Other events that may need to be reported (by the fund members) include:

- Personal injury contributions that you make into superannuation arising from a structured settlement;
- Loss of super through fraud, dishonesty or void transactions under the Bankruptcy Act 1966;
- Payment splits upon divorce or relationship break down.

Funds in full accumulation phase are not required to report until at least one member commences an income stream in retirement.

Reporting Due Dates

To make sure you comply the TBA regime requires events to be reported more on a real time basis. This means that reporting is required, in some cases, as often as quarterly. The lodgement requirements will depend on:

- Whether a retirement income stream has commenced or been commuted; and
- The total balance of your superannuation accounts.
NON-CONCESSIONAL CONTRIBUTIONS

To add to the confusion, effective 1 July 2017, a second relevant cap changed that uses $1.6m as a threshold. This relates to the total balance you can have in your superannuation fund and the concessionally taxed contributions you can therefore make.

There are two types of contributions you may make into superannuation:

1. Concessional – these are the contributions that are made into your superfund before tax e.g. they are made by your employer from pre-tax salary or you are eligible to claim a tax deduction for the contribution. These are capped at a total of $25,000 each year and are taxed upon entering the superannuation fund at a rate of 15%.

2. Non-concessional – these are the contributions that are made into your superannuation fund from your after tax income, or as spouse contributions. The amount of contributions that can be made in this form is also capped each year and these contributions are tax free in the superfund.

From 1 July 2017, the amount of non-concessional contributions you can make into your superfund has reduced to $100,000 per annum from the previous amount of $180,000.

So where does the $1.6m amount come into the equation? Where your total superannuation balance is $1.6m or more, you cannot make non-concessional contributions without paying extra tax on them.

Your total superannuation balance is the total amount of super held in both retirement and accumulation accounts across all Australian super funds. So it is potentially easier to reach this $1.6m limit than the $1.6m limit on transfer balance accounts.

Further, the laws have changed to limit the ability to bring forward the non-concessional contributions cap into an earlier year. For example, previously you could put three years’ of non-concessional contributions into one year. Now, the ability to do this is limited by the total balance of your superannuation accounts.

For example, if your total superannuation balance at 30 June 2017 was between $1.5m and $1.6m you cannot bring forward any future year cap so that the maximum non-concessional contribution allowed in the 2018 year is $100,000. The ability to bring forward and increase your non-concessional contributions becomes more available with total superannuation balances below this amount.

OTHER NOTABLE SUPERANNUATION CHANGES

Now for some good news. From 1 July 2018, high-income employees with multiple employers will be able to opt-out of the Super Guarantee regime to avoid unintentionally breaching the $25,000 concessional contributions cap. This can be an issue because employers have an obligation to contribute to an employee’s superannuation up to a salary of $216,120 per annum at a rate of at least 9.5%. Above this salary an employer does not have to pay towards super. This would mean one employer would contribute $20,531 into super for that employee. Where an
Expert Outsourced Medical Billing

- User friendly billing app
- All billing fees 5% or lower
- Fees include expert collection
- All work performed in Australia
- No sign up fee, no contracts

Register now and watch your income grow!

1300 809 484

www.medbill.com.au
e-mail billing@medbill.com.au
employee has multiple employers who
each have the same obligation you can see
how the $25,000 limit on concessional
contributions can be breached.

The new laws means that instead of
receiving compulsory super contributions
from multiple employers, employees with
income exceeding $263,157 (which would
translate into $25,000 of superannuation
contributions at 9.5%), will be able
to apply to the ATO for an “employer
shortfall exemption certificate” which
prevents their employer from having a
superannuation guarantee shortfall if they
do not make superannuation contributions
for a period.

An employer covered by the exemption
certificate will not be required to contribute
into super for that employee for the quarter
to which the certificate relates.

The ATO can only issue a certificate
at the request of an employee (not the
employer) who would otherwise be likely
to exceed the concessional cap. The
employee must still have at least one other
employer liable to make superannuation
contributions on their behalf.

Although we have tried to demystify
the more recent changes made to
superannuation, these laws are very
complex we recommend all medicos to
seek advice on how they may apply to
their own situation and maximise their
superannuation accumulation.

Choose the best structure for your needs
If you would like to speak to an accountant, please contact us for an introduction to
Angela Stavropoulos or Kristy Baxter.

The information in this article is current as at 13 August 2018. It is general information
only and is not intended to provide you with financial product advice. The information
provided has been prepared without taking into account your objectives, financial
situation or needs. You should consider, with a financial adviser, whether the information
is suitable for your circumstances.
How much is your practice worth?

How much more can your business grow?

Is it worth selling?

Request a complimentary initial consultation, visit aldeacondulting.com.au
Using Referral Marketing Data for Sustained Practice Growth

Jason Borody, of Australia’s medical marketing specialists Vividus, talks about the benefits and opportunities of data-based referral marketing.

In today’s hyper-connected modern world, people have more options than ever before. Gone are the days where medical practices simply needed to put out an ‘open’ sign to attract a steady flow of patients.

Instead, we can find pretty much any information online. Deciding which clinic to visit is no longer simply a matter of geography - we’re spoilt for choice and can compare clinics with a quick Google search.

Without a comprehensive marketing strategy actively working to build referral relationships, retain client base, and stay ahead of the competition, it’s nearly impossible for private medical practices to maintain a healthy bottom line.
Physician referrals are the lifeblood of many medical practices, and (done right) can provide a steady supply of new patients and grow the business. Yet physicians often struggle with consistency and sustainability when it comes to growing referrals.

Quite often a measuring stick for whether referrals are growing is a slap-hazard spreadsheet and a gut feeling (or an empty waiting room). With a drop in referrals not only impacting immediate revenue but also cutting off potential to generate each patient’s lifetime value, managing a robust referral marketing strategy is essential for practices looking to thrive in Australia’s competitive medical landscape.

Medical marketing providers such as Vividus use a data-driven blend of systemisation, analysis, and refinement to make smarter decisions and help clinics stay ahead of the pack. Data analysis is the key to any successful marketing strategy, allowing physicians to continuously measure results and increase patient growth without the guess work.

As the saying goes, what can be measured, can be improved.

According to *Heinz Marketing*, when a marketing company manages a referral program (instead of in-house), companies are 3x more likely to achieve revenue goals. It’s certainly proven true for us – our referral strategy analysis allows us to:

- Identify referrer trends and opportunities to leverage better results.
- Compare historical data to identify events that may be factoring into lost business.
- Establish a baseline to measure performance against competitors.
- Visualise patient-to-service referral location flows.
- Determine which areas are underperforming and develop programmes to strengthen them.
- Make new discoveries about the business, referrers, and patients.
- Target high referring physicians and practices with an approach tailored to their professional objectives.

We use this and more insightful data analysis to develop marketing agendas that stimulate growth and solidify a competitive place in our clients’ local healthcare landscape.

The data can even be used to enrich a referrer-attraction strategy. Referring doctors are looking for providers they can trust – using data insights to show you understand their patients, and to demonstrate your dedication to providing a high quality of care, could tip the scales in your favour when it comes time for them to refer their patients to a specialised provider.

At the end of the day, a healthcare marketing strategy is an investment. It’s one that pays off when helping you build a scalable, predictable and repeatable growth machine for your business. Waiting to implement a marketing strategy until your existing patient list grows thin will leave your practice painfully unprepared for longevity. As doctors themselves say, prevention is better than cure!

So, let me leave you with a couple of questions. How are you currently tracking key growth indicators in your practice? More importantly, what are you doing about the insights you’re identifying?

**Marketing solutions for medical practices**

If you’d like to discuss the benefits and opportunities of data-based referral marketing further, please contact us for an introduction to Jason Borody.

This Medical Marketing article has been prepared by Vividus Pty Ltd (ABN 25086684884). The article may contain information from third parties and Vividus does not warrant the accuracy or completeness of such information. To the extent permitted by law, no liability is accepted for any loss or damage as a result of any reliance on this information. The information is believed to be accurate at the time of compilation and is provided in good faith.
Special Needs Healthcare Design

Natassja Wynhorst is Client Experience Executive of Interite Healthcare Interiors.
The mandate for a healthcare interiors firm should be to retain and promote design which is human focussed and enhances user outcomes.

This approach is implemented into the vision, strategy, design and construction of our healthcare projects in order to mindfully tailor the environment to best serve its inhabitants.

Design which is human focussed identifies users – including doctors, support staff, clients and caregivers - then creating solutions to build the space to suit their needs. To be successful, you need more than skill, qualifications and experience: you also need the facility to empathise for those you are designing for (Design Kit, 2018).

Successful Human Centred Design (HCD) imbues the physical environment with the ability to deeply resonate with the main users, developing the optimal level of patient engagement, client experience, and medical business growth (Thomsen, 2018).

SPECIAL NEEDS PATIENTS

There are a diverse range of patients from a wide demographic scope that may walk through the doors to your practices doors on a day to day basis. By adopting and promoted the Human Centred Design approach, you effectively cater for most patient needs.

One significant faction of society that may need more attention than most are your Special Needs clients and patients. The Special Needs population is extremely diverse, and a respectful environmental response is imperative. Personal safety, comfort, and the need for psychological relief and nurture are all enhanced. Not only so, the physical and mental alibility of this demographic to process the requirements of an examination or private consultation room may be comparatively reduced, and should therefore be accommodated respectively (ASDA, 2018).

THE CHALLENGES FOR DESIGNERS

There are various diagnosis’, signs, and behavioural aspects to be considered when designing a medical environment which facilitates warmth, acceptance and the often, heightened sense of security for Special Needs patients. Most importantly, designers must acknowledge and cater for a huge variety of users within what can be incorrectly labelled as a single demographic. Needs may vary across mental, emotional and physical disabilities and should be catered for individual, without being grouped within one stereotype.

Three major challenges associated with designing for those with Special Needs are a greater empathetic insight on the professional level, an inability to design for the person – as opposed to the disability – and the lack of input by those affected users, which can result in high frustration levels (Chew, 2013).

In order to overcome these complications, various strategies have been proposed to aid designers catering for the Special Needs population. By working with care and support groups who have tailored experience and perspective, designers can better understand the major needs and desires of their target audience. From this point, Special Needs patients themselves are “engaged as experts of their situations and [are] invited to collaborate closely with the designers,” (Chew, 2013).

Ultimately, this immersive strategy allows the designers to grasp a clear understanding of what the target audience wants, rather than just what they can not do. This prompts designers to successfully create varied solutions with highest applicability and a guaranteed positive impact (Chew, 2013). This approach is a great way of facilitating a further understanding of the main users of the facility and also incorporating future awareness and education among design and construction companies alike.

However, you should always consider if the practice is being created to specialise to a form of Special Needs, or whether there will be a variety of patient requirements. This delineation is required simply to focus design strategies for the most effective result.
DESIGNING FOR THE VISUALLY, AUDIBLY AND MOBILITY IMPAIRED

It is essential for those who are visually, audibly and physically impaired to be able to navigate through public environments with as much ease and efficiency as possible, and even more so within long-term healthcare facilities that ultimately may become their home.

Advances in modern technology have made it significantly easier for designers to create a human-centred environment which caters for those with hearing impairments, allowing them to feel comfortable within the physical environment.

Designers should consider aspects including acoustics, as echoes make it difficult for those who have hearing impairments to understand speech. Also, the implementation of heating and air-conditioning units and other forms of machinery can create loud and disrupting background noises, also making it difficult to understand speech. The use of high ceilings can amplify the tendencies of echoes, hardwood flooring can reverberate and interfere with communication, appropriate amounts of lighting should be implemented to create an ease for lip-reading and similarly, appropriate sight-lines are important for lip-reading (Invacare Interior Design, 2017).

Similar to those who have hearing impairments and those who are deaf, there are those who are visually impaired and those who are completely blind. The sensitivity to light, of those whom are visually impaired, makes the use of colours a crucial factor in directions and wayfinding. Although in the design world yellow is used sparingly, this colour works best for the visually impaired when incorporated in stairways, walkways and entrances as it assists in navigation (Mugo, 2016). For individuals who are blind, other senses offer welcome assistance. Therefore, designers should implement a smart use of sounds, smells and textures to assist the patients in gaining a “consciousness of the changing environment,” (Mugo, 2016).

For those whom are mobility impaired, it may be increasingly difficult to use stairs and open doors. Designers must consider the use of incorporating disabled parking spaces by the entrance of the facility to allow easy access. If the building is raised, incorporating ramps to the entrance is critical for easy access and functionality. Similarly, if the practice is in a multi-storey space or hub, there should be the implementation of elevators and lifts to the desired floor. The smart use of automatic sliding doors at the entrance and throughout the practice is essential, as many clients with mobility impairments may not be able to manage large, heavy doors.

DESIGNING FOR DOWN’S SYNDROME

When designing a medical facility for patients with Down’s Syndrome, an appropriate amount of storage facilities for specific objects and utensils should be utilised. This organisation is essential in order to avoid any tripping hazards and should be paired with the construction of a simple layout to create ease of locomotion. Appliances throughout the practice need to be safe and simple to use with the incorporation of automatic settings to turn off, and the use of coloured images to make tools easy to understand and master. Likewise, all door knobs are generally recommended to be replaced with handles for ease of use (Bell, 2015).
Always the first choice for medical indemnity insurance and protection for doctors

Comprehensive medical indemnity cover

Risk education - free with a premium discount on completion

24/7 emergency medico-legal advice and support

Personalised advice and claims support

Earn Qantas Points on your insurance payment to MIGA

Get a competitive quote on your insurance 1800 777 156 or www.miga.com.au

1 Insurance policies available through MIGA are underwritten by Medical Insurance Australia Pty Ltd (AFSL 255906). Membership services are provided by Medical Defence Association of South Australia Ltd. Before you make any decisions about any of our policies, please read our Product Disclosure Statement and Policy Wording and consider if it is appropriate for you. Call MIGA for a copy or visit our website at www.miga.com.au.

2 A business must be a Qantas Business Rewards Member and an individual must be a Qantas Frequent Flyer Member to earn Qantas Points with MIGA. Qantas Points are offered under the MIGA Terms and Conditions www.miga.com.au/qantas-tc. Qantas Business Rewards Members and Qantas Frequent Flyer Members will earn 1 Qantas Point for every eligible $1 spent (excluding GST) on payments to MIGA for Eligible Products. Eligible Products are Insurance for Doctors, Medical Indemnity Insurance Policy, Eligible Midwives in Private Practice Professional Indemnity Insurance Policy, Healthcare Companies: Professional Indemnity Insurance Policy. Eligible spend with MIGA is calculated on the total of the base premium and membership fee (where applicable) and after any government rebate, subsidies and risk management discount, excluding charges such as GST, Stamp Duty and ROCS. Qantas Points will be credited to the relevant Qantas account after receipt of payment for an Eligible Product and in any event within 30 days of payment by you. Any claims in relation to Qantas Points under this offer must be made directly to MIGA by calling National Free Call 1800 777 156 or emailing clientservices@miga.com.au. © MIGA November 2017.
DESIGNING FOR ATTENTION DEFICIT DISORDER

When designing a healthcare facility to cater to the needs of patients affected by Attention Deficit Hyperactivity Disorder (ADHD), it is important to take the colour palette into consideration. Colours have the ability to alter and effect our moods and the ambience of the environment, which is why it is important to choose the right colours for those who are affected on a greater scale. The use of soothing and muted colours assists in alleviating stress, where as bright and bold colour tend to create agitation and may become too distracting. The correct use of furnishings in the consultation, examination and waiting rooms are critical in order to help the patient remain focused and attentive; this includes the minimal use of distracting furnishings such as swivel chairs (Mcrae, 2017).

DESIGNING FOR PSYCHOSIS

For patients whom are diagnosed with psychosis, designing a safe and flexible environment is integral. Many components of the physical environment are designed to impart messages and meanings onto the users, which can result in triggering thoughts and actions. A design example of this is the use of artworks and imaging. There needs to be careful consideration when choosing what images to display in the medical environment as they may influence erratic and unpredictable behaviours. In addition, other sensory inputs can trigger effect, such as types of smell and sounds used.

Of course, there are numerous other forms and variations of Special Needs, and many different design aspects that need to be avoided, included, changed and considered in order to create the optimal healthcare facilities whilst maintaining safety, comfort, functionality and welcoming atmospheres.

The utilisation of a human-centered approach is an effective and fool-proof guide for designers, and design and construction companies alike should take it on board and educate themselves to form an understanding of exactly who they are designing for. The importance of having a clear and concise understanding of the main users of the facility cannot be stressed enough, as it not only has an impact on the client’s experience, but also your financial return.

It is becoming increasingly important to understand the specific needs of practices who see a high volume of, specialise in, or are long term homes for Special Needs patients. Designers should not be focused on what these individuals cannot do and tasks they cannot perform. Instead, they must understand what is needed in order to make the most out of the user’s experience, maintain safety and security, perform as functionally as possible and influence engagement.

When designing and constructing a practice and facility, it is always important to remember who you are designing it for.

Need help designing your healthcare practice?
For more information contact, please contact us for an introduction to Natassja Wynhorst.

Views, information or opinions expressed within this article are solely those of the author rather than the ‘individuals involved.’ This article does not necessarily represent the official policy or position of any other agency, organisation, employer or company and includes information obtained from third parties. These views are subject to change and revision.
No two people are the same, and financial advice shouldn’t be either. When you develop a relationship with Perpetual, there are no pre-determined plans. Your tailored strategy only comes after we fully understand you and your goals. It’s personal, collaborative, and anything but cookie cutter.

THE ONLY THINGS OFF THE SHELF ARE THE BISCUITS.
collectable
classic &
prestigious

John Varrasso, Dutton Garage.
John Varrasso, Dutton Garage talks of collectable, classic and exotic cars from Dutton Garage.

John has forged a successful career managing iconic brands such as Ferrari, Alfa Romeo, Jaguar and Volvo since the late 70s.

John, how has the classic car industry evolved from when you first started to present day?

With the development and growth of the internet, consumers are more informed especially about classic cars. Furthermore, word of mouth is still a massive factor in the equation. Today, I see more people worldwide wanting to buy and invest in the classic car market. I’ve also observed a substantial growth in the value of the modern and classic car markets in the last three years which has in some cases performed better than real estate.

Can you tell us about some of the collectable cars currently at Dutton Garage?

Yes, we’ve currently got a 1953 Lancia Aurelia B20- Series III, it’s one of the most collectible models in the Lancia stable. It has had a total nut and bolt restoration, which was done in 2007 by Historic & Vintage Restorations in Melbourne to Concours-standard. The car is also eligible for ‘Mille Miglia’.

We also have a highly sought-after Ferrari Enzo, which was the only Enzo to be delivered new into Qatar. It has stunning Rosso Corsa coachwork with Rosso leather interior, it’s an absolute highlight from the Ferrari Scuderia Stable.

Looking into the future, how do you see the luxury and classic car market changing?

I think it will keep growing and the demand for cars like the early Ferraris, Bugatti’s, Porsches and the McLaren F1s will be strong.

In 2015, John celebrated his 25th anniversary as part of the extended Dutton team. 🎉

Need help choosing the right luxury car?

If you would like more information about Dutton Garage, please contact us for an introduction to John Varrasso.

This publication has been prepared by JAMES LANE MOTORS AUSTRALIA PTY LTD ACN 615 833 040. The statements, views, or opinions expressed in this publication reflect the views of the author only. The material contained in this publication is of a general nature only, and does not take into account your circumstances, investment objectives or financial situation. It is not, nor is it intended to be, financial or legal advice. We recommend that you seek professional advice before taking any action in relation to the content of this publication.
Testing times
Let the doctor decide

Anthony Mennillo
MIGA Manager – Claims & Legal Services at MIGA looks at situations when a patient requests a test or investigation at the recommendation of a third party, such as a naturopath.

As a General Practitioner, you see a patient, conduct an examination, order an investigation, make a diagnosis and prescribe medication. Sounds straightforward, but as we know there are areas of vulnerability where something goes wrong and a patient suffers an adverse outcome.

What if we add another layer of complexity; where you have no involvement in the assessment of the individual and you are asked to order an investigation or prescribe treatment not knowing much about the test and/or treatment?

A further layer of complexity can be introduced if the requesting party is not a health practitioner and the information comes second hand via your patient.

Adding layers of complexity equates to increasing medico-legal risk and at MIGA, we have received enquiries from practitioners concerned about their medico-legal exposure in this increasingly common scenario.

In one particular example posed to MIGA, a patient consulted their general practitioner asking him to run a series of investigations at the request of a naturopath they had recently seen. Until that time the general practitioner was not aware the patient had been seeing a naturopath.

In another example a general practitioner who was no longer registered with the Medical Board of Australia intended to offer complimentary health services, such that they would continue to prescribe a variety of hormone treatments and ask other registered practitioners to order pathology tests and prescribe medication.

COMPETING CONSIDERATIONS

It may be tempting to please your patient and order a test or prescribe medication in these circumstances. Your patient probably believes the request is simple i.e. to order a test or secure a prescription for something that they have already agreed to with a third party. However, it is not so simple.

The Medical Board’s “Good Medical Practice, A Code of Conduct for Doctors in Australia” requires every medical practitioner to consider the benefit and harm to their patient in all clinical management decisions. That includes ordering tests and prescribing medications. Furthermore, medical practitioners are required to give priority to investigating and treating patients on the basis of “clinical need” and effectiveness of the proposed investigations or treatment.

It is difficult to give due consideration to these requirements when you know little about the investigation and/or treatment.
There is a potential imbalance between the patient’s request for what may be an uncontroversial issue in their mind with the doctor’s own concerns about the merit of the treatment proposed by a non-health practitioner.

Recently, the Royal Australian College of General Practitioners (RACGP) issued a statement recommending their members refuse patient test requests from naturopathic practitioners. While the RACGP recognised the harm, this may cause to the doctor/patient relationship, ordering inappropriate pathology or medical imaging carries significant medico-legal risk including litigation.

The RACGP’s position is consistent with the Medical Board’s Code of Conduct which requires general practitioners to only order medical imaging and pathology tests that are clinically indicated.

ACHIEVING THE RIGHT BALANCE
The patient’s wellbeing must be the primary consideration in determining whether to order a particular test or prescribe treatment. If there is any doubt in the practitioner’s mind we recommend that caution be exercised. It may be that a further discussion with the patient and/or the complimentary health provider may illicit further information that allows the practitioner to order a test or prescribe medication. It is for the practitioner to decide whether to have those discussions or not.

The Medical Board also respects the right of practitioners not to provide treatment in certain circumstances. The Code of Conduct requires practitioners to be aware of their right to “not provide or directly participate in treatments to which [they] consciously object, informing [their] patients and, if relevant colleagues of [their] objection and not using [the] objection to impede access to treatments that are legal.”

WHERE IT CAN GO WRONG
In the event of an adverse outcome it is not a defence to state that you simply ordered a test or prescribed medication at the request of a third party. It is your responsibility to assess the clinical need and if you are not satisfied that it is in the patient’s best interests to have the test carried out or treatment prescribed then you should not do so.

If a practitioner orders an investigation it is their legally recognised duty to take the necessary action based on the test result (including following up the patient if required). If the practitioner does not know the reason for the test and is unable to properly interpret the result this may lead to an error, an adverse outcome for a patient and adverse consequences for you.

Ordering a test which, in the practitioner’s mind, is not clinically relevant also has potential adverse implications if any Medicare benefits are paid for that test.

The RACGP has a number of resources available to assist practitioners to communicate with their patients and complimentary alternative medicine therapists on this sensitive topic which can be found HERE.
REFERRALS TO THE PUBLIC SYSTEM – ARE YOU RESPONSIBLE FOR THE DELAYS?

The public health system provides an extremely valuable service. Unless a medical emergency exists, there are unfortunately well known delays associated with receiving timely care.

For patients without private health insurance, the public health service is often the only alternative where specialist care or treatment is required.

Despite a prompt referral to the public system, a patient might still have to wait months or even years to be seen prior to being treated for a particular medical condition.

POTENTIAL LIABILITY

This is one of a number of unfortunate situations where the waiting list has delayed the possible effective management of the patient which may have adversely affected the outcome.

At first blush the general practitioner’s management seems entirely appropriate. The patient’s symptoms were adequately

---

Case study

A general practitioner consulted a 40-year-old patient in January 2013. The patient had recently returned from an overseas holiday with symptoms of nausea, vomiting, diarrhoea and cramping abdominal pain.

She attended hospital and was diagnosed with gastroenteritis and given opiate analgesia due to the severity of her pain. She subsequently attended her general practitioner at which time the vomiting and nausea had ceased but her frequent bowel actions persisted, although there was no blood or mucous in her stool.

The general practitioner referred her for a faecal occult blood test and also prescribed Buscopan. The general practitioner requested the patient return if her symptoms did not resolve for consideration of an upper GI ultrasound.

The patient returned two weeks later with persisting upper GI pain which was worse after eating. The patient’s diarrhoea had persisted, and the patient recently noted blood in the stools.

The general practitioner referred the patient for an abdominal ultrasound and asked her to return for review for consideration of a colonoscopy.

When the patient returned a few days later she reported the GI symptoms had improved and the upper abdominal ultrasound and the blood tests were normal.

The general practitioner performed a PR examination and noted a small tender external haemorrhoid but no bleeding.

The patient returned six weeks later with recurrent PR bleeding the previous week at which time the general practitioner decided that a referral for a colonoscopy was required.

The patient did not have private health insurance and was referred to the local public hospital at which time she was placed on the waiting list for a semi-urgent colonoscopy.

The general practitioner was aware that the waiting list for urgent colonoscopies was 14 months.

While the patient was still on the waiting list she presented to the local emergency department and was diagnosed with obstructive bowel cancer.
YOUR PATIENTS GET PERSONAL ATTENTION.
WHY SHOULDN’T YOUR BUSINESS?

KEY SERVICES FOR MEDICAL PROFESSIONALS:
- Cashflow and business planning
- Structuring
- Asset protection
- Tax effective advice
- Collaborative approach

To learn about how we can help your practice contact Kristy Baxter or Angela Stavropoulos on (07) 3023 1300 or taxmed@pilotpartners.com.au
investigated and followed up and a timely referral was made when the symptoms persisted.

There are at least three possible arguments at this point:
1. The general practitioner is not responsible for the delays in the public hospital system and their duty of care ended when the patient was referred for the colonoscopy.
2. There may be some exposure for the general practitioner in not adequately assessing the urgency of the case or to ask the patient to return if symptoms worsened and they had not been seen at the public hospital.
3. The general practitioner has an obligation to follow up the patient and their ongoing condition, form a view on urgency and discuss options with the patient.

As far as we are aware, there has been no court decision on this point which may provide some guidance on the legal responsibility for the general practitioner.

One of the factors a Court will consider in deciding on the extent of the duty of care is the reasonable foreseeability of harm occurring and the burden (financial or otherwise) on the defendant (the general practitioner in this case) to take steps to reduce the risk of harm.

**RISK MANAGEMENT TIPS**

In this case the general practitioner was aware of the long waiting time for a colonoscopy.

In our view the general practitioner’s duty of care would have been satisfied by:
- Advising the patient of the likely waiting time;
- Offering any alternatives available including private referral and likely costs;
- Asking the patient to monitor their symptoms and to return if symptoms worsen.

---

**General Practitioners Support**

Guidance such as that provided in this article is just one of the many ways MIGA helps its insured clients. MIGA offer superior cover complemented by expert medico-legal support that is available 24/7. If you’d like to discuss further, please **contact us** for an introduction to Anthony Mennillo.

Insurance policies available through MIGA are issued by Medical Insurance Australia Pty Ltd. MIGA has not taken into account your personal objectives or situation. Before you make any decisions about our policies, please read our Product Disclosure Statement and Policy Woring and consider your own needs. Call MIGA for a copy on 1800 777 156 or visit our website at www.miga.com.au. The information contained in this document is of a general nature only and does not purport to take into account or be relevant to your personal circumstances. This information is not intended to be nor should it be relied upon as a legal or any other type of professional advice.
At Interite Healthcare Interiors, we are committed to designing and building optimised spaces for the delivery of superior healthcare services, which in turn deliver improved patient outcomes.”

Winston Judd, Director
Keeping up with your Immunisations

Robin Jerome is the Founder & Managing Partner of ZEEP Medical
Robin Jerome, Founder & Managing Partner of ZEEP Medical, explores the reasons why not keeping up to date with your immunisations could end up costing more than your health.

Vaccinations; it’s a hot topic and often polarises those in favour and those against. Here in Australia, whilst there is a growing body of anti-vaccination groups, there is a general acceptance to have your children and yourself vaccinated. But ask most specialists for a complete list of their own vaccinations, expiry dates and boosters, and they would often have no idea.

As ZEEP Medical has become the leading supplier of locum and permanent doctors in the country, we have seen a significant change in the level of mandatory proof that the health districts require as well as an ever-increasing number of required vaccinations.

Working as a locum always has an amount of paperwork and compliance to complete. Traditionally, a statutory declaration stating you were up to date with your vaccinations was perfectly acceptable. But as litigation and bureaucracy increases across the public sector, the demands on a locum doctors’ personal serology has never been greater.

The typical list that most public hospitals now require prior to starting a locum includes:

- TB
- Varicella
- Mumps
- Measles
- Rubella
- Diphtheria
- Tetanus
- Pertussis (Whooping Cough)
- Hep A
- Hep B
- Current Season Flu

The TB vaccination is a perfect example. Many of us remember being immunised as a teenager, but we don’t necessarily have proof of it. Especially in a country like Australia where millions of us are born overseas with limited or no access to our childhood vaccination records. But it gets more complicated; NSW Health, for example, have compiled a list of 116 Countries where if you were born in one of these listed countries, then mandatory testing for TB is required. Never mind that you may have been living in Australia for 20 years and been in a permanent appointment for all that time, to locum you will now be required to have a Mantoux Test or a QuantiFERON Gold Blood test.

Now I am very much in the pro-vaccination camp and think it essential that all staff working in our hospitals are vaccinated. The challenge is combining this with daily practicality and respecting personal beliefs. Think of those who have severe allergic reactions to a basic flu jab.

It’s not uncommon that we will have an urgent request for a doctor to start the very next day or week. They are available, fully credentialed but then discover that Hep A serology is required, a change from only last month when they did a locum, or perhaps a change as the hospital or health service have their own bespoke requirements.

The unfortunate outcome is that locum bookings can be cancelled as the doctor just doesn’t have the serology, especially as it has never been requested before. A 2-week locum paying $2.5K a day pays $35,000. Not having the results of that blood test can be an expensive omission.

The good news is that a simple blood test can check for almost all required immunisations. So, my advice to all doctors is to maintain a full, complete and up to date set of immunisation and serology records. You never know when you may decide to take on a locum job, earn some extra money and see some amazing parts of the country. Don’t let good record keeping be the reason to dictate your destiny.

Medical Professionals Recruitment

If you would like to know more about this theme, or locum or permanent placement and recruitment, contact us and we will connect you with Zeep medical.

Disclaimer: Robin Jerome of ZEEP Medical Pty Ltd ABN 17 618 244 956. All views expressed in this article are the opinions of the author. Information in this article is current as of July 2018.
What is it and how can it help adults with impaired capacity

“QCAT”

Prue Poole, Principal at McInnes Wilson Lawyers
Prue Poole, Principal at McInnes Wilson Lawyers outlines “QCAT” and how it can help those who have impaired capacity.

Some people will have heard of “QCAT” but not many really know or understand what it does and how it can help support adults who have impaired capacity or those who may be concerned for the welfare of those with impaired capacity.

People may know that it’s a Tribunal not a Court and that it can resolve lots of disputes, but this only touches on its many functions.

Having a proper understanding of:
- the functions of QCAT;
- what its powers are; and
- how you can refer a matter there can really assist any professional who regularly sees or supports the elderly or other members of society who may now or in the future suffer from impaired mental capacity.

In this article, we highlight the above issues to try and broaden your general knowledge of this useful government entity.

1. WHAT IS QCAT?
“QCAT” stands for the Queensland Civil and Administrative Tribunal (QCAT). There is a similar entity in each Australian jurisdiction.

QCAT is an independent accessible tribunal that resolves disputes on a range of matters. Its purpose is to provide a quick, inexpensive avenue to resolve disputes between parties and make decisions.

QCAT has exclusive jurisdiction for the appointment of guardians and administrators for adults who lack capacity.

It is important to remember that at law every person is presumed to be able to make their own decisions. Before QCAT can exercise any of its functions (referred to below), it needs to be satisfied that:
- The adult has impaired decision-making capacity;
- There is a need for a decision; and
- A decision maker is needed to ensure that the adult’s needs are met, and their interests are protected.

Other areas in which QCAT has jurisdiction include anti-discrimination, building disputes, consumer disputes, minor civil disputes, retail shop leasing and residential tenancy disputes. These matters are outside the scope of this article however more information can be found on the QCAT website.

2. WHAT ARE THE FUNCTIONS OF QCAT?
QCAT’s functions within the jurisdiction of administration and guardianship for adults who lack capacity include:
- Making declarations about an adult’s decision-making capacity for some or all matters;
- Appointing guardians and/or administrators;
- Reviewing the appointment of guardians and/or administrators, including suspending the appointment where necessary;
- Considering applications for a declaration, order, direction, recommendation or advice in relation to the Guardianship and Administration Act 2000 (Qld) (Act) or the Powers of Attorney Act 1998 (Qld); and
- Ratifying an exercise of power or approving a proposed exercise of a power.

If the jurisdictional questions referred to above are satisfied, then QCAT may appoint an “Administrator” to make financial decisions for a person with impaired capacity, and/or a “Guardian” to make personal/health decisions for the subject person. These concepts are explained further below.

In practical terms, there are two common scenarios in which it may be necessary to apply to QCAT for the appointment or alteration of substitute decision makers for an adult with impaired capacity.

These are:
- where a person has not appointed their own substitute decision makers by putting in place an enduring power of attorney (EPA) and they subsequently lose capacity to do so; and
- where a person has put in place an EPA but since losing capacity, those arrangements become inappropriate and the adult, due to the lack of capacity, cannot update or amend their EPA to put in place more appropriate arrangements.
3. WHO CAN APPLY TO QCAT?
Any ‘interested person’ can apply to QCAT for an administration and/or guardianship order which will appoint a substitute decision maker for the adult. The adult themselves can even apply.

An ‘interested person’ is someone who has a sufficient and continuing interest in the other person.

Where there are no close family or friends, a service provider with a genuine and continuing interest in the welfare of the adult with impaired capacity would satisfy the ‘interested person’ test.

There could be circumstances where a medical professional may be the appropriate person to make an application to QCAT or at least suggest to family members that this occur. Therefore, being aware of QCAT and how it can assist is another avenue by which professionals can help support persons with declining capacity.

4. WHO IS AN ADMINISTRATOR?
Administrator’s make decisions about an adult’s ‘financial matters’. An administrator appointed by QCAT is similar to an attorney appointed for financial matters under an EPA.

Financial matters which an administrator appointed by QCAT may be involved in include:
- managing bank accounts and investments;
- paying expenses;
- recovering debts;
- entering into or completing contracts; and/or
- legal matters relating to the adult’s financial or property matters.

An individual (often a family member) may be appointed as an administrator. However, they must be:
- at least 18 years old;
- not a paid carer or healthcare provider for the adult;
- not bankrupt or taking advantage of the laws of bankruptcy as a debtor (in any jurisdiction); and
- Must be appropriate having regard to the appropriateness considerations set out in the Act.

If there is not an appropriate individual to appoint as administrator, then the Public Trustee of Queensland or a private trustee company may be appointed in this capacity.

5. WHO IS A GUARDIAN?
Guardian’s make decisions about ‘personal matters’. They are similar in function to an attorney appointed for health and personal matters under an EPA. However, a guardian formally appointed by QCAT is accountable to QCAT for their decisions and actions.

Personal matters which a guardian may undertake for an adult with impaired capacity include:
- Care;
- Healthcare;
- Welfare;
- Where they live;
- Who they live with; and/or
- Day to day decisions such as dress and diet.

A guardian cannot make financial decisions unless they are also appointed as the administrator. They also cannot make decisions about “special health care or personal matters” which include sterilisation, tissue donation, making a will, marriage or adoption.

An individual (again often a family member) may be appointed as a guardian. However, they must be:
- At least 18 years old; and
- Appropriate having regard to the appropriateness considerations in the Act.

If there is no one else appropriate to be appointed, the Office of the Public Guardian may be appointed.

6. THE GENERAL PRINCIPLES FOR ADMINISTRATORS AND GUARDIANS TO FOLLOW
The Guardianship and Administration Act 2000 (Qld) and the Power of Attorney Act 1998 (Qld) (the legislation) seek to balance the rights of an adult to maintain an independent role in decision-making with their right to adequate and appropriate decision-making support.

To achieve this balance, administrators are required to apply the stated general
principles. These include:
(a) presumption of capacity;
(b) human rights: regardless of
decision-making capacity,
decision-makers must recognise
the importance of encouraging
the adult to exercise their
rights and that everyone has
the same basic rights;
(c) individual value: each person
is valued as an individual
and their human worth and
dignity is respected;
(d) valued social role: an adult’s right
to be a valued member of society
is recognised, as is the importance
of encouraging and supporting
them in social roles such as home
owner, bank customer, investor,
shopper, worker or volunteer;
(e) participation in community life:
the adult should be encouraged and
supported to live life in the general
community and to take part in
general community activities;
(f) encouraging self-reliance: to
achieve the adult’s maximum
physical, social, emotional and
intellectual potential and to
become as self-reliant as possible;
(g) least restrictive option: anyone
performing a function or exercising
a power under the legislation must
apply the least restrictive option
that is consistent with the adult’s
proper care and protection.
(h) maintenance of existing supportive
relationships: decision-makers
must recognise the importance of
maintaining the adult’s existing
supportive relationships;
(i) maintenance of environment and
values: decision-makers must
recognise the importance of
maintaining the adult’s cultural
and linguistic environment
including any religious beliefs
and lifestyle choices;
(j) appropriate assistance: the
assistance given to the adult
in a particular situation must
meet their current needs and
be adapted to their individual
characteristics; and
(k) confidentiality: decision-
makers must recognise the
adult’s right to confidentiality
about personal information.

Guardians also have detailed
Health Care Principles which they must
observe. In summary and echoing
those above for administrators,
guardians need to exercise their powers
in a way that is least restrictive to the
adult’s rights, appropriate to maintain
or promote the adult’s best interests
and in all the circumstances be in the
adult’s best interests.

7. WHY THIS INFORMATION
IS SO IMPORTANT
Unfortunately, in society the
mistreatment (sometimes even
unintentionally) of those with
impaired capacity appears to be
increasing. It is important to care for
those who cannot care for themselves.
QCAT is a forum within which
adults with impaired capacity can be
supported and if necessary protected
from such mistreatment.

Medical practitioners are often
at the forefront of seeing the decline
of a patient or even witnessing
mistreatment or declining care of the
vulnerable. It may of assistance to
such persons for you to be able to have
a sensible discussion either with the
patient or family member about what
function QCAT can fulfil.

The above information confirms
that a medical practitioner can be
an appropriate person to bring
an important matter to QCAT’s
attention so that appropriate
measures can be put in place. It is
important to understand further the
responsibility and obligations placed
on administrators or guardians. This
understanding may indicate if those
standards are not being met and
whether a vulnerable person may
be at risk.

Need help understanding the role of a medical practitioner and QCAT?
If you would like more information about “QCAT” and how it can benefit you, please contact us for an introduction
to Prue Poole.

DISCLAIMER: McInnes Wilson Lawyers Pty Ltd ABN 30 137 213 015 | The information provided in this article is of a general
nature and does not take into account individual objectives, legal and financial situation or need.
This article is intended to provide general information only. It is not intended to be formal advice and should not be relied
upon as such. Formal advice should be sought for any circumstances pertaining to the reader of this disclaimer. The author
disclaims liability for any loss incurred by any person who acts in reliance upon the information contained in this article.
Should the contents of this article be posted on any other publication then the reader of this disclaimer acknowledges
that the author has no control over its nature, content and accuracy Any references to the author do not imply a
recommendation or endorsement of the views in those other publications.
It’s been a tirade of emotional pain points for property investors who have been reading articles on the market in mainstream media lately.

Words like “avalanche”, “plunge” and “brutal” have been used to describe the falling trajectory of property prices and the related credit that banks have sought to strip from buyers at an alarming rate.

Fortunately, the media has suggested that households “avoid panicking”, which is like telling someone who is afraid of heights not to look down.

Some independent financial sources have even been quoted as saying that sales values are down one-third on a year ago and more than 50% lower than 18 months. Quotes like this are enough to set off talk-back radio like a bush fire on a hot dry day.

Of course, the ‘significant correction’ that they were referring to the total average value of the real estate sales market as a whole – a figure that could easily be taken out of context by regular readers who haven’t understood the data.

Still, there has been some semblance of sanity coming from an actual research company.

Core Logic released two important articles last week.

The first shows the annual change in median values for 3 price groups – the top 10% (10th), the median, and the bottom 10% (1st).
This is an invaluable graph for investors as it shows a real story.

In the previous Sydney boom from 1998 to 2003, the cheapest properties (blue line) showed the greatest gains. Since then they’ve generally shown the lowest level of losses. Core Logic made mention that the surge in first home buyers through stamp duty concessions has seen a floor kept under housing demand at the cheaper end.

By many accounts this graph would suggest that if you wanted to preserve your capital in the property markets, the cheaper end of town is actually the best place to be.

What’s equally interesting though is the top end of town (grey line) seems to be the most volatile – that is, when times are good they show the greatest growth, but when things are bad they are the worst performers.

While some mainstream media outlets are suggesting that the property market is struggling, research conducted by Core Logic’s indicates that the $3 million to $5 million housing market is the most vulnerable. Reading these charts, it’s clear that what is happening shouldn’t come as a surprise. The top end of town is suffering but they’ve also seen some of the greatest peaks – it’s par for the course.

The second lot of information that came from Core Logic is far more insightful for investors looking to keep an eye on the bigger picture. Again, I’m going to use the example of Sydney to keep things consistent and because the Sydney market is so large it often drives a lot of the commentary.

The following chart spans 38 years and tracks the declines of the market from their previous peaks. In other words, it shows all the periods in which Sydney prices generally fell.

You can see one of worst periods in property was in 1988 to 1991, where the markets fell 11.6% over a single period (Australia’s last recession).

Looking at Sydney’s latest decline (black line), the market is showing a loss of 4.5%. This data is always 3 months old though and no one is seeing any turnaround in auction clearance rates at the moment, so we would expect the data to reflect another one or two percentage points decline to bring it up to speed.

Why I love this chart though is because it shows the periods over the last 38 years of the market actually bottoming out before it starts to gain ground again.

Looking at where the market has historically started to recover once these periods finish provides us with a good gauge as to what to expect moving forward, and potentially where we will see prices starting to improve.
So rather than getting caught up in the emotional ups and downs that drive many of today’s headlines, let’s put things in perspective. Yes, lending restrictions mean tougher credit conditions, and oversupply and affordability are influencing factors in key markets. Household debt is also at record levels and wage growth is minimal. But this is Australia’s 27th recession-free year. Unemployment is around 5.5% but nowhere near the 10.7% we tackled back in 1992. Inflation has sat stubbornly under 2% but is certainly not out of control. Interest rates are at record lows and for the last couple of years borrowers have been assessed at rates nearing 7% to protect against eventual rate rises. And finally, the last time property markets dropped more than 10% in a single period of time was nearly 30 years ago during a recession. Next to that, things have remained remarkably resilient. There’s never been a perfect time to buy. There’s always economic or market issues both here and overseas that could change things at any moment. Despite this though, savvy investors will continue to make money by keeping things in perspective and taking action when the opportunity presents itself.

Need help choosing the right property?
Property can be a lucrative investment, however researching the market and buying the right property can take time. This is where an expert property consultant can help. If you would like assistance with choosing and buying the right property, please contact us for an introduction to Josh Masters.

Past performance is no indication of future performance. Any information contained within this article should not be relied upon as investment or financial advice. Before acting on any information please speak with a qualified investment adviser, accountant and solicitor. To the extent permitted by law, BuySide Pty Ltd and its associates will not be liable for any costs, loss or damage arising in any way from the information contained within this article.
WE’RE SPECIALISTS TOO

Providing personal solutions to healthcare professionals and their practices, as no two are the same.

Family Law | Wills & Estates | Tax & Superannuation | Property | Asset Protection | Practice Structuring | Business Succession | Private Insurance Claims

www.mcw.com.au | 07 3231 0600 | mcw@mcw.com.au
Here are some of the results we’ve had sourcing property investments for our clients.

Call us now to see how we can get the same results for you.

1300 87 99 03

Please remember that past performance may not be indicative of future results. Different types of investments involve varying degrees of risk, and there can be no assurance that the future performance of any specific investment, strategy, or product made reference to directly or indirectly in this brochure, will be profitable, equal any corresponding indicated historical performance levels, or be suitable for your portfolio. Due to various factors, including changing market conditions, the content may no longer be reflective of current opinions or positions. Moreover, you should not assume that any discussion or information contained in this brochure serves as the receipt of, or as a substitute for, personalized investment advice from BuySide. To the extent that a reader has any questions regarding the applicability of any specific issue discussed above to his/her individual situation, he/she is encouraged to consult with the professional advisor of his/her choosing.