THE GIFT OF GIVING
How to establish a charitable foundation

GOOGLE GLASS
Wearable technology to change the face of medicine

YOUR PEOPLE
The right staff will save time, money and energy

RISE OF THE DOCTORPRENEUR
Medicine + business can change the world
CONTENTS

Click on titles to go directly to each article

4  The Editor’s Welcome
6  Upcoming Courses & Workshops
8  The Private Practice Events
12  Economics & Markets
   Chris Caton’s take on the economy
14  Accountancy
   Acquiring property within super
16  Medical Defence
   Mitigating a range of risks
20  Estate Planning
   An overview of philanthropic options
24  Finance Product
   A credit card with medical benefits
26  Medical Billing
   Getting to grips with Telehealth
32  Technology
   A close look at Google Glass
34  Design
   Five steps to renovation success
38  Insurance
   Trauma insurance and your options
42  Staff
   The importance of good hiring
48  Property
   Key considerations for investors
53  Succession Planning
   Selling your practice at the right price
54  Technology
   Big Data and the healthcare sector
60  Marketing
   Getting down to website specifics
64  Protection
   Who owns your cyber assets?
66  Wining & Dining
   Putting the spotlight on Bar H
70  Property
   How to avoid investment headaches
72  Wellbeing
   The power of the placebo effect

Cover image: Dr Sam Prince, Chairman and Founder of One Disease at a Time.

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Thank you to our growing community of medical colleges, societies and associations, course and workshop delegates, magazine and newsletter subscribers, and Facebook friends. Your overwhelming support galvanises our resolve to do everything in our power to help make healthcare-centric education in business, financial and lifestyle management easily accessible across the Australian healthcare community.

Really, we’re all about awakening the business person – or dare I say, entrepreneur – within. Apart from making your life (and the lives of your family and co-workers) easier, running your practice and financial life like a ‘well-oiled machine’ will help you to become the best doctor or healthcare provider you can be – multiplying exponentially the ‘good’ you signed up for.

I repeat this over and over at our education events. While it’s true to say that, by and large, most healthcare professionals are pretty hopeless at running a business and managing their money, some of the world’s finest entrepreneurs have come from medicine, for instance:

• **Dr Amy Lehman** is the founder of Lake Tanganyika Floating Health Clinic, an international organisation whose mission is to address the problem of healthcare access and education for isolated communities in the Lake Tanganyika basin/Great Lakes region of Central Africa.

  In her role, Amy has become knowledgeable in multiple ancillary fields, including water security, food security, environmental conservation, rural development, mineral rights and mining issues, Great Lakes global security issues and the rural digital divide.

• **Matt Jameson Evans** is a British doctor and the co-founder of HealthUnlocked.com. His background is in Orthopaedic surgery and medical politics. He trained in London at Guy’s, Kings College and St Thomas’ hospitals, and at the Royal National Orthopaedic Hospital. In 2006 he co-founded Remedy UK, a pressure group representing junior doctors, and quickly generated a following of 15,000 British doctors, lobbying medical issues in the Houses of Parliament and throughout the United Kingdom’s mainstream media.

  In 2008 Dr Evans co-founded HealthUnlocked with business partner Jorge Armanet. This health technology company partners with patient organisations, healthcare providers and industry. It uses online tools to support patients and healthcare providers, and generates real world data regarding the effectiveness of clinical services and treatments.

• **Thom Van Every** trained at the University of Birmingham Medical School and graduated in 1995. He worked as a junior doctor in London, Jersey and Cape Town before specialising in Obstetrics and Gynaecology. He was awarded his MRCOG in 2000 and then left full-time clinical medicine to study an MBA at London Business School. After receiving his MBA he worked for Deloitte Consulting before setting up DrThom.com and co-founding PatientChoice, a private medical insurance company.
Dr Thom was purchased by the national pharmacy chain Lloydspharmacy in 2011, where Thom is now Medical Director, with responsibility for its online doctor service, www.lloydspharmacy.com/doctor. PatientChoice was sold to Westfield Health the same year. Thom also sits on the healthcare panel of several venture-capital companies. He remains very interested in disruptive innovations that improve the delivery of healthcare.

- **Dr Alexander Finlayson** is Head of Research at London’s King’s Centre for Global Health, Deputy Director of the INDOX research network at Oxford University and CEO of MedicineAfrica Ltd. He has previously held positions as a researcher with Dr Bryan McIver at The Mayo Clinic, a Kennedy Scholar in systems biology and genetics at Harvard University and an Academic Clinical Fellow in Cancer Medicine at Oxford University.

  MedicineAfrica is an attempt to address the mismatch between the global burden of disease and the global clustering of healthcare expertise. It provides real-time mentoring, tutoring and clinical support to isolated healthcare workers in low and middle-income countries, specifically Somaliland, Ghana, Palestine and Tanzania, with Rwanda, Uganda, Sierra Leone, Zambia and Zimbabwe soon to be included.

- **Dr Sam Prince** is a shining example of the Doctorpreneur on our own shores. By applying business rigour to development and healthcare, the 27-year old entrepreneur, medical doctor and philanthropist intends to advance education and eradicate disease across the globe.

  Dr Prince established Zambrero, a Mexican grill franchise, at the age of 21, while studying medicine. He has since grown Zambrero to over 15 outlets across the country, and counting. In 2010, the business, which employs 170 staff and brings in over $10 million in revenue, was recognised by Business Review Weekly as the fastest-growing franchise in Australia.

  Paying homage to his parents’ modest origins in rural Sri Lanka, Sam has set his will towards democratising healthcare and education for young people, in Australia and across the globe. Off the success of his rapidly expanding Zambrero group, Sam created the Emagine Foundation in 2007. To date the foundation has built and equipped 15 IT learning centres in rural Sri Lanka, ensuring children in these areas are not prevented from accessing the education required to better their lives simply by virtue of their geographical location and socioeconomic circumstance. There are plans for 100 centres by the end of 2014, along with expansion to Cambodia and Vietnam.

  Dr Prince is also founder and Chairman of One Disease at a Time – an aid organisation that aims to systematically eliminate infectious diseases from Australia for good, one at a time. This leads him to work much closer to home, to improve the health of remote indigenous communities where children suffer from the parasite scabies in epidemic proportions.

  Through his work, Dr Prince intends to achieve his dream of providing the infrastructure and opportunities for disadvantaged young people across the globe to empower themselves through good health and quality education. Sam’s success in business derives from an unusual ability to visualise practical solutions to seemingly vast problems, and to drive these to implementation through a calculated approach and by force of willpower and inspiring others to believe in his vision.

  He believes aid work should be run with the same rigour as business, and has demonstrated the outcomes that can be achieved when this is applied.

  In our Summer edition we will be talking to Dr Prince about how he juggles medicine and business, and the importance of applying entrepreneurial skills and framework to his big-picture healthcare projects.

  While we are not all motivated by the same ideals, nor aspire to be global in the influence of our work, thinking big and having sound business principles underpinning our practice and personal ‘operations’ will, most certainly, greatly expand our positive impact on our family, our community, our country and the world.

  Thanks again for your support. We hope you enjoy our eleventh offering of The Private Practice eZine.

  Happy reading!

Steven Macarounas, Editor
editor@theprivatepractice.com.au
Courses & Workshops

The Private Practice prepares doctors for the challenge of establishing and managing a successful medical practice that supports their desired lifestyle.

‘Best Practice’ Business Programs

Our program includes education events that range from half-day briefings to three-day ‘comprehensive’ courses convened as part of a medical college’s scientific meeting or as stand-alone events.

Our speakers are industry leading experts predominantly (if not exclusively) working with medical professionals. Programs are tailored to address the specific issues facing doctors at different stages of their personal and practice lives.

Topics of discussion include:

• Practice Set-Up and Management
• Practice Audit & Review
• Medical Practice Business Planning
• Leadership & Team Building
• Cultivating Referrals
• Accounting, Taxation & Business Structures
• Financial Decision Making
• Medical Billing and Medicare
• Banking and Finance – Products & Strategy
• Estate Planning & Asset Protection
• Investment Planning
• Superannuation Strategy
• Real Estate
• Personal Risk Management & Insurance
• Medico Legal & Practice Risk Management
• Recruitment & Employment Contracts
• Human Resource Management
• Working With Pharmaceutical & Device Companies
• Media & Communications Training
• Marketing
• Social Media & Medical Practice
• Practice Design & Construction
• Information Technology – Hardware & Software
• Day Surgery Development
• Strategies for Work/Life Balance
• Retirement & Lifestyle Planning
• Practice Succession Planning
The Private Practice Comprehensive
For senior trainees and recent fellows seeking knowledge and guidance in their transition to private practice.

The Private Practice Symposium
For established practitioners and practice managers wishing to review and benchmark their current systems, procedures, arrangements and knowledge of practice and financial management.

The Private Practice Marketing Workshop
- Branding, Positioning & PR
- Websites, SEO & Appointment Scheduling
- Ethics-Based Social Media Strategy
- Patient Satisfaction Surveys
- Referrer Education & Loyalty Program
- Patient & Referrer Events
- Practice Design
- Creating a Marketing Plan + more

The Property Symposium
- Becoming a Medical Property Landlord
- Practice/Day Surgery Development
- Project Management – Process & Strategy
- The Latest Investment Property Hotspots
- The Role of Superannuation in Practice & Investment Property Ownership
- Funding – Product & Debt Management Strategy

The following events are either already scheduled or in preparation stage. We welcome your participation and invite you to express your interest by following this link to our website http://theprivatepractice.com.au/contact
EVENTS

Private Practice ‘Comprehensive’
26-28 July
It takes a specialist bank to create a credit card for specialists

Investec has come up with a card specially designed for the medical profession. It's quite clever: for instance, buy a car or equipment on your Investec card and you can earn Qantas Points on that eligible purchase and then roll it over into a lease with Investec. You can also pay off your new and existing equipment or fit-out contracts with your card to earn even more points. Then all you have to do is start planning your next holiday.

Take a look at investec.com.au/medical or call Michelle Gianferrari on 0414 475 012 to find out how she can help.
EVENTS

Business Planning Workshop
3 August
Too many questions and not enough answers?
We're here for you.

You have devoted many years to looking after others and have not been able to find the time to obtain the answers to all the questions you have about financial matters; your business; you and your family's future.

We know this because many of our clients are Health Care Specialists like you. We understand many of the questions you have, and we'll take the time to discover any other issues which are specific to you.

Click here to find out more about our Health Care Specialist Advice and Consulting Program

Or visit us: www.lanemoses.com
The Australian share market rose by 1.6% in August, bringing its year-to gain to 10.5%. For once, the domestic market out-performed the US share market, which registered a fall of 3.1% in the month, leaving its year-to gain at 14.5%.

The dominant influence on markets continued to be the likely tapering of quantitative easing by the US Federal Reserve. I discussed this recently, and suggested that there was no need for markets to fall when the tapering began. Given that markets are forward-looking, any likely effect has probably already happened.

This is clearest in the bond market. Quantitative easing is designed to lower long-term interest rates. It certainly did this, with the 10-year bond rate reduced to a paltry 1.63% in early-May but back at 2.78% in recent days. The market is effectively doing the Fed’s work for it; in its view, QE has already ended.

The tapering will probably begin on 18 September, after the next FOMC meeting. Expect some volatility in markets (what’s new) but there is no need for any depressant effect.

BAD ECONOMICS
Did anyone else notice that there was an election campaign going on? Now that the expected result has come in, it is likely that business confidence will be lifted, which should be positive both for the economy and for financial markets.

We are told frequently that economic management is a – perhaps the – key issue in the election. What is interesting about this is there is no clear evidence that one side is a more competent manager of the economy than the other. In recent times, the Coalition got to manage the commodity-price boom while the Labor government got to deal with the GFC. Who is to say that if the roles had been reversed the results would have looked very different?

The plain fact is that most of what determines how the Australian economy performs has little to do with the government. The rest of the world matters a lot, monetary policy is independent and the private sector goes about its business every day. In Hamlet’s words, there’s a divinity that shapes our ends, rough-hew them how we will. The Federal Government does the rough-hewing.

This is not to argue that government makes no difference. Indeed, both sides should be given credit for the bipartisan approach to economic reform that dragged the Australian economy into the 20th century in the 1980s and 1990s. The days of bipartisanship are, unfortunately, long gone.

Election campaigns are frustrating for economists because they see their discipline misused time and time again. Here there is bipartisanship; both sides are equally guilty.

One of the biggest distortions is this endless hammering away at the idea that Australia (or rather the Labor government) has amassed this huge pile of government debt that will, somehow or other, impoverish us or our children (or perhaps their children). The plain and simple truth is that, measured relative to the size of our economy, Federal debt is less than a quarter of the average for the developed world.

One could legitimately argue that the Budget should be closer to balance, but not that it has left us with a major debt problem. The phobia about debt is not without
consequence; the day that a country succumbs to it is the day it begins to under-invest in infrastructure.

There is also an apparent assumption, on both sides and certainly in the media, that the state of the Budget is the most important indicator of the economy (and of the Government’s ability to manage). It is not; the unemployment rate is a far better candidate. We have lost sight of the fact that the Budget is there to serve the purposes of the economy and not the other way around.

Economists (at least most of them) also find perplexing the sudden focus on foreign investment, particularly in agricultural land. For the past 200 years, Australia has benefitted hugely from the influx of foreign capital. We will continue to need the latter for as long as we don’t save enough domestically to finance our own capital needs. We already have a Foreign Investment Review Board whose job it is to assess large-scale purchases with an eye to the national interest, and there is no evidence that this process is broken.

In addition, foreign investment in agriculture is relatively small; less than 2% of the total. Finally, raising new barriers runs the risk of flouting our international obligations.

Then there is the carbon tax. If it is, as we have been told, “a great big tax on everything”, how can it be that scrapping it saves the Budget money because the compensation paid to business is more than the revenue collected by the tax?

Strange days indeed!

ON A FINAL NOTE
The Australian dollar fell marginally in August, from 90.7 US cents to 89 cents. This leaves it above fair value. During the month, the Reserve Bank characterised it as still high, and I share that view. The downward move may not be over!

In early August, the RBA cut the cash rate to a record low of 2.5%, a move that was “fully passed on” in mortgage rates. Financial markets remain convinced that there is a further cut out there. I’m less certain; the RBA would probably like to think that it is finished. The key for a further cut is the unemployment rate. It’s currently 5.7%, which is relatively low by international standards. But it was 5% as recently as April last year and the trend is ominous. If it continues, unemployment will soon be higher than it was at the worst point of the GFC. If it hits 6%, expect a further rate cut.

I thought I made a mistake, but I may have been wrong...
In mid-June, when the ASX200 stood at 4739, I cut my end-of-year forecast from 5300 to 5100. This after having raised it from 5100 to 5300 in early-March! Now either forecast looks equally plausible. Perhaps I should just settle for a range of 5100-5300!

Trumpet blowing...
In July, the Fairfax press awarded me the ‘Palme d’Or’ for being the most accurate forecaster (among economists) of the share market for the financial year 2012/13. This was on the basis of a forecast I had made 12 months earlier when the share market was around 4100.

I believed at the time that concerns about Europe (and particularly about a Greek exit from the Eurozone) were overstated, and hence that the market was clearly cheap. My forecast for 30 June this year, of 4750, actually turned out to be low, given that the market finished the year at 4803. Every lottery has a winner!
Note: This article is intended to be general in nature and should not be relied upon by any person without seeking advice concerning their own circumstances.

Anna Carrabs is a Director at William Buck.

Aimng to acquire property within your self-managed superannuation fund? Anna Carrabs outlines the important questions to be asked before you proceed with signing on any dotted lines.

Recent years have seen a significant increase of individuals moving their retirement savings from larger retail funds to a self-managed superannuation fund (SMSF). One of the key benefits of moving to an SMSF is that it provides an individual with greater flexibility regarding the types of assets that are funding his or her retirement benefits.

Another advantage of using an SMSF is the ability to move assets already owned by the individual from outside the superannuation environment and into the concessional taxed environment within the SMSF (with earnings being taxed at a maximum rate of 15% within a complying SMSF). Assets held for longer than 12 months by the SMSF get a discount of one third (i.e. taxed at 10%).

Also, where the SMSF members start a pension on retirement, the earnings on assets supporting the pension in the SMSF (as well as any capital gains on the sale of those assets) may not be subject to tax at all.

With changes to superannuation legislation over recent years, there has been a rise in the number of real property acquisitions within SMSFs. In certain circumstances, this may include the transfer (or contribution) of business premises that you already own to your SMSF.

This article explores some of the key tax and superannuation aspects that should be considered before acquiring property within your SMSF.

Which property types can my SMSF purchase?

Broadly speaking, an SMSF can acquire two types of property for market value:

- **Commercial property:** Commonly referred to as ‘business real property’, commercial property includes property which is ‘wholly and exclusively’ used in one or more businesses (whether carried on by the SMSF or not). The property merely needs to be used in ‘a’ business in order to be business real property, so this may include property which you use in your business. There is no restriction on who the seller of business real property is (i.e. it could be an unrelated third party, or even the individual). An added benefit of business real property is that it can be leased to the individual or a related party. However, the lease must be on arm’s length terms.

- **Residential property:** There are a number of restrictions that should be considered before acquiring residential property in your SMSF. Unlike business premises, your SMSF cannot acquire a residential property from yourself or a related party. Furthermore, the residential property cannot be leased or rented to you or any related party of the SMSF.

Can I transfer a property I already own into my SMSF?

When it comes to transferring property that...
you already own, only business real property can be acquired by the SMSF. Where the business real property is held by an individual member or members of the SMSF, the property can be contributed into the SMSF – this is commonly referred to as an ‘in-specie’ contribution.

A word of warning: Each member is subject to annual contribution limits depending on a number of factors, such as age, income levels and meeting specific working conditions. For example, it is possible for an individual member who is between the ages of 60 and 65 (and subject to other conditions) to contribute up to $485,000 to superannuation in one financial year. With mum and dad in the SMSF, this could equate to $970,000.

Where the business premises are used in the individual’s own business, the member may also have the opportunity to utilise what is referred to as a ‘CGT cap’ under the small business CGT concessions, contributing up to an additional $1.315 million (for the 2013/14 financial year).

An added bonus of contributing the property into a SMSF is that the property can continue to be leased to a related party of the SMSF, provided it is on commercial terms.

What if my SMSF needs to borrow?

An SMSF is permitted to borrow but there are a number of very strict rules governing what the borrowed money can be used for. Loans of this nature are commonly referred to as a ‘limited recourse borrowing arrangement’.

The rules surrounding limited recourse borrowing arrangements are quite complex. In essence, the SMSF can borrow under an instalment warrant arrangement, such that the lender has limited recourse over the property (and no other asset of the SMSF).

While under the limited recourse borrowing arrangement, the property must be held on trust for the benefit of the SMSF. Additionally, the SMSF must only use the borrowed money for the property alone, and cannot use the borrowing to improve the asset.

An advantage of the limited recourse borrowing arrangement is that the SMSF trustee doesn’t have to borrow from a bank and third party lender. In fact, the SMSF can borrow from a related party of the SMSF.

However, before taking out a limited recourse borrowing within the SMSF, you should consider the costs of doing so – including establishment costs, legal fees, stamp duty considerations and ensuring that there will be enough superannuation contributions or rent received by the SMSF to fund loan repayments.

Are there any hidden costs or issues?

Usually, stamp duty will be payable on the property acquisition and will vary from state to state. However, where the property is acquired by the SMSF from an individual (who is a member of the SMSF), concessional rates of stamp duty may apply. For example, in NSW there is a concessional stamp duty rate of $50, subject to meeting a number of conditions.

Importantly, when transferring or selling property you already own into the SMSF, you should consider the tax cost, namely capital gains tax. However, where the premises are used in the member’s business, it may be possible to access small-business CGT concessions.

Acquiring property in your SMSF is often a complex transaction and, importantly, you should consider both the advantages and costs of doing so. It is strongly recommended that you seek the advice of a tax and superannuation professional before entering into the transaction.

For more information on how you can acquire property in your SMSF, speak to a William Buck advisor. Visit www.williambuck.com to locate your nearest office.
RISK REDUCTION

As Chris Mariani explains, seeking expert advice on insurance is key to mitigating the various risks associated with being in private practice.

Medical practices are exposed to a variety of complex risks every day, with the obvious major risk being an allegation of medical negligence against either the practitioner, practice entity or staff.

As medical indemnity insurance is required under medical registration, most practitioners hold medical indemnity and, where required (such as in group practices), most practice entities hold medical indemnity covering the entity and practice staff. While medical indemnity is undoubtedly a key risk, there are a number of other risks that are often overlooked.
REVIEW YOUR RISK

One of the best risk-management strategies is to seek advice from an insurance broker. Insurance is complex, particularly for medical practices, and a broker can help you identify your key risks and then put in place an insurance program to protect your assets and liabilities.

Engage a broker to visit your practice and ask them:
- What do you see as my major risks?
- What strategies do you recommend I put in place to reduce my risks?
- Which insurances should I consider, and what will they cover and cost?
- Which insurances am I required to hold by law or contract?
- What insurance expertise do you have in the medical sector and what are your qualifications and experience?
- Which services can I expect from you and what are the fees involved?

An initial review will generally be free of charge. A broker is generally paid commission from the insurer and/or the broker may charge you a fee for their advice and placement of the policies.

Some of the advantages of dealing with a broker can include:
- **Personal service:** A single point of contact for all your insurances (rather than call centres or dealing online).
- **The broker’s duty is to you:** The broker can provide personal advice based on your circumstances, and as brokers access multiple insurers, they will find the right policies at the most competitive premiums (if you deal with an insurer direct, they can only sell you their product, and won’t tell you if there is a more suitable product available from another insurer).
- **Allows you to focus on your business:** A good broker will save you time and money – they will get to know your business and do the running around for you. They should be part of your extended support team, along with your lawyers, accountants and financial planners.
- **Back-up:** Should you ever need to claim, the broker is in your corner to ensure the insurer lives up to their promise to pay valid claims.

GET SPECIFIC

Which insurance does the ‘average’ medical practice hold? No two practices are the same, so the insurances needed will depend on the individual circumstances of the practice. When I meet with clients to understand their business, I talk about the ‘Five insurance pillars’ to consider as a starting point. These are:

1. Medical Indemnity – Doctor
2. Medical Indemnity – Practice entity
3. Business Package (including public liability, property, business interruption and other covers)
4. Management Liability
5. Workers’ Compensation

This list is not exhaustive and there are often other risks that may require insurance cover. I have also only focused on key business risks and not ‘personal’ risks (such as life insurance, income protection, trauma/total and permanent disability, and other policies to cover key persons).

The following table summarises some common risks in private practice.
<table>
<thead>
<tr>
<th>Key risk area</th>
<th>Common risks</th>
</tr>
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</table>
| 1 Medical risks                       | • Civil claims alleging medical negligence against doctors.  
• Civil claims alleging medical negligence against the practice entity and/or practice staff.  
• Related ‘medico’ risks – i.e. medical board investigations, coronial, Medicare audits, etc. |
| 2 Practice premises & business risks  | • Patient and visitor slips/trips (public liability).  
• Product risks (particularly where you are the manufacturer or importer).  
• Physical loss or damage to premises, fit-out, IT equipment, plate glass, etc.  
• Machinery/electronic breakdown (and spoilage of vaccines or other cold-storage goods).  
• Business interruption cover (loss of revenue and increased costs following physical loss, say from a fire or water damage that prevents or reduces trading, or requires you to rent temporary premises). |
| 3 Management & employment issues      | • Responsibilities as a director or officer of the company.  
• Employment practices liability (discrimination, unfair dismissal, etc).  
• Crime (employee theft).  
• Statutory fines and penalties (e.g. OH&S fine).  
• Tax audits.  
• Injury to workers (Workers’ Compensation) |
| 4 Cyber risks                         | • A growing area of risk. Policies are now available to cover for example cyber extortion (including costs to manage the event as well as any loss of revenue) and third-party liability (i.e. privacy claims resulting from a breach of patient privacy following a cyber event). |
| 5 Other risks which may require cover | • Business travel.  
• Business motor vehicles.  
• Fit-out or construction of premises (contract works insurance).  
• Transit insurance or goods away from the practice premises.  
• + Others. |
The following two forms of insurance are commonly overlooked:

**Public Liability Insurance**

Many practitioners mistakenly believe their medical indemnity policy will cover public liability claims. For example, several years ago a specialist who operated in a private hospital as a VMO accidently caused bodily injury to a nurse during an operation. The employed hospital nurse lodged a workers’ compensation claim and the workers’ compensation insurer then ‘subrogated’ against the specialist seeking to recover their costs.

The specialist discovered the matter was not covered by their medical indemnity policy, as it was a public liability matter. The specialist did not have public liability cover, which he or she could have easily purchased (a $10 million policy for a single doctor would be less than $500 annually).

Be aware that public liability insurance is often a requirement in contracts such as in lease agreements, independent service contracts or VMO contracts. Check any contracts you have entered into (there is normally a section titled ‘Insurance Requirements’). Better still, send the contract to your insurance broker to review the insurance requirements and indemnities sections.

**Management Liability**

Management liability is another overlooked policy and is made up of a package of covers that include cover for:
- Directors and Officers Liability (and Organisational Liability)
- Employment Practices Liability (eg. An allegation of unfair dismissal or discrimination)
- Crime (theft by employees)
- Statutory Liability (fines and penalties)
- Internet Liability (operating a website)
- Kidnap, Ransom & Extortion (including cyber extortion)
- Tax Audit and a range of other covers.

The policy is designed to protect both the company and the directors and officers (e.g. the management team) against liability as a result of a ‘Wrongful Act’, committed while carrying out the duties of directors and officers. Claims can be brought from many sources, such as regulators (e.g. ACCC, ASIC, ATO), employees, competitors, customers/suppliers and shareholders, particularly minority shareholders.

An allegation may be completely without merit, but without cover you leave yourself exposed to expensive and time-consuming litigation to successfully defend any allegation.

For a medical practice with gross turnover between $1-3 million annually, expect to pay circa $1700 total premium for a $1 million main policy limit (or circa $2100 for a $2 million policy).

There is often some overlap between management liability and other insurances you may hold. For example, some medical indemnity insurers provide cover for disputes with employees (such as an unfair dismissal allegation), but generally if cover is provided, it is limited to legal costs only (not the compensation awarded), and the employing entity must be wholly owned by you – which obviously would not be the case in a group practice owned by multiple doctors. A management liability policy fills in these cover gaps.

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If you have any questions or would like to arrange an obligation-free discussion and review, contact Chris Mariani on 02 9905 7005 or 0419 017 011, email chris@mgrs.com.au or visit [www.mgrs.com.au](http://www.mgrs.com.au)
The gift of giving

Want to know how you can establish a charitable foundation during your lifetime? **Ivana Bosio** outlines your philanthropic options.

If philanthropy is a priority for you during your lifetime, rather than making a series of charitable donations it might be appropriate to consider establishing a long-term giving structure that can perpetuate your long-term philanthropic intentions.

While you are alive, there are two long-term giving options available to you:

- You can set up an account within a charitable endowment fund (CEF).
- You can establish your own private ancillary fund (PAF).

In determining the most suitable option for you, you should consider matters such as how much you would like to give and how involved you want to be in the process of giving, as well as the reasons that drive your philanthropy. Ask yourself if you would like to be engaged and involved on a long-term basis, if you would like to leave a significant sum of money, or if you would like to leave a legacy and involve future generations of your family.

**WHAT IS A CHARITABLE ENDOWMENT FUND?**

This is a public charitable fund in which you can establish an account. You can nominate the charity or charities you would like to benefit from your donation. While the trustee will consider your nomination, the trustee makes the final decision about the distribution of funds. You will not have any input in the investment strategy of the fund.

A CEF would be appropriate if you want to establish a long-term charitable giving program but do not have a desire to be involved in the investment management or decision-making process.

**WHAT IS A PRIVATE ANCILLARY FUND?**

A PAF is a private fund into which tax-deductible donations can be made. It allows you to build an investment portfolio of carefully selected assets for the purpose of supporting philanthropic causes that have significant meaning to you. This fund is appropriate if you want to apply a significant amount of your wealth to charitable purposes and be involved in the ongoing decision-making and application of that money.

A PAF has several benefits over short-term giving. Instead of a one-off donation, the perpetual structure of a PAF allows you to create a long-term giving strategy for your nominated charities that will provide funding in your (or your family’s) name forever.

Using a perpetual structure also means that you can give your trustees discretion as to how the PAF is managed. This ensures...
that, if necessary, the trustees can redirect funds to where they are most needed in order to fulfil the purpose of the PAF.

**HOW DOES A PAF OPERATE?**

In the PAF deed you can specify the causes you wish to benefit from the funds, as well as giving your trustee the discretion to decide how the funds are to be applied. This gives your trustee the flexibility to respond to things such as medical advancements, which can give rise to many areas of research requiring funding today that would not have been thought possible 50 years ago.

The trustee of a PAF must be a corporation. The directors of the trust must include at least one party who meets the definition of a ‘responsible person’ and is actively involved in the decision-making of the PAF. The ‘responsible person’ cannot be the founder, a major donor or an associate thereof. The trustee of a PAF is subject to both the common-law principles of trust law and the Trustee Act of the state or territory in which the PAF operates.
There are also major tax advantages that come with establishing a long-term giving program, as the income and capital gains earned within this type of structure are exempt from tax. This also means these funds can attract a refund of franking credits attached to dividends received, which can further enhance the amount available for distribution to beneficiaries. These tax concessions mean these long-term giving structures often generate income and capital faster than the same portfolio held in any other way. In addition, the PAF is a deductible gift recipient (DGR), meaning contributions made to the PAF are tax-deductible.

Consider a one-off donation of $1 million compared to the establishment of a PAF with the same amount. If you establish a PAF, which distributes 5% per annum and generates capital growth of 5% per annum (assuming constant annual returns), after 20 years the PAF will be worth more than $2.5 million and will have distributed close to $1.6 million.

This is a simple illustration but there are many real examples of PAFs established many years ago that now have a significant capital sum and have distributed millions of dollars to benefit the community.

PROFESSIONAL ASSISTANCE

At Australian Executor Trustees (AET), we can work with you and your adviser to establish your PAF and put in place the necessary documents and governance structures so it will operate smoothly and efficiently in the future. We can provide a trustee solution, acting as a trustee and overseeing the investment of funds held in trust.

Our company directors are highly experienced in trust management and fiduciary services, and will ensure your PAF meets the active ‘responsible person’ requirements at all times.

As the fiduciary, AET takes on the risk and ensures the compliance and daily management of the PAF are taken care of. This allows your investment adviser to focus on the investment management and you to focus on engaging with philanthropic organisations and finding worthy programs to fund.

The Australian Taxation Office has issued strict guidelines that must be adhered to when establishing and managing a PAF, and may penalise the directors of the corporate trustee for failing to comply with prescribed guidelines. By utilising professional services, you can be sure that your PAF will be established correctly and managed prudently and efficiently into the future. ☺
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We recognise the importance of the role played by Practice Managers like you. When your practice joins Avant, you receive access to a range of tools, guidance and Avant Risk IQ – our leading risk management resources. Helping you to better identify, manage and minimise risk so you can focus on the day-to-day management of your practice.

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VALUE ADDED

With an Investec credit card you can boost your Qantas Points and have access to a range of exclusive services.

One of the golden rules of any business is to ensure it is operating as efficiently as possible to maximise the return from every dollar spent. How attractive, then, is the option to make big-ticket business equipment and asset purchases such as motor vehicles on your credit card and earn Qantas Points in the process?

That’s exactly what’s on offer with an Investec Visa credit card.

“We had one client who recently purchased equipment for $400,000 on their Investec card, and that meant they earned a sizeable number of Qantas Points as we offer one point for every $1 of eligible spend, with no cap on how many points you can earn,” explains Michelle Gianferrari, a Financial Specialist at Investec.

“We then do is simply convert that card transaction into a finance contract with Investec, which pays off the purchase from the credit card. Additionally, we allow the client to make their monthly repayments for that contract on their Investec credit card so they can earn even more points – generally at least twice as many points as the purchase alone would earn.

“This is a service not available through most other financial organisations, but we make it easy for our clients as we facilitate the whole process for them.”

Clients can then redeem their points on the Qantas website.

“This can be a significant benefit for clients in terms of taking care of their travel needs for the future, all by doing something as simple as using your Investec credit card,” Gianferrari adds. “It could also be of huge benefit if the client is taking a well-earned holiday and they have enough points to upgrade their flight.

“But the value of adding to the balance of Qantas Points is not all about flights. For those who are not interested in flying there are also retail store vouchers and merchandise that can be redeemed using the points on the Qantas Store. We have clients that use them to buy end-of-year gifts for patients and staff!”

YOUR CHOICE

Clients can choose between two credit cards:

- **The Investec Signature card** offers one Qantas Point for every $1 of eligible spend in Australia, and two Qantas Points for every $1 of eligible international spend.
- **The Platinum card** offers one Qantas Point for every $2 of eligible spend in Australia, and one Qantas point for every $1 of eligible international spend.

In addition to Qantas Points, every return ticket purchased on an Investec card is automatically covered by up to 90 days of travel insurance, protecting the safety of not only the cardholder but also their spouse and dependent children, if travelling together.

Other benefits for primary signature cardholders include a Priority Pass membership, which opens doors for the client and a guest to over 600 VIP lounges in 300 cities, as well as providing access to Visa Concierge and the Visa Luxury Hotel Collection for services at a selection of superior hotels.

Note: The information contained in this article is general in nature and has been provided in good faith, without taking into account your personal circumstances. While all reasonable care has been taken to ensure that the information is accurate and opinions fair and reasonable, no warranties in this regard are provided. Investec recommends that you obtain independent financial and tax advice before making any decisions.
BONUS REWARDS PARTNERS

Investec is a specialist financial service provider for medical and dental clients and has a bonus partner reward program for a range of suppliers within the medical and dental industries.

“So, even if you use the Investec Visa card to buy business consumables, through this deal with the specific partners, you can further enhance your Qantas Points balance as well,” Gianferrari says.

“If people can earn rewards that enable upgrades or free tickets or merchandise, and they can do all that by just using their credit card, then it is a pretty easy way to travel for free.

“We are striving to deliver value to our clients, with minimum fuss. Our clients see a real value in these points as it opens up so many possibilities with regards to business and personal banking, and they only need to carry one card – the Investec card.”
Telehealth – the delivery of a specialist video consultation through the Internet – is recognised as being an ideal medium to improve accessibility to specialist medical services in rural and remote Australia. Numerous telehealth success stories were trumpeted at the recent Health Informatics Society of Australia (HISA) conference in Adelaide, together with real concern over recognised barriers to using the new technological system. Among the barriers was the dearth of knowledge about the Medical Benefits Scheme (MBS) and how to correctly bill for these services.

The new MBS telehealth items were first introduced on 1 July 2011 and include both specialist and patient-end rebates, which are claimable for outpatient services in ‘telehealth eligible’ areas. An eligible-area exemption applies to all residential aged-care facilities and aboriginal medical services, so indigenous people and residents in nursing homes have access to telehealth at all times.

There are two ends of the service to consider – the (usually rural) patient end and the (usually metropolitan) specialist end. From 1 November 2012, these two ends must be at least 15 kilometres apart. The specialist-end service must be an eligible service (meaning a rebate is available).

Questions relating to telehealth claiming arise in a variety of contexts, some of which are quite straightforward – such as questions concerning referrals and aftercare. All requirements for valid referrals (which you can read about in the Winter 2013 edition of The Private Practice eZine) apply to telehealth, as do the aftercare rules – so, no rebate for aftercare, real or virtual.

TELEHEALTH CLAIMING ESSENTIALS

- The threshold question is always related to the patient, not the provider.
- All usual Medicare requirements, such as referrals and aftercare, apply.
- The specialist service must be claimable before the patient-end service becomes claimable.
- Both services do not have to be claimed but must be claimable.
But, as is always the case, there is nothing to prevent any patient-end service being charged to the patient outside of the Medicare scheme. If the specialist service is not claimable then neither is the patient-end service, and an MBS item number should not be claimed, but more about that shortly.

At the other end of the spectrum are more complex questions, with the answer lying buried deep in the health-law labyrinth of acts and agreements. Consider the following examples.

**CASE STUDY 1**

*A patient from a residential aged care facility attends an outpatient appointment at a public hospital by video consultation from their local general practice. The specialist they see does not bill the patient because they choose not to exercise their right of private practice in this particular situation. Can the GP or other eligible healthcare provider bill a telehealth item number for assisting with the consultation?*

This scenario raises two issues:

- Can the patient-end service be claimed if the specialist-end service is not claimed, or visa versa?
- If the patient lives in a residential aged-care facility but is transported to the GP for an arranged public hospital outpatient appointment, does the residential aged-care facility exemption still apply?

As with all Medicare claiming, the threshold question always relates to the patient, not the provider. The legal validity of our national health scheme rests on the constitutional guarantee provided in s51(xxiiiA), ensuring Medicare rebates are always payable to patients not providers. Once a service has been provided, a patient can choose to assign their right to the Medicare rebate to the provider, which we all know as bulk billing.

Therefore the initial question does not relate to whether the specialist is exercising a right of private practice but whether a claim can lawfully be raised against the patient. In general terms, if the patient is a public patient in a public hospital, Medicare benefits cannot be claimed. If the patient is private, Medicare benefits can be claimed, and telehealth services can only be claimed when the patient is located in an eligible telehealth area and the two providers are at least 15 kilometres apart. Easy!

A preliminary point concerns the difference between an item being claimed and an item being claimable. The key machinery provisions of the Health Insurance Act 1973 are sections 10, 20 and 20A. Section 10 creates an entitlement to a Medicare benefit, section 20 sets out who obtains that entitlement and section 20A provides for the assignment of the entitlement. Nowhere in the Act is there a further provision giving rise to a legal compulsion to claim or collect the entitlement. In fact, it’s quite the opposite. Providers have two years in which to submit claims, after which a late lodgement application is required to show cause as to why benefits should be paid after so long. Sound policy when you consider that the current cost of Medicare claims (not including PBS claims and the grants to the states to fund public hospitals) is in the vicinity of $22 billion per annum.

In the telehealth context, the threshold issue of whether a private claim can lawfully be raised against the patient is therefore not dependant on whether the specialist chooses to claim, but whether the patient is physically in an approved telehealth location where a Medicare service can be claimed.

Given the intention of telehealth is to increase accessibility to specialist services, the specialist service takes precedence over the patient-end service and must be claimable before the patient-end service will be claimable. But the two are not interdependent, in that there is no necessity for both services to be claimed.

So, the answer to the first issue raised in the case study is ‘Yes’ – if the patient is in a telehealth eligible area.

The second issue raised by the case study relates to the patient’s location at the time the consultation takes place. This is pretty simple if the patient had stayed in the residential aged-care facility. Under the exemption the service would have met the telehealth requirements, and the patient-end service would have been claimable even if the specialist had chosen not to lodge a claim.

But by moving the patient to the GP’s surgery, the service would only remain a telehealth-eligible service if the GP’s surgery was located in an eligible telehealth area. If not, this service would no longer meet the telehealth criteria.

So, if the GP’s practice is in a telehealth-eligible area, it is a telehealth-eligible service. But if the GP’s surgery is not in a telehealth-eligible area (such as metropolitan Melbourne), it is not claimable as a telehealth service.

The GP could perhaps claim a usual attendance item for the surgery attendance if all other requirements
of the MBS item descriptor were met, but the specialist would be excluded from claiming at all.

But an aged-care facility, no matter where it is, is a telehealth-eligible area and a telehealth item can be claimed. This means nursing homes are in and GP practices in non-telehealth eligible areas are out!

Remember, you can solve most telehealth conundras by asking one simple question: Where is the patient physically located at the time the service is provided? But even that can be baffling sometimes. Consider this second example.

CASE STUDY 2

**A patient attends the emergency department of a rural hospital in a telehealth-eligible area. The doctor seeing the patient would like some specialist assistance in dealing with the patient, so rapidly sends a referral to a specialist and then conducts a video consultation with the specialist. The patient, at this point, has not been admitted to the hospital. Can the specialist claim a telehealth-consultation item number?**

Medicare has always provided health-sector funding across two distinct domains. The first subsidises private services rendered by health practitioners on a fee-for-service basis, and the second is the provision of free public-hospital services by federal grants made to state and territory governments.

Since its inception, Medicare rebates have been available to two categories of patients – inpatients and outpatients. So, if a patient is located in the emergency department and has not been admitted to the hospital, the patient would be an outpatient and therefore potentially eligible for a telehealth consultation – right?

Wrong! Over many years our federal and state governments have concocted a magnificent interface between the Health Insurance Act 1973 and three legal documents, which together have redefined the entire concept of an outpatient service and, consequently, who funds what.

**DEFINING MOMENTS**

The National Healthcare Agreement 2012 is the latest iteration of the agreement between the federal and state governments to fund public hospitals. It sets out the shared and individual responsibilities of all parties to the agreement, upholds the general Medicare principles of equity and accessibility based on clinical need and cross-references to the National Healthcare Reform Agreement.

The National Healthcare Reform Agreement provides details of the shared intentions of all governments to deliver the COAG reform agenda, including Activity Based Funding, and features key operational provisions – known as ‘business rules’ – which are found in Schedule G.

Appendix A to the Agreement is the definitions section, which cross-references to the latest version of the National Health Data Dictionary, v16 2012.

Still with me?

For present purposes we can narrow down the relevant definitions:

- Outpatient department means any part of a hospital (excluding the Emergency department) that provides non-admitted patient care.
- Outpatient clinic service is described as ‘non-admitted patient service activity’, excluding emergency department.

As you can see, there are now two subdivisions under the outpatient banner – non-admitted patient service and emergency department.

Business rule G18 provides that eligible patients presenting at a public-hospital emergency department must be treated as public patients before a decision to admit is made, and business rule G17 prevents emergency department patients being referred to an outpatient department to
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Now 1stAvailable.com.au will change forever the way Australians book their health care appointments.

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On the basis that emergency department clinicians are being paid by the hospital for the services they provide, their services will not generally give rise to eligibility for MBS rebates (of course there are exceptions, which I will come to) – to do otherwise would be to allow those clinicians to double dip.

Any temptation to move a patient quickly to an outpatient department to circumvent this provision would be a breach of the National Healthcare Reform Agreement. It’s quite nicely stitched up when you look closely, and it effectively excludes all telehealth claiming in the emergency department environment. That’s right – currently if the patient is in the emergency department they cannot be the subject of a telehealth claim, end of story.

Referring back to the case-study example, it is irrelevant that the urban medical specialist has received a valid referral and is ready on the end of the video. A patient’s location determines what happens next and, as we have seen, in a public emergency department the patient cannot have MBS charges raised against them. The exceptions are described in business rules G21 and G22, which create specific exemptions for GPs who provide emergency medical services in the emergency departments of small rural hospitals or other approved facilities. However, this does not impact or alter anything else telehealth related.

The correct answer to case-study 2 is therefore ‘No’. The specialist cannot claim a telehealth item and, as a consequence, neither can the GP. The GP may be able to claim a consultation (though not a telehealth consultation) if a specific remote exemption applies.

LIFE SAVING

When considering the bigger health-funding picture, a Medicare-claiming avalanche could certainly result from opening up telehealth claiming to all state hospital emergency departments. Yet numerous examples do spring to mind whereby a specific exemption would save lives and millions in healthcare costs, such as this example:

Patient presents to a remote public hospital emergency department with a developing stroke. CT scanning is required and the clot busting drug TPA, if administered within four hours of symptom onset, may be lifesaving. The local GP has access to a CT scanner at the hospital but needs specialist support and advice to make the decision to use TPA safely.

Aren’t examples like this why we introduced telehealth in the first place?

Make no mistake, the federal government wants clinicians to use telehealth, and substantial incentives are still available both for getting on board (currently $3900) and for each claim.

Here’s what a standard physician consultation currently looks like:

- $128.30 – the usual 85% rebate for item 110
- $64.13 – telehealth item 112 (50% x schedule fee for item 110 x 85%)
- $192.43 – subtotal paid overnight if claimed electronically
- $39 – claim incentive paid quarterly

Total = $231.43

Telehealth is a rational approach to addressing specialist shortages in rural and remote Australia. It will boost specialist care for those living in aged-care facilities, as well as providing much needed specialist support for our indigenous population.

It is supported by cash incentives and, while the claiming can seem complex, it really boils down to one question – where is the patient?
Websites That Attract Patients

8 out of 10 Australians search for healthcare information online.
Without an effective website you are missing out.

Most medical websites are dead on arrival when it comes to getting enquiries or new patients. They are either poorly designed, hard to find, or lack the best practices necessary to motivate people to call you.

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The blogosphere is abuzz with commentary on Google Glass and how we’ll use it in our daily lives. At Software Advice, we think Glass has especially exciting implications for the field of medicine.

Produced by Google, Glass is essentially a computer you wear as glasses – it’s hands-free, voice-activated and literally in your face. Though currently only being used by a small audience of contest winners, Glass is slated for public release at the end of 2013.

According to Google, Glass gets technology ‘out of the way’. Version 1.0 still looks a little goofy, and there are those who think it won’t catch on. But the wearable model heralds an evolutionary step forward – an exciting new way for people to interact with technology.

**FORWARD VISION**

Let’s speculate on three areas where Glass could impact the way healthcare providers deliver care.

1. **A second opinion and reference library for diagnoses**

Let’s say a patient presents with an itchy red bump on her arm. Glass, activated by the physician’s voice, could prompt the doctor through a differential diagnosis for a suspected spider bite.

Glass could suggest questions to ask – e.g. ‘Are you experiencing any nausea?’. It could respond dynamically via voice recognition to words and phrases picked up in the doctor/patient conversation. If you’ve ever used Google Now, you’ll have an idea how graceful this functionality could be.

Some sophisticated EHR systems already offer diagnosis-prompting features, but harnessing this power in a hands-free device that can ‘understand’ and react to spoken words would integrate more seamlessly into a patient encounter. What’s more, Glass wouldn’t require the physician to turn his back on the patient or focus attention on an external screen.
And what if Google collected and stored de-identified images from global networks of participating physicians – a sort of picture archiving and communication system on steroids? With a voice command, our doctor could snap a picture of the patient’s bite and have Google instantly compare that image with others in the database (in a similar manner to Google’s Goggles application).

Google could suggest a match with other documented cases and display important information about the potential diagnosis. The doctor could inspect the database images and the spider bite in front of him all in the same plane of vision.

2. **A heads-up display for surgeons**

Glass’s built-in video functionality will be useful for surgeons. Imagine a surgeon live-streaming her procedure to a class of medical students, or a surgical resident live-streaming his procedure to a supervising physician. Perhaps in a few years we’ll even see a Glass ‘certification’ of sorts – a training hospital guaranteeing that certain resident-performed procedures are monitored in real time via Glass.

With some additional software development, Glass might be able to go beyond broadcasting video to third parties. What if Glass could deliver intraoperative imaging directly to an operating surgeon?

In order to monitor exactly where in the patient’s body their surgical instruments are, surgical teams sometimes take periodic X-rays throughout a procedure, or a surgeon may insert a scope equipped with a tiny camera. The image is then projected onto a screen, which the surgeon can reference to accurately gauge positioning.

Here, Glass could again solve a problem of focus. With basic integration between Glass and the imaging system, Glass’s screen could display the X-ray image or video feed to the surgeon ‘in eye.’ This would allow the surgeon to maintain focus on the surgical site, rather than having to move attention away from the patient to a peripheral screen.

That’s not exactly X-ray vision, but functionally it’s getting close. And I have to imagine that a tool with the ability to limit distractions during surgery would improve surgical outcomes.

3. **Eye on site for virtual medicine**

The burgeoning field of virtual medicine would reap major benefits from a highly portable, easy-to-operate device with hands-free video recording and transmitting functions.

One typical virtual medicine scenario today (pre-Glass) might play out as follows: A patient in a rural setting needs to see a specialist not available in his community. Rather than have his primary care physician refer him to a specialist far away, the patient might arrange a video appointment with a specialist without having to leave home.

Let’s take that a step further. Imagine if the primary care physician could call up said specialist on Glass live during the patient visit, giving that specialist first-person access to the patient encounter in real time. This would save time and money, not to mention taking integrated care to new levels.

Similarly, first responders or others in the field could video-conference with a specialist to show what they’re seeing on the ground in real time. A military physician on a field of battle treating an eye injury, for example, could consult live with an ophthalmologist. An EMT called to the scene of a heart attack could conference-in a cardiologist to provide live feedback.

The specialist would be able to see what the practitioner on the ground sees, up close and personal. In turn, the physician or first responder would have valuable medical feedback placed quite literally before his eyes.

Glass’s ease of use means a practitioner on the ground could voice-activate the entire exchange without having to set up equipment or have someone hold a camera, both of which present logistical challenges in the field. Such instant access would save money and, more importantly, time – which in medicine tends to equate with saving lives.

The possible applications of Google Glass in medicine present promising opportunities for improved efficiency and quality care. Getting technology out of the way, as per Glass’s mission statement, would mean allowing physicians to access and share powerful information quickly, without sacrificing their connection to the patient or procedure at hand.

And let’s remember that Glass is still in its infancy. Wearable technology is fertile ground for software developers, and it’s likely that in a few years’ time Glass and other wearables be used in ways even *Star Trek*’s Dr McCoy couldn’t imagine today. ©
A surprisingly high number of healthcare practitioners are so afraid to start a renovation process at their current practices that many projects are postponed indefinitely. Items such as the renovation cost, the disruption to their businesses and the impact on their staff and patients are the main concerns in the short term that cloud the benefits of undergoing the renovation in the first place.

Living in a competitive and more informed business environment also applies to medical and specialists’ practices these days. The current patient that approaches the practice now gets more informed of what they’d like to receive on their consultation and the expectations are set up high even before they walk into the practice. The result of that experience is a mixture between different factors, including the impression they’ll receive of your practice environment.

Good design that results in a welcoming and pleasant environment for your patients will not only highlight the services you provide but will enhance staff efficiency and performance, resulting in an amicable attitude to your patients.

So, how do you achieve this? Following these five steps will get you to your goal.

1. **Assess the feasibility of the project**

Assessing the feasibility of renovating or creating a new practice is the first step to be taken. If you are close to the end of your lease it may be a good opportunity to check the option to purchase your own property or get the most out of the deal if you renew the contract at your current premises. Landlord incentives are increasing and can cover the cost of your fit-out or give you some free rent upfront, or a combination of both.

There are some cases where staying is more suitable so you don’t have to move your patients to a different location (losing some of them in the transition). Most importantly, you can save money by only doing a partial renovation or a simple facelift.

Engage the design firm (preferably a design and construction firm, as they understand the entire process) from day one, as they should take your hand to run through the entire process. Engaging experts from the beginning is crucial – it will ensure that you aren’t spending your valuable time...
consumed by the project and that your patients and practice aren’t affected.

Aspects the design firm should consider may include:

- Premises conditions – lease, potential to acquire the premises and incentives, etcetera. Consider if this property is the right place in the long term.
- Potential of future growth at the current premises.
- Management of the disruption to your business during the renovation process.
- Feasibility and compliance of your current property.
- Your target market and the community your practice serves.

## Develop a clear brief for the project

Having a clear understanding of your practice goals in both the short and long term, along with what is required to achieve those goals, is the first step in providing a clear brief for the redevelopment of your practice. Your brief should include the corporate values of the practice, the vision for the next five to 10 years, a clear business plan and needs assessment, and the number of health professionals you have and will have in the future.

Make sure you take enough time for the planning process, as it will drive the success of the rest of the project. Your design firm should outline this process for you, as well as interviewing the staff, establishing a ‘needs analysis’ of your current space and providing you with a final brief document for your review.

One good exercise may be to conduct a series of informal discussions with the staff to obtain their ideas, expectations and general thoughts on the potential renovation. Remember, your staff will be the main users of the space and will appreciate the new environment even more if they were involved at the development stage.

## Establish your budget

Whether you are aiming for a new fit-out or are giving your existing practice a facelift, establishing your budget will be key to a stress-free process. As a result of the activities in points 1 and 2, you will be able to determine a clear budget at this stage.

Get the designers to make a space plan of the proposed refurbishment and provide a costing of the works involved. You can then adjust the budget in accordance with your situation and expectations without wasting time by going into a full design and documentation process, and ending up with an unrealistic and unachievable budget. This will save valuable time for everyone and will set up your targets for the project from day one.

## Understand the impact of the refurbishment

There are a number of ways to develop your renovation while keeping your practice open to the public. The benefits of keeping your practice open need to be assessed against the practicality of completing the fit-out works all at once. Bear in mind that if your practice will be open during the construction process, the works will take more time to be completed and the disruption will last longer.

Some factors to consider are:

- Available space to use temporary rooms or communal areas.
- Flexibility of the space to be staged during construction. Would you be able to work from two rooms instead of three? Could you use a temporary reception desk during the construction period?
- The patients’ experience during the construction process. Make sure you engage a firm that has worked on tenancy projects before and is able to maintain a clean and tidy site for your patients. Fully enclosed working areas without noise during trading hours,
as well as a site that appears to be completely clean every morning, need to be guaranteed.

Get the design firm to provide a proposed program and staging of the works so you can accurately measure the impact of the refurbishment on your practice.

5 Get the right contract in place

One of the main areas of risk during your practice set-up is the construction side. Unexpected variations, inexperienced contractors in the medical industry and non-compliance with current codes and accreditation schemes are main factors that could jeopardise the successful completion of your practice fit-out. The contract must clearly describe:

- The scope of services to be provided.
- The timeframe during which services will be provided.
- The respective parties’ rights and responsibilities.
- The fee schedule and other items that define the nature of the relationship between the owner and development team member.

Establish the fee arrangement with the designers and contractors, or with the design and construction firm, that will lead the process for you. The most common fee arrangements are:

- **Fixed fee structure:** Here a company quotes a fixed price for the entire project.
- **Hourly billing:** Hourly rates are a flexible method of payment when the exact project scope is not fully defined.
- **Percentage of construction cost:** This payment approach ties the compensation to total construction costs.

Fixed-price/lump-sum design and build has proven to be the simplest, quickest and most cost-effective method. By using a company with both design and project-management capabilities, you will have only one point of contact throughout the project. As well as being managed under the same roof as the fit-out is designed, costing will be presented to you in a fixed-price contract, so you know exactly what the cost is before you start. This eliminates variations and cross-responsibility disputes – two things you definitely want to avoid in the quest to smarten up your practice. 😊
In the winter edition of The Private Practice eZine we delved into trauma insurance, and in particular what to consider when working out how much cover you need. Your adviser can help guide that conversation, and once you’ve settled on the amount of cover, the next step is to decide on the structure.

To recap, trauma insurance covers you in the event of diagnosis of cancer, cardiac conditions (such as having a heart attack) or degenerative diseases, such as multiple sclerosis, motor neurone disease or Parkinson’s disease. Policies may cover up to 60 specified diseases, injuries and events. If you are diagnosed with one of these conditions and meet the definition used in the policy, the full sum insured is payable as a lump sum.

You may already have trauma insurance or know it by a different name – some policies are called ‘Living Insurance’, ‘Crisis Recovery’, ‘Critical Illness’ or ‘Critical Conditions’. In Australia, the maximum level of cover you can generally purchase is $2 million. Policies can be indexed to inflation and hence rise above this amount over time, but if you’re taking out a new policy, $2 million is the maximum available. There are a couple of products in the market that will provide sums insured above this level, but entry is restricted and you’ll need to speak to your adviser to find out if they can provide you with access.

TYPES OF STRUCTURES TO CONSIDER

While other lump-sum personal insurances – such as life insurance and total and permanent disability (TPD) insurance – can be owned inside a superannuation fund, trauma insurance is best owned directly. In fact, from 1 July 2014 superannuation funds will no longer be able to purchase new trauma policies. When insurance is owned inside super, a claim is payable to the fund rather than to the individual. The individual then needs to meet a ‘condition of release’ for the trustee to be able to release those monies.

Conditions of release include death, permanent incapacity or retirement over the age of 55, none of which are necessarily present with a trauma-cover claim. Therefore, if trauma was owned by a super fund, you may find that a claim is payable but the claim proceeds become trapped inside the super environment.

This doesn’t mean your cover must be kept entirely separate to your policies inside super. Trauma can be purchased as a stand-alone or linked policy. ‘Stand alone’ means that a claim on the policy will have no impact on any other policies you may hold. So if you had life insurance and/or TPD and suffered a heart attack, resulting in a claim on your trauma insurance, your life and/or TPD cover would be unaffected.
LINKED TRAUMA POLICY
Alternatively, you may have your cover linked. A claim on a linked trauma policy will reduce the sum insured on your life and/or TPD insurance. For example, if you have $1 million of life and TPD with a linked $400,000 trauma policy, the amount of cover on your life and TPD would reduce by the sum payable. Hence, your $1 million of cover would become $600,000.

Most insurers will allow you to link a trauma policy owned in your own name with life and TPD policies owned inside superannuation. Linking your cover, rather than opting for a stand-alone policy, will result in a lower premium.

If you opt for linked cover, there are two benefits that may mean you don’t necessarily lose your life cover in the event of claim. The first is called ‘Life Cover Buyback’ and is built-in with most providers. It enables you to literally repurchase the life cover you have lost 12 months after a claim. If you take the example above, 12 months after the trauma claim was payable for a heart attack, you would be able to reinstate your life cover back to $1 million.

DOUBLE TRAUMA OPTION
There is also an option that goes one step further. Double trauma (also known as ‘Double Living’ or ‘Crisis’ options), means that 14 days after the trauma claim is payable, the life insurance amount is restored. In addition, premiums are waived on the life cover from that point onwards. ‘Double’ is effectively referring to a double claim, as the policy is now free and will provide a payment in the event of your death, whether that be in the near future or even in old age.

TRAUMA REINSTATEMENT
The third important option to consider is ‘Trauma Reinstatement’. Your eligibility for personal insurance is always based on your health history, and following a trauma claim you are likely to be uninsurable, meaning you could not purchase more insurance.

Trauma reinstatement gives you the option to reinstate your trauma cover 12 months after your claim. You won’t be covered for the condition you claimed on, but you’ll still have the cover if you suffer from a different defined illness or injury.

As you can see, there are multiple structures and options to ensure you can tailor the cover to your specific needs. But these choices can also make personal insurance seem complicated. Your adviser is the best person to help find the right policy, one with a structure that is most appropriate for you and takes into account your budget and circumstances.

CASE STUDY
Alexandra is a 40-year-old mother of three. She has $800,000 of life insurance, with $300,000 of linked trauma. She is diagnosed with multiple sclerosis and receives the full trauma sum she is insured for. Her life insurance policy reduces to $500,000. Twelve months after her claim she is able to utilise her ‘Life Buyback’ and ‘Trauma Reinstatement’ benefits. Her life cover increases back to $800,000 and she has a new stand-alone trauma insurance policy for $300,000.

Four years later Alexandra is diagnosed with breast cancer. She is able to claim on her trauma policy again. As her policy is now ‘stand alone’, her life insurance does not reduce at this time. Her life insurance will continue for as long as she retains the cover.
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HIRING THE RIGHT PEOPLE

As Dr Aniruddha Malpani points out, investing in good staff will save you time, money and energy in the long run.

Dr Aniruddha Malpani is a consultant IVF specialist and author in Mumbai, India.
“When you hire people that are smarter than you are, you prove you are smarter than they are.” – R. H. Grant.

Most doctors take a very casual approach towards employing staff. Vacancies are filled as and when they arise, and employees are left to muddle their way through till they either learn to do the job or walk off.

In India, where I live and work, most doctors can get away with this because labour laws are still very primitive and there are few safeguards for employees working in doctors’ clinics. However, not only is this very wasteful of the doctor’s time and energy, it is also very shortsighted. After all, you need to remember that just as you spend a lot of time, money and energy before buying an ECG machine, you need to spend a lot of time before employing a new staff member.

Your employees are an investment in a successful practice and you need to build a high-quality staff to keep your practice running smoothly so you can spend your time practicing medicine.

THE TOUGH APPROACH

Your formula for hiring and managing your staff should be ‘Hire Tough – Manage Easy’. This is a simple yet powerful principle will help you to hire the right person, therefore reducing staff turnover. A good manager should be able to go on a holiday and come back to a clinic which is functioning as efficiently as when they left.

A good manager is one who has truly learned to manage by getting the work done through other team members. You need to teach your employees a sense of responsibility for their tasks, and you should not need to constantly monitor whether they are fulfilling their duties. The secret is to hire a person with the right attitude, and then teach them the skills they need to get the job done.

Each employee represents a major investment. Many doctors only consider how much they actually pay each employee without devoting much thought or energy to hiring the right candidate. However, remember that hiring the wrong employee can prove expensive. If you lose even one patient thanks to the inefficiency of your staff, this can be a major financial loss to you. Your employees are your public face – they represent you to your patients, so select them with care.

The quality of your clinic can never exceed the quality of the people who make it up. You need to have a systematic method towards employing staff, and you can learn a lot from the techniques employed by the HR departments within large companies. Losing an employee can cause havoc in your practice, as training a new employee is a time-consuming affair. To avoid costly staff turnover, hire the best personnel possible and then make your medical practice a place they won’t want to leave.

GETTING STARTED

When looking to hire new staff, follow these tips to screen all suitable applicants:

• **Prepare a job description:** Outline the duties the job entails and write a ‘person specification’, which describes the type of person you want for the job and details skills required, qualifications needed and personal qualities necessary. Advertise appropriately then screen résumés to find those applicants with all or most of the necessary skills, education and experience to meet the position. You can also ask your present staff to suggest people they feel would make good employees.

• **Pre-screen probable candidates by phone:** A brief conversation with those who look good on paper can help you to judge the candidate’s telephone manner. If you don’t get a positive feeling, neither will your patients. Just a few minutes on the phone can eliminate some candidates and save time that would be wasted in an interview.

• **Use an application form:** Develop an application for your practice or use a commercially available one. Do not just accept the applicant’s résumé. Having the applicant complete the form also allows you
to judge handwriting and spelling skills.

- **Look for clues during the interview:** During the interview, watch for signs that the candidate will mesh with your practice philosophy and culture.

- **Consider testing:** To give you an idea of how the applicant will perform on the job, develop some basic skills tests or use commercially available, standardised tests for English, spelling, math and keyboarding.

- **Check references:** When calling for references, provide the applicant’s name and dates of employment shown on the application, and mention the position for which she has applied. Ask open-ended questions and encourage the person to keep talking. Suggested questions are: Was the candidate reliable? What were his/her strongest and weakest points? Why did he/she leave? Would you rehire him/her?

**HIRING & TRAINING**

When you find the perfect candidate, hire them. Be sure your salary and benefits are in line with those in your area. A qualified candidate may have several job offers and you don’t want to lose that individual for the sake of a few dollars. Hire qualified people and give competitive compensation.

Many doctors take pride in paying the absolute minimum to their receptionist, and this explains why staff turnover can be so high. Turnover generates hiring costs and undercuts efficiency, since it takes time for employees to get to know your patients, your idiosyncrasies and the system of patient flow.

Consider offering more than the average salary for your area. If that’s what it takes to have a first-class person representing you at the front desk, it’s well worth it.

All newly hired employees should be given a probation period during which time you can assess their on-the-job skills. As your interviewing skills are honed, this period should just be an affirmation that you selected the right person to fill the job.

Once the probation period is over, it’s a good idea to sign a formal employee contract. This gives your employee the job security they need and also helps to give you peace of mind that they are likely to stay with you for at least the period of the contract.

Just hiring a new person is not enough. To make the most of that person, you need to train them so they fit in well within your office. Unfortunately, many doctors simply employ a new person and then expect them to learn on the job, often by trial and error. This is less than optimal and can lead to poor performance, poor patient care, low job satisfaction and high employee turnover.

A simple way of implementing a formal training process is to have a checklist of the duties a new employee is supposed to master, and then to provide training in each. When new employees know what is expected of them, they can take a more active role in their training and feel they are truly succeeding. In turn, this can boost job satisfaction for all employees in the practice, increase efficiency, improve patient care, reduce the rate of employee turnover and decrease long-term practice expenses.

**STEPS TO SUCCESS**

A four-step training approach is recommended when you are breaking in a new employee:

1. Demonstrate the skill as you want it performed. As you demonstrate, point out the important aspects so your
employee understands why each part is important.

2. Role play with the employee. Always give the employee an opportunity to practice with you first. Don’t force your staff to experiment a new skill on a patient.

3. Give the employee feedback on what was done correctly. Too often managers only correct mistakes. Positive feedback is much more important in training new skills. Once you have explained what was done appropriately, give feedback on what needs to be improved.

4. Supervise the skill in a real-life setting. This last step gives the employee an opportunity to ask questions if necessary. After you watch the skill, give feedback. Be sure to point out the strengths before you point out areas that need improvement.

**SETTING STANDARDS**

A procedure manual is a useful tool for training. It simply sets the standards the entire clinic lives by in writing. Since procedures are formalised, they guide the performance of everyone in the clinic and help to keep things uniform and consistent. Every clinic should have a procedure manual, but sitting down to write the manual can be dull, dry work, so ask your staff to pitch in. Each staff member can write down how they perform their own duties, and you can then correct this.
Some of the details a procedure manual should contain include:

• **Telephone procedures**: Answering techniques, calling missed appointments, scheduling new patients and handling problems.

• **Regular patient procedure**: Sign in, filling treatment rooms and scheduling the next appointment.

• **Collecting money**: What to say, handling unusual problems, sending statements and phone call collections.

Since writing procedure manuals is a new experience for most people, there is one important technique that makes it easier. Each step should describe a specific action. If you start each sentence with a verb, you will have an action step.

Below is a simple example of the procedure that needs to be followed when opening the clinic in the morning. Writing all this down might seem like a lot of trouble, but if you set up systems you will find they save you time, energy and money.

**OPENING THE CLINIC**

1. Unlock doors
2. Turn on lights
3. Turn on air conditioner
4. Check messages on answering machine
5. Turn computer on
6. Check for cleanliness
7. Check bathrooms for toilet paper and towels
8. Check appointment schedule
9. Pull out patient charts

Remember that working in a doctor’s clinic is a stressful job, with constant distractions and the need to handle multiple jobs at a time – greeting patients, collecting money, answering phones, putting patients on hold and ensuring the doctor’s workflow is running smoothly. It’s a demanding job and the time, money and energy you invest in hiring the right person will pay off a hundred fold. ☺️
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Jonathan Rivera is Associate Director of Urbis.
When looking to invest, buyers should consider three key factors – population, infrastructure and employment. **Jonathan Rivera** reports on current trends and reveals why Brisbane is a property hotspot.

In the past couple of years, Australia’s residential property market has revealed a number of trends that only a correction in the market would make clear. The major trend identified, and one that had been largely forgotten, is the notion of time. Residential property is historically a long-term investment class, and those seeking greater gains in a short timeframe may need to wait for the cycle to return.

The concept of time and residential property also identifies a greater learning, a learning that was not completely understood in the past and saw some markets register above-average growth, and will see markets in the future outpace others.

The correction in the residential market emphasises this factor and shows the importance of ‘place superiority’ – a concept that demonstrates to developers and purchasers that focusing on product alone may no longer sell as it did in the mid 2000s. Finishes, amenities and views will no longer compensate for developments in marginal locations, and buyers are the first to vote with their wallets.

Lasting appeal and enduring value will be the most important motivator for buyers moving forward and, amid today’s new market demands, those regions accommodating a unique formula will dominate the landscape over time.

At Urbis, we have investigated the trends that will deliver sustained and confident growth, now and into the future. This involves recognising the key fundamentals that investors should seek to secure returns, as well as identifying regions that will be the most desirable to live, work and play in.

To help identify these locations, our team has concluded that the most desirable locations will be those locations offering ‘P.I.E.’ – population, infrastructure and employment.

**POPULATION GROWTH**

Healthy and sustained population growth usually equates to a healthy and prosperous residential property market. Look for emerging and growing regions, and ask yourself why they are growing.

An easy way to clearly identify a region with sustained population growth is to understand the local employment nodes, increase in development activity and low vacancy rates for rental property.

**INFRASTRUCTURE & INVESTMENT**

Locations supported by adequate useable (existing) infrastructure and amenities are prime areas for residential development and growth. Residential developments are more desirable when infrastructure and amenities are within walking distance or transit accessible.

Additional infrastructure and amenity investment is also as important, as this supports greater population growth and employment opportunity.

**EMPLOYMENT OPPORTUNITIES & DIVERSITY**

Proximity to employment nodes and centres is fundamental to strong residential growth. Localities well supported by employment generally drive a greater demand for residential dwellings, particularly those located within walking distance of, or reinforced by, sufficient public transport and accessibility.

**Editor’s Note:** We are extremely pleased to welcome one of this country’s most regarded and awarded property developers, Lend Lease, to our network of education partners.

The three key investment factors discussed by Jonathan Rivera of Urbis – *Population, Infrastructure and Employment* – are all supporting features of the Lend Lease RNA redevelopment and its first stage, *The Green* – see the advertisement at the end of this article for details.
SPOTLIGHT ON BRISBANE

Across Australia, Brisbane is acknowledged as a lifestyle destination – a diverse and energised global city recognised as a leading destination for business and investment, major events and international education.

According to population projections, the Brisbane local government area (LGA) is set to increase by 9000 residents per annum between now and 2031, equating to approximately 174 new residents per week.

The most significant growth is predicted to occur between now and 2021, with a projected increase of over 12,000 new residents per annum, or approximately 235 new residents per week.

Looking at actual figures between 2002 and 2012, the increase was just over 17,000 new residents per annum. This equates to, on average, 331 new residents per week over this 10-year period.

If we apply a rate of 2.5 persons per household, this equated to a requirement of approximately 132 dwellings needed per week to accommodate this growth.

The Brisbane Population Growth vs. Dwelling Approvals graph (on page 51) indicates that the number of dwelling approvals in Brisbane, despite an incentive-driven upturn in 2007-2008, has continued to decline in spite a consistent population growth over the period 2002-2012.

Newly released Census data further highlights the supply and demand imbalance, suggesting an increase of 175,000 residents between 2001 and 2011. Over the same period, an increase of 57,800 dwellings was recorded.

At an average household size of 2.5 persons per dwelling, the demand based on population growth was 70,000 dwellings. This suggests an undersupply to the tune of approximately 12,200 dwellings over the 10-year period to 2011.

The housing shortage, driven by a sluggish development and building performance within Queensland, and in particular within inner Brisbane, has been one of the main reasons behind tight vacancy rates and increasing rental rates.

Residential Rental Apartment Rates

KEY FUNDAMENTALS

The Brisbane LGA has strong fundamentals in place that are helping to drive the market out of the trough and into the recovery and growth periods of the real-estate cycle. These strong fundamentals are:

- **Demographic**: Growth and dwelling shift in key Gen Y demographic, influencing demand for apartments and rental markets in inner-city locations.
- **Economic**: Commodities boom filtering into Brisbane, privatisation of the Brisbane Port and continued private and public investment into other key nodes will drive further employment opportunities.
- **Employment**: Continued investment into the region will aid in future employment prospects, promoting migration from interstate.
- **Migration**: Increase in population growth may drive further demand for dwellings, advancing the supply and demand imbalance within the residential market.
- **Development**: Improved confidence and economic conditions may lead to further investment and development, providing key infrastructure and amenities to support growth.
The latest rental vacancy rates data, produced by the Office of Economic and Statistical Research Queensland, indicates a current imbalance between supply and demand for rental dwellings within inner Brisbane.

The inner Brisbane vacancy rate was 2.2% at the end of the June quarter 2012, registering a significantly lower vacancy rate than the Brisbane Surrounds and Queensland Benchmark.

The inner Brisbane vacancy rate has demonstrated a solid declining trend since the June 2009 quarter. This decline was subsequently driven by a lack of new dwellings entering the market, further adding to the supply and demand imbalance.

With population growth continuing to remain strong for the region and dwelling supply remaining low, it is probable to expect that the inner Brisbane vacancy rate will remain tight in the short term – a positive sign for investors.

KEY INSIGHTS

- The estimated resident population within inner Brisbane increased by 3.7% per annum over the 10 years ending 2011. This compares to the growth of the wider Brisbane local government area, which recorded a growth of 2% over the same period.

- In comparison to this growth, the Bowen Hills catchment (made up of the Bowen Hills and Fortitude Valley statistical local areas) recorded a population growth of 7.4% per annum over the 10-year period ending 2011.

- The $2.9 billion development of the Brisbane Showground Masterplan will be a core driver of capital price and rental growth, through structural uplift, in the suburb of Bowen Hills.

- Infrastructure such as the Airport Link and the Northern Busway will provide residents of Bowen Hills with an ease of access to significant employment nodes and amenities.

- The suburb of Bowen Hills is located less than three kilometres from Queensland’s largest employment node, the Brisbane CBD.

- The state’s largest hospital and major employment node, the Royal Brisbane and Women’s Hospital, is directly adjacent to the Brisbane Showgrounds.

Source: Urbis Residential Market and Economic Outlook, Queensland, Brisbane and Brisbane Showgrounds June 2013
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Reaping Your Reward

Many doctors miss the opportunity to sell their practice at the price it deserves. As Linda Sirol writes, the secret is in the transferable assets.

So, you have a successful practice with strong patient loads, an excellent network of referrers, a loyal team and wonderful goodwill. When you come to retire, therefore, you should be able to sell it for a great price, right?

Not necessarily. For too many doctors the reality is that a buyer will offer very little for what looks like a thriving practice, and sometimes the vendor's only option is to walk away with little – or nothing at all.

It’s an extremely disappointing, not to mention financially painful, outcome for doctors who have put in the hard yards building up a practice they assumed would be a significant contribution to their retirement fund.

EXIT STRATEGY

Why does this happen? As Tom McKaskill, author of Ultimate Exits, says: “Selling a business is not about valuation, it is all about creating a compelling opportunity for the buyer.”

When a doctor is looking to buy into a practice, their first consideration is whether buying in will be a better option than establishing, or expanding, their own practice. They will ask themselves: Will this practice continue to thrive after the vendor has left?

If it becomes clear that the majority of the value rests in the goodwill generated by the retiring doctor, then it starts to look like a risky investment – one that will collapse the moment the vendor exits.

Put simply, a practice that rests heavily on the personal goodwill of an individual doctor is not a compelling opportunity.

How can a medical practice become compelling to a buyer? The best way is to maximise the value embedded in the assets of the practice itself; value that will remain in place when you retire.

SALE ABILITY

The good news is that if you have three or more years to go before you’re thinking of selling, you have plenty of time to take a look at your practice from a buyer’s perspective, and adjust the balance between personal goodwill and practice goodwill in favour of the latter.

Here are 10 practice assets that typically add value:

1. A reliable and sufficient patient load.
2. Patient relationships with the practice, rather than the individual doctor.
3. Experienced and efficient administrative and clinical support staff.
4. Clear and robust contracts with staff and suppliers.
5. An established documented systems and procedures.
7. Referrer relationships with the practice rather than individual doctors.
8. Well-presented rooms.
9. Appropriate and modern equipment.
10. Growth opportunities for the practice.

Getting a great price for your practice is not just about increasing your retirement fund, however. It’s also about ensuring that your patients, staff, referrers and suppliers can continue the relationship they have enjoyed with your practice long after your departure. It’s about reaping rewards all round.
Whether you are familiar with the term or not, ‘Big Data’ signals a significant change for the Australian healthcare sector, says Kevin Morgan.

Not just another tech term, ‘Big Data’ is the next generation of intelligence that is transforming a range of Australian industries.

With the proliferation of Internet-connected devices, data is being produced in greater quantities than ever before. Individuals are using digital media and disseminating data, such as photographs, videos and social-media dialogue, at an unprecedented speed. Every day we create 2.2 million terabytes of data. According to Hewlett Packard, 90% of the data in the world today has been created in the last two years alone.

TRACKING TRENDS

The commonly accepted definition of Big Data comes from US information technology research and advisory company Gartner, which defines it as “high-volume, high-velocity and/or high-variety information assets that demand cost-effective, innovative forms of information processing for enhanced insight, decision-making and process optimisation”.

With such an abundance of data available in the digital world, it is critical that we adopt Big Data analytics to make sense of the information and create value. Indeed, the private sector has made significant headway in capturing this data, with many companies gathering huge amounts of information about their customers.

These companies have pioneered data analysis and are continually redeveloping business products to meet ever-changing consumer behaviour and demands.

Supermarkets, for instance, can examine data from customer-loyalty cards to identify sales trends, optimise their range of products and develop special discount offers accordingly.

In the transportation sector, taxi companies can now offer real-time and predictive analysis to accurately predict taxi collection times and spot taxi-travel trends.
In the finance sector, global financial organisations have started using Big Data to model dozens of economic scenarios in near real-time.

**ADDING VALUE**
The key question is: What opportunity does Big Data present to the Australian healthcare industry?

Big Data has the potential to transform the healthcare industry by increasing the quality of the care provided and reducing the overall cost of providing that care. In other words, insights garnered from data will become key to reducing healthcare expenditure while simultaneously improving overall patient care.

In the context of an ageing population, future population growth and a turbulent economic environment, the potential benefits of Big Data are huge. (Source: Autonomy, Hewlett Packard)

The healthcare industry has come to a tipping point. Big Data has the capacity to truly transform the healthcare industry.

The Value of Analytics in Healthcare, a 2012 report conducted by IBM, has reaffirmed that analytics will play a crucial role in the future of the healthcare industry. IBM has pointed to the potential for Big Data to help improve three of the greatest problems in the healthcare industry – industry inefficiencies, higher consumer expectations and increasing levels of competition.

**BOOSTING EFFICIENCY**
The healthcare industry in Australia is increasingly challenged by deep-rooted inefficiencies. These inefficiencies can be attributed to the ineffective gathering, sharing and use of information.

Many argue that healthcare in Australia is a ‘volume-based business’ rather than a ‘value-based business.’ According to the Australian Institute of Health and Welfare, the average annual out-of-pocket expenditure on healthcare has almost doubled from about $583 in 2000 to $1075 in 2010 – $94 above the weighted Organisation for Economic Co-operation and Development (OECD) average of $981. Experts say there is extensive waste as a result of systemic inefficiencies in the Australian healthcare system.

The launch of the eHealth system has been the first step towards minimising some of these inefficiencies. For instance, a patient will be less likely to double up on unnecessary tests or vaccines if their health record demonstrates they have already had the necessary tests and treatments. The launch of the eHealth system is the will collate nation-wide healthcare data, and will lead the way for future data developments.

As IBM’s analytics report states: “Analytics can improve effectiveness and efficiency. From managing small details to large processes, analytics can aid exploration and discovery; help design and plan policy and programs; improve service delivery and operations; enhance sustainability; mitigate risk; and provide a means for measuring and evaluating critical organisational data. Perhaps
most important, it can expand access to healthcare, align pay with performance and help hold down growth in healthcare costs.”

GREAT EXPECTATIONS
To add to the challenges faced by today’s healthcare industry, there’s now additional pressure from patients who have increased service demands. Patients want more tailored medical solutions. The solution to this is to use Big Data to provide more tailored medical solutions.

Personalised medical treatment is central to any discussion on the integration of Big Data in the healthcare industry. A report based on the Intel Healthcare Innovation Summit 2012 reinforced the capacity of Big Data to deliver personalised medical solutions for patients.

Martin Leach, Chief Information Officer for the Broad Institute of MIT and Harvard, points to the need for a “Google-like search capability that allows natural-language searches, straight-text searches, image based searches, and structural searches”. Leach envisions finding the data he needs from various sources, combining the data through a common data exchange.

An important issue discussed at the Intel Healthcare Summit 2012 was the impact of Big Data on early drug discovery stage. According to Mike Miller, Senior Director of Pfizer Global Pharmaceuticals, “Merging disparate bits of data will help speed the process and development of personalised medicine.”

John Halamka, Dean of Technology at Harvard Medical School, has suggested the eventual product of Big Data will be event-driven medicine – when the data combines to signal a potentially emergent situation, clinicians are alerted and the data drives an actionable event that keeps the patient well.

PREVENTION PLANS
While the integration of Big Data in the healthcare industry is still at a very early stage, there are already examples of companies that have successfully used Big Data technology to develop healthcare applications.

One such example identified in the aforementioned McKinsey&Company report is a GPS-enabled tracker developed by Asthmapolis that monitors inhaler usage by asthmatics. The information gathered from the app is sent to a central database and used to identify individual, group and population-based trends. This information is then combined with existing information about known asthma catalysts to help physicians develop personalised treatment plans and spot prevention opportunities.

Another example is a mobile application developed by Ginger.io, in which participating patients are tracked through their mobile phones and assisted with behavioural health therapies.

By monitoring the mobile sensors present in smartphones, the application records calling information, texting information, location and even movement information. The application then integrates this information with public research of behavioural health data, which may give specialists a more accurate understanding of what triggers anxiety, enabling them to tailor treatments.

FUTURE FOCUS
From a market perspective, it is critical that healthcare executives and industry stakeholders acknowledge the role Big Data can play in ensuring healthcare businesses remain competitive. Market dynamics and competitive pressures require enhanced understanding of underlying Big Data trends.
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According to a recent IBM Global CIO study, more than 90% of healthcare CIOs for top-performing organisations cited analytics as a key focus for their organisations over the next three to five years, compared to 65% of underperformers. Furthermore, 83% of healthcare CIOs said business intelligence and analytics was their number-one priority.

It is expected that the leading healthcare companies of the future will apply analytics to innovate, stand out and remain competitive.

While the future of Big Data in Australian healthcare seems bright, the process of adoption and implementation seems daunting. We are entering an era of open information in healthcare, with numerous countries worldwide digitising their medical records.

The Australian Government has spent over 10 years building an eHealth system, which can store a patient’s health records electronically. This marks an important step in the move toward transparency by making decades of stored data usable, searchable and actionable by the healthcare sector as a whole.

This increased ‘data liquidity’ has brought the Australian healthcare industry to a tipping point. It is at this point in time that industry professionals, businesses and stakeholders must consider the potential of Big Data.

An ageing population combined with future population growth will result in exorbitant future costs for the healthcare industry. We have an abundance of under-utilised healthcare data and a number of deep-rooted inefficient practices that inhibit sector progress and enhanced efficiency.

**NET BENEFITS**

Healthcare stakeholders now have access to technology that will allow them to make sense of data and utilise Big Data. While still in the early stages, Big Data could enable the Australian healthcare industry to improve healthcare quality and address the problem of accelerating healthcare spend.

In March 2013 the Australian Government released its *Big Data Strategy* paper. This was an important step in recognising the opportunities Big Data presents to Government sectors, including healthcare. The next step is implementation.

Healthcare is one of the slowest sectors to adopt and implement information technology. In fact, new-technology adoption is laden with a number of processes, including an assessment of the efficacy and cost-effectiveness of the technologies, deployment of these technologies within a complex organisational structure and monitoring the use of these new technologies.

Despite this, it is critical for the health industry to stay on top of technological developments. After all, the priority is patient outcome.

In the era of Big Data, one of the most important steps for healthcare practitioners is to have an online presence. Any healthcare practitioner that does not have a complete online offering will miss out on gathering valuable data and will be left behind in the face of future competition.
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We’re more than just a leading accounting and advisory firm. We become true partners with our clients and work hard to keep you one step ahead.
In the digital age, websites serve as the face of your medical practice and the way clients research and engage with your services. Having a modern, user-friendly website that effectively introduces potential patients and referrers to your practice is essential to your business.

Simply throwing together a website with some poorly thought-out content will not impress potential patients who are researching practitioners for themselves and their family. Patients want to know their healthcare is in capable hands.

Creating a first-class website for your medical practice will bring numerous and ongoing benefits, writes Jason Borody.

Site Specifics

Jason Borody is Director of Vividus Marketing.
By creating a first-class website for your medical practice, you have the ability to:

• Interact with existing and future clients easily.
• Provide information through an easy-to-use interface.
• Gain valuable feedback from clients.
• Present a polished brand for your practice.
• Exhibit your values, your expertise and the character of your practice.

SETTING THE TONE

There are several steps to creating a useful website that will bring more patients to your practice. Your first task is to recognise the fundamental purpose of the site itself. Some sites are used to acquire email addresses for marketing campaigns, while others aim to 'sell' a particular service. Generally, medical-practice sites are used to convey how you operate as a clinic, outline your range of services and facilitate phone enquiries and bookings.

One of the best ways to create a successful website is by appealing to your ideal clientele – who do you want to attract to your practice, how old are they and what are their primary concerns?

Use your creativity to conjure up a strong image of your clients and their reason for looking at your site. By anticipating their questions, your website can pre-emptively provide the answers. Considering your current and potential patients’ needs will help shape everything you do with your website.

Once the direction of the site is clear, it’s time to start thinking about content. Always remember the purpose of writing content for a website is to drive traffic to the site itself. While there are secondary reasons for content, the primary focus is to demonstrate your expertise as the best option for potential clients.

There are three tried and tested methods that will assist you in crafting quality web content that drives people to your site.

1. SEO copywriting

Search Engine Optimisation (SEO) Copywriting focuses on making the content of a site easier for search engines to index. In the old days, this meant packing blog articles and page information with keywords to boost your rankings in search engines. Today, search engines are too smart for keyword packing. In fact, many of them will downgrade your site ranking because they see 'link stuffing' as cheating the system.

Most search engines read pages like humans, so they understand how many times a keyword should reasonably appear. This means your website copy should read naturally and provide valuable, relevant information that is easily found.

While most people are able to write web copy, the job of a professional copywriter is to determine how best to engage with a specific audience. They will research keywords for hours to see which words and phrases are being used by your particular audience. They will then craft content that reaches out to your targeted audience and draws them in.

Many people might think it is easier to write their own web content but even if the groundwork is laid down by the site owner, it is always advisable to let a professional edit the content. Even a subtle change can make all the difference, but you must have the knowledge of what does and doesn’t work.

2. Link building

The more links there are to your site, the more valuable your site will be regarded by search engines. You can build links internally from one page to the other on the actual site but it is far more important to get other sites to link back to yours. The more popular the sites are that link back to yours, the better for your site.

Think of it as website referrals. If the receptionist and the CEO both write job references for you or vouch for you to another company, the CEO’s referral will be more valuable. Your website works the same way. The more trusted the source that links to your site, the more ‘link juice’ you receive for boosting your site’s standing with Google and other search engines.

One of the best ways to receive inbound links from other sites is to write content for other websites. After an article is posted, there will often be a small blurb about the author with a link back to their own website. Again, the quality of the post and the site itself will have a direct impact on your own site’s rankings due to that particular link. The more popular the post, the more people will click through to your site. The more that people click through, the higher your SEO ranking.
Finding guest-blogging opportunities requires some research. In every industry and niche there are well-known blogs. A great way to look for sites that accept guest writers is to type in search terms, such as the following suggestions, into your search engine:

- ‘Writers’ guidelines for …’ (insert keyword for your niche)
- ‘Guest writers for …’
- ‘Guest blogs for …’
- ‘Guest post guidelines …’

These searches should draw up a list of sites and blogs that allow people to write guest posts. When writing a guest post it is critical that you abide by the site’s guidelines. Failure to do so will mean your post will not be published and, perhaps even more importantly, you may not get the chance to write for that particular site again.

In addition to writing for other sites, sharing valuable information on your own website from other experts or related blog posts can work well. Firstly, the person you ‘repost’ may return the favour. Secondly, your patients will see that you are genuinely interested in providing them with the most helpful, relevant information, even if it is from another source. This is where you start to build bridges to new patients and referral sources.

3. Social-media marketing

Social media can have a huge impact on your search-engine ranking. It is therefore a good idea, no matter how scary it might seem, to get interactive on some of the social-media sites. Even adding a button to ‘share’, ‘like’ or ‘tweet’ things from your website will be a step in the right direction.

In Australia, potential patients are concerned about the personality and demeanour of a practice before searching for credentials. Social media is a great way to showcase both your own personality and that of your practice. For example, Facebook posts show how you convey information and engage with clients – whether it be in a formal, informational or conversational manner. Each patient has different preferences and they care about your personality.

Tips for social-media marketing:

- **Keep your accounts separate.** Perhaps use LinkedIn to comment about news articles and breakthroughs, and use Facebook to ask questions and chat with people researching your type of practice. This will allow you to keep people engaged across channels, giving more credibility to your site.

- **Try automated updates.** By utilising social-media management tools, you can write personalised updates on your social-media pages but have them scheduled to appear at the beginning of the week or month. This not only means that you don’t have to remember to update the pages but helps to keep your social-media presence active even when you are busy with other projects. Remember though, that social-media presence is all about timeliness and interaction, so although the automated updates can help, your patients will still need to be replied to, and no social-media management tool can compensate for that.

- **Interact with other people and professional colleagues.** It’s important to build professional relationships. Social media is a great ice-breaking tool that isn’t used by enough people. Not only can it be used to gain new patients and keep existing patients updated, a brilliant Twitter, Linkedin or Facebook page can bring new professional contacts into view who may even be able to offer professional referrals down the line. The power of good social-media networking skills cannot be underrated.
ONGOING MAINTENANCE

Once the above points have been followed and the website is operational, you can leave it alone and hordes of people will come through the door of your practice, right? The answer here is a resounding 'No'.

For a website to work optimally, it needs to be consistently updated and maintained. People like to know the information they are seeing is recent and that you care about potential patients. Additionally, search engines identify well-maintained websites. Even bi-weekly blog posts give your site some attention and show others you are engaged.

Create a blog

Blogs are a great way to update a website with fresh, interesting, engaging content without writing long professional papers. People often ask how many times a blog should be updated per month and there is no real right or wrong answer. The amount of blogs per month doesn’t matter, only that the schedule is consistent. If a person starts off blogging twice weekly then drops the posts down to once a month, there will be a definite decrease in the amount of readers and a drop in search-engine rankings. Email your patients to identify their interests and concerns. If you keep getting questions about flu vaccines, write a post. Just keep it timely and relevant.

Do some tweaking

Every website owner should be conscious of keeping track of things that work effectively and things that don’t. There are many ways to track a website’s popularity. Google Analytics is a great platform for discovering how people engage with your site. It has the ability to tell you:

- Where your traffic is coming from around the world.
- How people are finding your site and through which keywords.
- Which of your inbound links from other websites are most popular.
- What content is being read the most.

Armed with this knowledge, you can then tweak the site as necessary. If people keep coming to your site because of a post about a breakthrough breast-cancer treatment, write a longer series on the topic. To attract more readers from a certain geographic area, write pieces that address comments on local news articles and post a link to them on those websites. Or you may want to write more guest posts for a particular site that has been sending traffic your way.

Analytics are key to understanding your readership so you can get them to repost your materials, attract more people and best meet their needs. A little effort can go a very long way.

Running a practice is time consuming, and just staying on top of medical advancements is tough. The good news is that creating and maintaining a first-class website for your medical practice doesn’t need to be a fulltime job. There are a number of tools available nowadays to help people build a site that is truly useful and will grow with your business. To show you genuinely care about your patients and public health, offer a patient-focused service and a patient-focused site – this can improve practitioner/patient relationships significantly and open up substantial opportunities for practice growth.

At Vividus, we find that most of our healthcare clients simply don’t have the time to self-manage their SEO and web content. We work with them to provide customised medical content on a regular basis, as well as other SEO services. We specialise in healthcare marketing for medical specialists, dentists, medical centers and pharmaceutical businesses. We understand the laws and codes that regulate medical marketing in Australia, and develop content and SEO strategies that are compliant, professional and effective. For more information, contact Vividus on 07 3283 2233 or www.vividus.com.au
Bruce Willis created a stir last year when he threatened to sue Apple over the ownership of his iTunes library – the actor intended to bequeath the library to his daughters on his death. The dispute highlighted that Willis had not acquired the music itself, but a perpetual license to listen to it, and the license was not assignable on his death.

As we live our lives increasingly online, this controversy raises important questions about the ownership of virtual assets and online information, and how they are dealt with when we die.

Generally speaking, social-media outlets such as Facebook, Flickr, Instagram, Yahoo and Google will:

• Not allow login or access to the deceased’s online information.
• Not, in some cases, deactivate an account without a court order; or will, in other cases automatically shut down an account on death.

Part of the problem faced by executors dealing with online service providers is that often the original terms and conditions of the service provider govern the use of and access to information. There is little by way of uniformity among providers or laws governing this specific issue.

While much of our online information and assets are of sentimental value only, some may be inherently – and sometimes surprisingly – valuable.

Think your cyber assets can automatically be passed on via your will? Donal Griffin suggests you take a closer look at the fine print.

Virtually Yours

Donal Griffin is Director of de Groots Lawyers.
Consider the following moneymakers:

- Popular YouTube clips.
- Domain names, blogs and websites.
- Online characters (think World of Warcraft).
- Manuscript novels, film scripts and music held only in digital form.

FOR THE RECORD

Here are some quick tips for dealing with your virtual information and assets:

- Keep a record of your digital life. Note: Recording details in your will is not advisable as the will may become a public document and each password or username change must be recorded in a subsequent codicil.
- In some circumstances executors should arrange for account payments to continue to be made to avoid account closure. For example, Flickr currently has five million images stored on its site and subscribers must pay a fee to access all photographs held on their account, failing which it will be closed.
- Ensure that domain names are renewed until they can be dealt with by the estate. This is particularly important where the domain name is a valuable asset associated with a business or other enterprise.
- When drafting a will, consider the nature of each digital asset (whether a chattel, intellectual property or a license), and ensure the will is carefully drafted to capture that asset.

DONATING LIFE

Earlier this year de Groots was pleased to support the DonateLife campaign and particularly DonateLife Week, which took place from 24 February to 3 March. The campaign sought to create awareness of the need for us all to ‘Discover, Decide and Discuss’ organ and tissue donation. It was led by the Organ and Tissue Authority as part of the national DonateLife campaign and supported by community events and activities across Australia.

It’s a fact that Australia has one of the lowest organ-donation rates in the western world, generally because Australian families often don’t know the wishes of their loved ones. The family of every potential donor in this country is always asked to confirm the donation wishes of their loved one before organ and/or tissue donation can proceed, but at present 44% of Australians do not know or are not sure of the donation wishes of their loved ones.

To register your wishes on the national register, have your Medicare card number handy and follow this link – http://www.degroots.com.au/make-your-wish-count/
A Rare Gem
The Sydney suburb of Surry Hills offers an abundance of outstanding dining venues but for Steven Macarounas, Bar H stands out from the crowd. Having emerged as the epicentre of gastronomic creativity in Sydney, Surry Hills boasts some of the city’s most inventive and accessible dining experiences. A stroll through the inner-city suburb’s Melbourne-like lanes yields exciting treasures at every turn – from the rustic chic of the Latin American-inspired Porteño and the strong Italian vibe at Vini and 121BC Cantina & Enoteca to Marque, named Australian Gourmet Traveller Restaurant of the Year for 2012.

For me, a shining light in this bustling destination is Bar H, owned and operated by Hamish Ingham and Rebecca Lines. Humble Head Chef Hamish classifies his fare as ‘Asian homestyle cooking’, but Bar H offers an experience more akin to theatre than a night at your local Chinese. The atmosphere is effortlessly warm and ‘cool’ – a paradox, I know, but worth mentioning as it’s extremely rare to feel so comfortable and welcome despite the obviously hip foodie vibe. We are greeted by the genuinely hospitable restaurant manager Nicole and seated at the dimly lit bar overlooking the kitchen, then have our coats and drinks orders taken by ever-smiling Mikey (assistant manager and sommelier). A feeling of familiarity and belonging starts to creep into our consciousness – it feels as though we’ve arrived at an age-old friend’s house for a dinner party. This sense is accentuated by the seemingly effortless rhythm of meal preparation unfolding in the kitchen in front of us and followed up by the clear explanation of menu options. It’s almost like a scene out of The Big Chill, but with an updated soundtrack.

Chefs Renee and Roy perform before us with both meticulous precision and unmistakable pride and joy – they really love what they do, and it shows. Waitress Paloma and Handy the kitchen hand (yes, that’s his moniker) round out the quintet of players, all of whom are perfectly synchronised to the movements of each other in a display of natural choreography. Then there’s the food.

**ON THE MENU**

Our table opted for a mix of dishes to share:
- Steamed pork & prawn wontons with chilli oil & red vinegar
- Sashimi of ocean trout with seaweed & radish salad
- Steamed pork buns with fresh coriander, Vietnamese mint & chilli
- Crisp rice noodles with sweet soy, peanut, bonito flakes & truffle
- Salt & Sichuan pepper calamari with a side of kim chi
- Crisp spatchcock with strange pepper sauce – a mix of native pepperberry, green pepper & Sichuan pepper
- Steamed hapuka fillet with ginger & shallots
- Caramelised beef rib braised in masterstock then caramelised. Served with pickled yam bean, shiso & pickled mustard greens
- Pomegranate tapioca with coconut foam & candied cacao nibs
- Sorbets – blood orange with Campari & lemon iced tea
- Chocolate truffles – passionfruit & dark chocolate
Each dish was superb, the favours clean, crisp and distinct. Some packed a flavoursome punch, like the rice noodles and the beef rib, while others were subtle, delicate and full of nuance, like the spatchcock and hapuka.

Other dishes were a complete surprise. The steamed buns were fluffy and featured an exquisitely mouth-watering filling, and the tapioca was truly inspired – a slow-motion explosion of diverse and strong yet remarkably complementary flavours and textures.

The sophistication and generosity of the food is the end product of an evolution of experience and tutelage. In 1990 Hamish apprenticed at Boronia House in Mosman, and was subsequently offered the position of Sous Chef at Milsons Restaurant, in Kirribilli. Then, in 2000, he joined the start-up team at Billy Kwong, helping Kylie Kwong and then co-owner Bill Granger to pioneer the fresh and modern take on Chinese food we've all come to love.

Working on cookbooks and food styling for TV on behalf of Kylie Kwong no doubt helped to hone Hamish's strong aesthetic, as well as his mastery over flavour combinations.

JEWEL IN THE CROWN

In 2004 Hamish was awarded the ‘Josephine Pignolet Young Chef of the Year’ award, which led to travel and work in the food capitals of New York and San Francisco. Armed with international experience and deep passion, Hamish returned to Billy Kwong, helping cement its reputation through to 2009. The following year saw Hamish as a young gun for hire in Sydney – he put in stints at Marque, Sean’s Panorama in Bondi and The Bellevue Hotel in Woollahra, as well as teaching cooking classes at Simon Johnson and Accoutrement.

While developing plans with partner Rebecca for their Bar H concept, Hamish was also involved with Sydney’s burgeoning ‘guerrilla dining’ scene – an underground movement whereby a restaurant is set up for one night in somebody’s home, vacant warehouse or other non-restaurant site, and advertised via social media and word of mouth.

Now focused on Bar H, Hamish and Rebecca have jointly created a jewel that is perfect placed at the heart of the Surry Hills gourmet scene. This place is decidedly fun and friendly. It dishes up world-class grub accompanied by inventive cocktails and a superb beer and wine list, all backed up by genuine and hearty hospitality.

Our night at Bar H was hands-down one of my all-time favourite dining experiences. 😊
MENU

Steve Feletti’s oysters served natural
Spiced nuts
Crisp fried old man saltbush w chilli mayo
Cucumber w black fungi salad
Steamed pork & prawn wontons w chilli dressing
Crisp pork & prawn wontons w sweet chilli
Beef short rib on sesame leaf
Sashimi of ocean trout w radish & seaweed salad
Steamed pork bun
Crisp rice noodles w sweet soy & peanut, truffle & bonito flakes
Salt & Sichuan pepper calamari w lemon
Stir-fried mushrooms
Crisp-fried tofu w five flavoured sauce
Crisp chicken w strange pepper sauce
Red-braised duck pancakes w cucumber & shallots
Steamed fish w ginger & shallots
Dong-po por
Caramelised beef rib
Steamed saltbush & warrigal greens w oyster sauce
Sichuan spiced eggplant
Mixed leaf salad
Kim chi /Rice
To ensure that your investment property doesn’t cause unnecessary headaches, **John McGrath** says it’s important to be covered by the right insurance policy.

It’s essential to protect your investment with the appropriate insurance, which should include everything from building, contents, public liability, workers’ compensation and loss of rent due to damage or tenants simply not paying.

Insurance is a very low-cost item for a landlord yet one in five Australian landlords don’t have it, according to a survey conducted by research house BDRC Jones Donald.

Skimping on insurance may save you a few hundred dollars in the short term, but if you have an issue with your investment property or tenants, not having insurance could result in a significant proportion of your income being wiped out. It’s absolutely not worth the risk.

**A ONE-STOP OPTION**

At McGrath, we recognise that insurance products can be tough to compare and most landlords don’t have the time to trawl through product disclosure booklets to identify which policy is best. So, we got together with a reputable insurer to develop a great insurance offer for our clients, and it’s one of the most comprehensive policies of its type in Australia. It covers all the necessary items plus some other situations we wanted included for our clients. This one package costs a tax-deductible $310 per annum. It’s cheap as chips.

Say a tenant leaves without giving you notice. This insurance has you covered for at least 15 weeks of rent while we find you another tenant (which might only take a few days to a week!). Say there’s damage to your carpet, curtains or blinds – you’re covered with this insurance policy for up to $50,000 in repairs minus a small excess. It’s a simple product and gives our landlords peace of mind.

When it comes to damage, you might think the tenants sound great – they’ve got good references and you feel sure they’re not going to cause malicious damage. And you might be right. But damage isn’t always malicious. Accidental damage, including...
fire, can be caused by even the best tenants, so why would you take the risk? Accidental damage is covered in our policy, so make sure it’s covered in yours.

TAKE NOTE

It’s worth also noting that insurance doesn’t just take the form of an insurance policy. Here are some other ways you can ‘insure’ yourself against costly problems.

1. Hire a great property manager who is going to vet your tenants thoroughly. A mature and responsible tenant with a clean history is unlikely to suddenly stop paying rent or cause malicious damage to your property. A good property manager will also conduct regular inspections and look for issues that might require small repairs now to prevent a much bigger problem later on.

2. When fitting out your investment property, make decisions that will reduce the impact of accidental damage. Spilled red wine on a white carpet is going to be an issue. If it spills on a dark carpet, you’re less likely to have to replace it. There are many different types of carpet out there and some are more resistant to spills, depending on the material they’re made of. Check these things out before deciding what to buy.

3. Don’t overcapitalise when renovating an investment property. Say your investment is worth $500 per week, don’t spend thousands of dollars on an expensive look that isn’t needed for this type of property. A $500 per week tenant is not going to care whether you have CaesarStone benchtops. Before you renovate, talk to your property manager about which enhancements will make the property rent for more and which ones are unnecessary.

Not having insurance could result in a significant proportion of your income being wiped out. It’s absolutely not worth the risk.
Will there come a time when digital medicine will have the power to exert a placebo effect? Dr Dike Drummond ponders this possibility.

Is the placebo effect something that demands the presence of a living human, or can we program it into a mobile-phone app? If so, what will happen to healthcare?

I have always been fascinated by the concept of placebos. You give research subjects with documented medical conditions a sugar pill and they get better; they heal themselves despite the fact they have not swallowed anything known to have an effect on their disease.

While placebos are fascinating, the placebo effect is truly inspiring. What is it about the encounter with the researcher that triggers the patient’s natural healing mechanisms? What did the doctor do or say, or what did the patient hear and feel? And how can we learn to use this ability to inspire patients to heal themselves consciously?

**HEALING FROM WITHIN**

There is an entire matrix of raging debates on what causes the placebo effect. The Wikipedia page for Placebo Effect is the largest I have ever seen.

I am just a simple country doctor and here are my old-school beliefs on its origin.

When a sick, hurting or scared person seeks out the advice of a healthcare provider who is emotionally present, empathetic, confident and optimistic, and they are given advice and treatment they understand and the assurance of follow up if things go awry it triggers a cascade of physiologic effects modern science is incapable of measuring at this time. The result is healing.

The healing can occur without outside assistance – as the placebo effect in drug studies shows – or it can augment whatever medication or procedure you might also prescribe. I believe it is the human qualities of attention and caring that trigger the placebo effect. These exist parallel to the provider’s ability to diagnose and select an appropriate medical treatment.

You can arrive at the correct diagnosis and treatment and not trigger a placebo effect. You can fail to make eye contact, write out a prescription, hand it to the patient and walk out the door, thus having no placebo effect. Your skills as a placebologist rely on the ability to create the expectation of healing in the patient. This is most definitely part of the art of medicine.
PROGRAMMED TO CARE

You may have different thoughts on the placebo effect and how to practice the art of placebology. I have a bigger question, however. Can the computer scientists write a program that exerts a placebo effect?

My hope and belief is that the answer is 'No'. Again I admit to being an old-school doctor. I believe that being an empathetic, caring, competent human being in the physical presence of my patients makes a huge difference. This is why the epidemic of compassion fatigue and burnout in medicine is so damaging to our profession.

With the tidal wave of clinical data that will soon come from the universal adoption of Electronic Medical Records, it is highly likely our clinical decision-making skills will soon be replicated by computers.

If the technical maestros figure out a way for the programs to feel like they actually care about you and solve the riddle of capturing the art of placebology in binary code, then we will all be out of a job. ☹️