The quarterly management magazine for health care professionals

WINTER 2012

GERIATRIC MEDICINE
Why the outlook is bright for this diverse specialty

MAPPING OUT THE FUTURE
Putting a business plan into action

GPCE & THE PRIVATE PRACTICE
A partnership in business and financial education

SUCCESSION PLANNING
Preparing for the sale of your practice and a rewarding retirement
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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.

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If you fail to plan, you plan to fail.

This age-old adage is central to the theme of our sixth edition of The Private Practice eZine. Some may question its validity with respect to the practice of medicine, after all the sheer dynamics of demand and supply mean most doctors and other healthcare professionals simply need to 'show up' and they will be assured a busy practice and financial success.

So, why the need for planning? Or, as put to me recently by a young cardiologist, “Plan for what?”

Business planning, no matter what the business may be, must always start with pondering what success looks like for you. This is the first and most fundamental of stepping stones on the road to fulfilment.

The need for planning starts to become evident when you take the time to consider what you really want to achieve and start asking yourself the following:

- What kind of practice do I want?
- What kind of patients do I want to see?
- What kind of work will I do?
- How many days will I work per week?
- How many family holidays per year and for how long?
- What kind of lifestyle do I want in retirement and what role will the value of my practice play in achieving this?

It seems to be that many practitioners don’t even ask the questions let alone work on the answers. But good business planning is all about posing these questions, working out the answers then documenting and managing the actions required to achieve the desired results.

It all starts with a vision and then, with a bit of guidance and the implementation of robust systems and risk-management strategies, all can be achieved.

There is a challenge facing healthcare practitioners, however, and that is the mental shift required to start running their practice as a business and to begin to work on it as well as in it. The articles in this edition provide guidance and outline systems and risk-management measures to help you work on your business.

This is one of our biggest editions yet and we hope it provides you with hours of interesting reading. We also hope that the ideas and strategies within inspire you to want to learn more and attend one of our courses, workshops or conference sessions.

For more information please click on this link: https://theprivatepractice.worldsecuresystems.com/programs

And please don’t hesitate to contact me should you wish to discuss your educational needs.

Happy reading!

Steven Macarounas, Editor
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Creating your own business plan is a crucial component of effective management. Many of us associate a business plan with starting a business, however effective businesses regularly review their plan and utilise it as part of their ‘Greater Profitability Strategy’.

Many principals will often ask why they need a business plan. In short, the actual process of creating the plan makes you focus your thinking, your strategy and your process. Having a plan in place will enhance the management of the practice and provide an agreed framework to achieve agreed goals. It will result in improved performance and enhanced profitability.

Business plans are really about getting results and improving your practice performance. Even creating a simple plan will provide you with the basic information you need to better understand and develop your business.

While there is no definitive business plan, there are some basic steps you can follow and tips you can use to develop a plan that reflects the unique nature of your practice and addresses all key issues. A business plan can take many forms – it may be created as an overall plan for the practice or could be as simple as a document that introduces a new service or technology.

Irrespective of the aim, a business plan should address three basic questions:

- Where are we now?
- Where do we want to be?
- How do we get there?

Remember, your practice is a small to medium business and will need to adopt sound business practices and professional management strategies if you wish to improve performance. Once you have made the decision to proceed with a business plan, it’s essential to have key personnel involved in its development. As well as the principal, a practice would typically involve the practice manager, key staff and members of the management team (accountant, lawyer and financial adviser), as and when they are required.
TAKE FIVE

There are five key areas to address when looking to create a practice-specific business plan:

1. **Defining the business**
   You need to identify the business you are in and the sector in which you are operating. By addressing the following elements, you will clearly understand your business:
   - **Overview**: Create a general outline.
   - **Structure**: Private, corporate, associateship or sole trader.
   - **Market**: Target, size and stability.
   - **Location**: The demographic of the area.
   - **Services**: The scope and whether your practice is general or unique.
   - **Competitors**: Who they are and how your practice compares.
   - **Competitive advantage**: Skills, experience, processes and quality.

2. **Establishing aims and objectives**
   When considering the aims of the business and the need for balance, you need to ensure that both the business and personal aspects are considered:
   - **Personal Aims**: To balance professional work commitment and personal lifestyle requirements; to receive an income.
   - **Business Aims**: Type of practice (size, number of principals, succession); Services – i.e. general, niche, support, retail or corporate.
   - **Objectives**: Your key goals should always be measurable and quantifiable.

3. **Doing a SWOT analysis**
   Performing the SWOT analysis (or similar) requires you to consider those internal and external factors that may impact on your practice. It’s not uncommon that during the process you find a particular item may appear in more than one category. For instance, your long-standing practitioner may be a strength, but if s/he left then this could have a severe impact on performance, thus creating a weakness.
   - **Strengths**: Established and respected doctors.
   - **Opportunities**: New item number relevant to patient base and practice nurse.
   - **Weaknesses**: Reliance on specific doctors’ limited private hospital operating hours.
   - **Threats**: Bulk-billing practice to open less than 1km from practice.

4. **Developing the plan**
   Having discussed the various issues involved around the plan, it’s time to put some structure and organisation into place so your thoughts have some logical progression and the plan can be consolidated and formalised. This involves documenting the following:
   - **Business objectives**: Clearly defined and measurable practice and personal goals.
   - **Organisational/Operational Strategies**: Required for effective implementation.
   - **Associated financial costs**: Internal and/or external sources of finance.
   - **Marketing**: Internal to staff, colleagues and patients; external to key alliance partners and stakeholders.
   - **Training**: Resources to up-skill, train and/or hire staff.

5. **Implementing and reviewing**
   Now that you have documented your plan, you can start to communicate and share it with those who will be responsible for making it happen.

Here you will need to:
   - **Communicate the plan**: Be proud of the plan and what it aims to achieve.
   - **Strategy highlights**: You may wish to create summaries of particular aspects to give to particular people. There may be personal items that are not relevant to all.
   - **Assign roles and delegate responsibilities**: Utilise the skills of the staff within your practice rather than trying to do everything yourself.
   - **Measure your objectives**: Have set measurable objectives. Make sure they are measured on a regular basis.
   - **Monitor and review**: Have measured and monitored performance. Ensure progress is reviewed objectively in line with your aims. Don’t get sidetracked.
   - **Modify as necessary**: If you don’t get your plan 100 per cent correct the first time, you can modify and fine-tune. The only thing worse than not getting it right is not making modifications when you have the opportunity.

In summary, it’s fair to say that you probably wouldn’t set off on a long road trip without planning the route. The same principle should apply to your practice and the business plan you prepare. Just keep in mind that even though you’ve planned the journey, the actual trip may involve unexpected delays, detours, hazards and distractions. With persistence, patience and adhering to the plan, you will get to the destination.

Along the way remember that the best business plan is the one that works for you!
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We offer insurances such as MLC Occupationally Acquired HIV, Hepatitis B or C and MLC Critical Illness Plus as well as protection for your practice.

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How would you cope financially if you became sick and couldn't practise medicine?
Chris Caton is Chief Economist of BT Financial Group.

The share market had its first negative month so far this year. The ASX 200 fell by 7.3%, the worst month in two years, and is now up by just 0.5% for the year to date. The US market, as measured by the S&P500 index, fell by 6.3% in May, to be up by 4.2% since the start of the year. Meanwhile, both US and Australian long-term bonds fell to record lows, which at least means bond holders had a good month.

IT’S ALL ABOUT GREECE

The share-market weakness in the month was entirely due to increasing concerns about Greece in particular and Europe in general. The first attempt to elect a new Government was inconclusive, and there will be a second-round election on 17 June. Greece has a proportional-representation system, which virtually guarantees there will be a Coalition government. The question is: will that be a Centre-Right coalition (New Democracy and PASOK) or a coalition of the left (likely dominated by the Syriza party). Recent opinion polls put the Centre-Right in the lead.

Importantly, neither of the likely winners wants to take Greece out of the Euro. The difference is that the Centre-Right parties appear happy to abide by the current austerity/debt-repayment plan agreed with the Troika (the ECB, the European Commission and the IMF) while the Left parties want to renegotiate, slowing down the austerity plan. Given that the Greek economy has contracted every year since 2008, one can sympathise with their view that the Greeks have suffered enough.

The issue is that at some stage during any such renegotiations, the two sides reach an impasse. This could then lead to a cutoff of bailout money from the Troika. This, in turn, would lead to increasing speculation of a Greek exit from the Euro and a run on the Greek banking system as depositors try to move their euros elsewhere before they are converted into drachmas. To stop this run, the Greek government would be likely to impose capital controls, which would mean that a euro inside Greece would no longer be the same as one outside, so Greece has then, effectively (and primarily accidentally), left the common currency.

It should be pointed out that deposits in the Greek banking system have already declined by a third since the crisis began three years ago.

There would probably follow a significant depreciation of the replacement currency and thus an outburst of inflation. Exiting the currency would inevitably lead to Greece defaulting on its Euro-denominated debt, which would seriously undermine its ability to borrow new money.

WHAT’S THE BIG DEAL?

This would be an unholy mess for the Greeks, but does it really matter for the rest of the world? After all, the Greek economy is very small these days; it is indeed smaller than the economy of the city of Philadelphia. Since Greece left the Ottoman Empire in 1832, it has been in default or restructuring after default more than 50% of the time. And other nations such as Argentina frequently default. Why is this such a big deal?

The answer is that it may not be. But the increasing interconnectedness of the financial system, and of the European economies, means it might be. A Greek
exit from the Eurozone will lead to speculation of other exits, such as by Ireland and Portugal, and hence possibly to runs on banks in those countries.

Again, this is no big deal; these are also small economies. The real risk is a spread to the Spanish or Italian banking systems. The ECB could endeavour to stop such contagion by making it clear that all Euro deposits are guaranteed, but would such a guarantee still be in effect for an exiting country? During bank runs, rationality is also often in short supply.

There was a run on the Northern Rock bank in the United Kingdom in late-2008 despite the fact that deposits were guaranteed up to 50,000 pounds sterling. Bank runs are pernicious things and the best way to stop them is before they start. But it is not always clear how to do this.

It is not the inevitability of a bad end that argues against a Greek exit from the Eurozone but, rather, the small possibility of a very bad end. Because of this, my view is that the other European nations will do ‘whatever it takes’ to keep Greece inside the tent. This may include a slower approach to austerity, or the issue of Eurobonds, which would lower borrowing costs for most countries.

If a Greek exit does occur, then it would be better if it were not done too hastily. A prepared exit would increase the period of uncertainty, it is true, but it would also allow time for “ring-fencing” to prevent contagion.

Of course, even if Greece remains in the common currency, the issue will not go away. Greece is massively uncompetitive, mainly because its nominal wages have risen faster than in other European nations, particularly Germany. It will take years to fix this. If Greece remains in, it has been estimated that its economic size in 2016 could still be 20% smaller than it was in 2007! There is no easy way out. And while the Greek election has now taken place, this only lessens rather than removes the possibility of a Greek exit from the Euro.

REGARDING OUR BUDGET...

Every year an enormous fuss is made about our national Budget, and every year, it seems, something else happens immediately afterwards to knock it off the front pages. One can look at the Budget in several ways, including as a statement of our national priorities and as a tool of economic management.

Suffice it to say that this year’s edition isn’t nearly as good as the Government would have us believe, nor as bad as the Opposition depicts it. In the view of this macro-economist, while it is correct to aim the Budget in the direction of surplus, it is simply unnecessary to aim for a surplus in the coming fiscal year.

Only three other OECD nations (Cyprus, Greece and New Zealand) are planning a fiscal contraction as rapid as ours. While much of the fiscal tightening is cosmetic rather than real, the change in our fiscal position is probably set to subtract 0.5 to 1 percentage point from GDP growth over the next year. Is now a good time to be doing that?

One other thing about the Budget... The following chart is borrowed from Treasury Secretary Martin Parkinson’s post-Budget address. It makes the point that Australia has never had a government-debt problem. Beware of shock jocks and other false prophets preaching otherwise!

So, six months into 2012, I see no reason (yet!) to change my end-of-year forecast of 4700 for the ASX 200. While there could be a nasty outcome in Europe, this is by no means inevitable and a lot of bad news is already priced in.
“The most successful people are usually the ones with the best information.”

This quote, published recently in an investment advice newsletter, really caught my attention and confirmed the widely held belief that good information is key to making good strategic business decisions. Bad information, on the other hand, can lead to the wrong decisions. No information, and you’re working in a vacuum.

If the most important person in any business is the customer, then surely the most vital piece of information a business owner can get hold of is how happy customers – or patients – are with the service being provided.

We’ve all experienced a hotel or restaurant that failed to meet our service expectations. We may have chosen not to complain at the time, but we swore never to return and probably related the experience to numerous friends. We might even have posted a negative review on Trip Advisor, Facebook or Twitter.

In this information age, the power of the consumers’ voice has never been greater and woe betide the service provider who doesn’t listen.

It seems the medical profession has taken note. In the UK, the National Health Service recently introduced a mandatory ‘patient satisfaction feedback’ program into all hospitals in the country. In Australia, various state health departments have implemented similar quality improvement initiatives.

In realising that a patient’s satisfaction with the service or treatment is just as important as the clinical outcome, many private practitioners are taking a pro-active approach by implementing their own ‘patient satisfaction feedback’ surveys. By reviewing the information obtained, practitioners are able to benchmark the satisfaction ratings of various aspects of the practice and use the information to find ways of enhancing the customer experience at every stage of interaction.

Let’s face it – if we’re highly satisfied with a previous experience, we’re more likely to return in the future.

GETTING RESULTS

It’s worth noting that research has shown that 65 per cent of clients are more likely to use and recommend a business with pro-active customer-feedback systems. Harnessing patient opinions creates a genuine win/win outcome, for both the patient and the practice.

For patients, responding to surveys:
- Provides the opportunity to voice any concerns about their experience in a non-confrontational setting.
- Makes them feel they have an opportunity to make a positive contribution to the practice.
Satisfaction

• Demonstrates that their contribution will ultimately result in an enhanced service experience.
• Engenders greater trust and confidence with their chosen practitioner.

For practices, obtaining patient feedback:
• Identifies where strengths and weaknesses are, from the perspective of patients.
• Sets you apart from your peers in a competitive environment.
• Demonstrates your commitment to the overall patient experience.
• Will enhance the loyalty of existing clients, who will feel that their opinions are valued.
• Shows potential clients you have confidence in your clinic’s quality of service.
• Establishes a relationship between the patient and the practice that goes above and beyond the bond with the doctor.
• Will promptly alert you to any emerging operational problems.
• Provides you with information that will help you streamline business operations and enhance profitability.
• Results in Patient Satisfaction Ratios, which are an excellent management benchmarking tool and can be used as Key Performance Indicators to motivate clinic staff.

YOUR SURVEY STARTS HERE

How do you set about implementing an effective survey? There are three key steps:

1. Creating a well-designed patient questionnaire
This the most critical part of the entire survey process. Start by putting yourself in the patients’ shoes and consider the sequence of all their interactions with the practice, from making an appointment until the time they leave.

   Consider what factors impact on those interactions – i.e. efficiency, courtesy, friendliness, helpfulness, compassion, privacy and even physical factors such as cleanliness, comfort and ambiance. From these factors you can create questions that get to the core of the patient experience at your practice.

   There’s an old expression in market research – ‘You can get any answers you wish, it just depends on how you ask the questions’. When phrasing the questions, you’ll need to ask yourself what you want to know, and what form of answer you require. Your answers will determine whether your questions should be qualitative or quantitative in nature.

   • Qualitative questions generally require the respondent to provide answers in their own words, in a commentary or narrative form. They typically start with a phrase such as, “Please comment on...” or “Describe your experience with...”. A suitable space is then provided for the respondent to provide their comments or opinions.
   • Quantitative questions typically provide a selection of pre-determined answers, to be ‘ticked’ by the respondent. The questions generally ask people to ‘rate’ their opinion on a specific issue according to the rating scale provided. Examples of common rating scales are: ‘Yes/No’; a numerical scale from 1-5; a quality scale that runs from Poor to Excellent; or an expectations scale that starts with ‘Did not meet’ and ends with ‘Exceeded’.

There are advantages to both question types and surveys often employ a combination of each.

2. Deciding on the ideal survey distribution method for your practice
Firstly, there is the issue of timing to consider. It may be better to ask patients to complete the survey a few days after their visit rather than before they leave the clinic – people may be reluctant to provide frank opinions if they are uncertain about anonymity being maintained. Additionally, the delay provides a chance to capture any ‘after-care’ issues.

   Secondly, how is the survey going to be delivered to the patient? If you choose a paper questionnaire format, make sure it is printed on good quality stock. A faded or dog-eared photocopy does not give the impression you’re serious about feedback. If you post it out, be sure to enclose a reply paid envelope to encourage maximum return rate. Alternately, you can email a PDF version of the survey form to the patient and ask them to email, fax or post it back.

   Online surveys are a simple, efficient and convenient way to obtain customer feedback. The questionnaire is set up in exactly the same format as a hard copy using an online-survey platform, and a hyperlink is provided for that specific survey.

   You can give patients a written request or send an email, which includes the embedded link. When they open the link, it will automatically take them to the questionnaire. Avoid placing the link to your online survey on your business website, as this leaves room for the possibility of tampering.
3. Developing a method of analysing the feedback

Having gone to the trouble of collecting all that valuable information, don’t simply give each response a quick glance then put everything into a filing cabinet. The power of information is all in the consolidation of data, analysing trends and using this to make informed decisions.

You’ll need to devise a method of converting the quantitative responses into ‘measurable scores’. The narrative comments should be consolidated into a single report so any repetetive issues become apparent.

Create reporting periods, either monthly or quarterly, and track the satisfaction-rating trends in response to any procedural changes you make to practice operations. Anything below a 10 per cent response rate to your survey should ring alarm bells.

SEEKING PROFESSIONAL HELP

You may wish to consider outsourcing your customer-feedback program to a professional service provider. There are several benefits here:

• A professional’s experience with designing surveys can help you get the information you’re really looking for and they can efficiently handle all the data analysis, reporting and benchmarking requirements for you.
• Behavioural studies have shown that customers are more likely to respond openly to satisfaction surveys conducted by an independent research organisation than to employees of the business, as it’s less confrontational and increases confidence that their anonymity will be preserved.
• Doing so provides the assurance that your feedback data has not been influenced in any way by anyone within the practice.
• Professionals generally host surveys on platforms employing ‘bank level’ encryption security for the data.

If you decide to outsource, be sure to select a service provider who really understands the particular needs of medical practices and will customise a survey and reporting solution that perfectly fits your business.

Finally, don’t keep your patient-satisfaction performance scores to yourself. Share the information with your clinic’s staff in the form of Key Performance Indicators, which can serve as powerful management tools to help motivate your staff and encourage them to generate ideas on improving the overall customer experience for your patients.

CREATING YOUR QUESTIONNAIRE

There are few general rules when creating a questionnaire to measure patient experience:

• First and foremost, absolute confidentiality must apply. It should be left to the patient’s discretion whether or not to give their name or other personal information. People will be more inclined to be totally frank if they can remain anonymous.
• The questionnaire shouldn’t be too intrusive. It should ask for opinions without necessarily getting into the specifics of why these opinions were formed. If patients want to add a comment, it should be their choice.
• Completing the questionnaire shouldn’t be an onerous task. Participants are giving their time freely so if there are too many questions they’ll be less inclined to participate. Tick-box-rating scales are a convenient way to cover most of the issues. A good rule of thumb is to keep the average completion time to less than 11 minutes to avoid survey abandonment.
• Clarity of the phrasing and response options are also important. Participants shouldn’t have to second-guess what is being asked.
• If you don’t want to risk losing credibility, keep your motives clear. Don’t turn your survey into a marketing exercise by asking for demographic or socio-economic data, or how they heard about the practice.
It’s the nausea that stops me going out for a meal, not my RA.  

A BIOLOGICAL CHOICE IN METHOTREXATE INTOLERANCE

METHOTREXATE INTOLERANT

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Contraindications and Precautions: Contraindicated in patients known to have hypersensitivity to any component of the product or with a history of any reaction consistent with hypersensitivity to any component of the product. Chinese hamster ovary cell products or other recombinant human or humanised antibodies, active, severe infections. Infusion and hypersensitivity reactions: Serious hypersensitivity reactions, including anaphylaxis with fatal outcome, have been reported in association with infusion of ACTEMRA. In the post-marketing setting, events of serious hypersensitivity and anaphylaxis, including in some cases with fatal outcome, have occurred in patients treated with a range of doses of ACTEMRA, with or without concomitant arthritis therapies, premedication and/or a previous hypersensitivity reaction. These events have occurred as early as the first infusion of ACTEMRA. Appropriate treatment should be available for immediate use in the event of an anaphylactic reaction during treatment with ACTEMRA. For prophylactic reaction or other serious hypersensitivity reaction occurs, administration of ACTEMRA should be stopped immediately and ACTEMRA should be permanently discontinued. Patients with a history of any reaction consistent with hypersensitivity to any component of the product must not be re-challenged with ACTEMRA. Development of infections; history of recurring or chronic infection; Serious and sometimes fatal infections have been reported in patients receiving immunosuppressive agents including ACTEMRA. Underlying conditions e.g. diverticulitis, diabetes, HIV infection, “ensure vaccinations are up to date before initiating therapy, active hepatic disease, or impaired renal function, monitor for elevated hepatic transaminases, thymocellular lymphomas and elevated lipid parameters, controlled sodium diet, increased risk of malignancy, cardiac disorders and central demyelinating disorders.” Macrophage Activation Syndrome may develop in patients with SAVA: ACTEMRA has not been studied in patients during a episode of acute MAS. Pregnancy Category C – not to be used during pregnancy unless clearly necessary. Consider the benefits/risk of breast feeding to the child compared to the benefits/risk of ACTEMRA therapy to the patient. ACTEMRA is not recommended for use with other biological agents. Suppression of CYP450 expression may be reversed with ACTEMRA. Patients taking medicines metabolised via CYP450s (e.g. atorvastatin, simvastatin, calcium channel blockers, theophylline, warfarin, phenytoin, cyclosporine, benzodiazepines) should be monitored as dose adjustment may be necessary. Dose adjustment should be based on the therapeutic response and/or adverse effects of the patient to the individual medicine. Adverse Reactions: Common (≥ 2%): upper respiratory tract infections, nasopharyngitis, headache, hypertension, cough, increased ACT/AST, dyspepsia; back pain, peripheral oedema, sickness, bronchitis; rash, alopecia, pain upper, gastritis, infrequent (≥ 2%): cellulitis, oral herpes simplex, herpes zoster, diverticulitis, stomatitis, gastric ulcer, pruritus, urticaria, weight increased, total bilirubin increased, leucopenia, neutropenia, hypercholesteraemia, hyperglycaemia, hyponatraemia, hypoglycaemia, dyspnoea, conjunctivitis, nephrolithiasis, hypothyroidism. Infections: Reported serious infections, some fatal, include pneumonia, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis, bacterial arthritis, opportunistic infections, Graft Refusal. Reported uncommonly as a complication of diverticulitis, including severe active diverticulitis and sepsis. ≥ 1%: hypercholesterolaemia, hypertriglyceridaemia, hypersensitivity reaction, dyspnoea, stomatitis, gastric ulcer, pruritus, urticaria, weight increased; total bilirubin increased, leucopenia, neutropenia, neutrophilia, hypoglycaemia. Infusions: reported serious infection, some fatal, include pneumonia, cellulitis, herpes zoster, gastroenteritis, diverticulitis, sepsis, bacterial arthritis, opportunistic infections, Graft Refusal. 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According to Dike Drummond, the fight between professional burnout and fulfillment is not fair. In the first of his two-part feature, he reveals what you can do to start evening the score.

Why does having a sense of satisfaction and fulfillment as a modern doctor seem like such a struggle at times? There is an invisible battle going on each day between our search for a fulfilling career in medicine and the hidden forces of professional burnout.

**WHAT IS BURNOUT?**

We all know what it feels like to be ‘fried’, ‘toasted’ and ‘spent’ after a long weekend of call or a tough night in the hospital. If you are able to recover your drive and energy before you return to work, great job – I hope your resilience continues.

Burnout begins when you are NOT able to recharge your batteries between call nights or days in the office. You begin a downward spiral with three distinct components:

- **Emotional exhaustion:** You are emotionally drained, depleted, worn out and unable to recover in your time off.
- **Depersonalisation:** You develop a negative, callous and cynical attitude toward patients and their concerns.
- **Reduced sense of personal accomplishment:** You see your work as poor quality, without value or meaningless and you see yourself as incompetent.

Dike Drummond is a US-based family doctor.

theprivatepractice.com.au
The standard scale for measuring burnout is known as the Maslach Burnout Inventory (MBI), whose originators describe burnout as “... an erosion of the soul caused by a deterioration of one’s values, dignity, spirit and will”.

So, how common is burnout? Numerous global studies involving nearly every medical and surgical specialty indicate that approximately one in three doctors is experiencing burnout at any given time.

The impact can be extensive, with burnout leading to:
- Decreased professionalism and quality of medical care provided.
- Increased medical errors and malpractice rates.
- Lower patient compliance and satisfaction with medical care.
- Increased rates of substance abuse, suicide and intent to leave practice.

Burnout can be thought of as one extreme of a continuum, with career engagement at its other end. Engagement leads to feelings of fulfillment and satisfaction. You feel your work makes a positive difference in people’s lives and your career has true meaning. Engagement is the emotional gold standard for career success.

In the day-to-day practice of medicine, the forces of burnout and engagement are in constant conflict with each other. This is not a fair fight as much of the battle lies outside of our normal awareness.

While we focus on our patients and their issues, our practice environment is filled with invisible stresses that feed burnout and block us from engagement.

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**STRESSING THE POINT**

Here is a partial list of daily stresses working on burnout’s team. Note that they all exist above and beyond everything you do to keep up to date in your clinical skills:

- **Being a doctor is stressful:** The most stressful professions are characterised as having a high level of responsibility and little control over the outcome. We are not selling widgets here – this is a tough job that saps our energy every single day.

- **We work with sick people all day long:** Our days are filled with intense encounters with sick, scared or hurting people and with all the emotional needs that come with an illness. In the absence of training on creating boundaries, our energy can be severely zapped by these emotional needs alone.

- **Balance, what balance?:** Medicine has a powerful tendency to become ‘The career that ate my brain’, pushing all other life priorities to the side. As we get older and have more family responsibilities, the tension between work and our larger life is a major stressor for many. Training on healthy boundaries would help here too, but is rarely available.

- **Being in a leadership role you are not trained for:** You graduate into the position as leader of a healthcare delivery team without receiving any formal leadership-skills training. By default we learn a dysfunctional ‘from the top down’ leadership style (medicine and the military are the only professions where the leaders give orders). This adds additional stress.

- **The doctor as the bottleneck:** The team can only go as fast as we can, and we are often behind schedule. Pressure mounts to perform at full steam all day long.

- **The confusion around payment:** The financial incentives are confusing at best. The patient is often not the one paying for our services and many of them receive their care with no personal investment on their part. You may have to deal with over a dozen health plans with different referral and authorisation procedures, of which the patient is blissfully unaware.

- **There are lawsuits waiting to happen:** The hostile legal environment causes many of us to see each patient as a potential lawsuit. This fear factor adds to the stress of all the points above.

- **Politics and ‘reform’:** Political debate drives uncertainty about what your career will look and feel like in the future. All the pundits share the same complete lack of understanding about our day-to-day experience as providers in the ‘trenches’ of patient care. There is no track record of common sense. We simply don’t know what to expect.

- **Things eventually get stale:** Beware of the 10-year threshold, when your practice suddenly seems to become much more of a mindless routine and loses its ability to stimulate your creative juices each week. All of a sudden it seems as if medicine is no fun any more.

That’s an impressive list, and I am just getting started... Which begs the questions: Who’s on your team, and what skills and strengths are we
bringing to this fight?
- We are intelligent, quick learning and hard working, with a drive to do our best. Once we know the tactics to defeat burnout, no-one will work harder at putting them into action.
- Our connection to our purpose, and why we chose to become doctors. The quality of this connection varies from day to day, however when the connection is clear it can serve as a source of immense power and endurance.
- We have invested over a decade of our lives in our medical training and are not going to give up easily.
- We are well paid.
- We are respected members of the community.
- Our families love and support us, and we can draw strength from them.
- We have a life outside of medicine where we can recuperate and recharge.

PREVENTATIVE MEASURES
While we can obviously take a huge amount of punishment, this really isn’t necessary. Recent research shows the efficacy of specific burnout prevention and treatment measures on both personal and organisational levels:

Personal prevention measures
- Self-awareness and mindfulness training: Remaining connected to your emotions and energy moment by moment and actively staying present during the work day.
- Appreciative inquiry: Doing more of what is working rather than focusing on what is not working
- Narrative medicine: Journal-writing or peer-group processing of your work experience.
- Work/life balance: Creating and maintaining healthy boundaries between the work and non-work aspects of your life.
- Lowering stress: Learning effective leadership skills; exerting control where possible over your work hours (female doctors are leading the way here); creating focus where possible on work activities that provide the most meaning.

Organisational prevention measures
There is a natural place for burnout prevention at the organisational level. Any decrease in burnout should produce measurable increases in profits for the provider organisation.

Recent research reveals a number of effective interventions:
- State an organisational intention to value, track and support doctor wellbeing.
- Institute regular monitoring for burnout among providers (MBI).
- Create continuing medicine education programs teaching the personal burnout-prevention measures above.
- Provide time and funding for physician support meetings.
- Provide leadership skills training.
- Support flexibility in work hours.
- Create specific programs to support doctors suffering from symptomatic burnout.

Burnout is waging a constant, invisible, soul-eroding battle with our healthcare providers. Doctors engage this enemy every single day and research shows one third of us end up among the walking wounded. It is time to share the research-proven tools to tip the odds in the favour of engagement, fulfillment and career satisfaction for our men and women ‘in the trenches’ of modern medical practice.
You spend your life looking after others, so let us help look after you.

In your line of work, you need to be ready to handle all scenarios, never knowing what medical challenge your next patient will present.

But how prepared are you with your own financial health? With such a demanding occupation you may have little time to carefully consider the management of your investments, superannuation or insurance.

If the unthinkable happened to you, would you be in a position to take as good a care of yourself and your family as you do your patients?

BT Wrap and BT Insurance can work together with you and your financial adviser to create, protect and manage your wealth – making sure you’re ready to face the challenges life may bring.

To find out how BT Wrap and BT Insurance can partner with you to achieve your objectives, speak to your Financial Adviser.
CLAIMING CONTROL

If a claim is made to Medicare with your provider number on it, Margaret Faux explains why the responsibility for it lies solely with you.

Consider this: You’re relaxing on a Greek island. A claim is submitted using your name and provider number for a service you conducted before heading off on holiday. The claim was prepared by Mary, who works on reception and always does your claiming. She knows what you do. Unfortunately, this time, Mary’s attention drifted and she made a mistake.

Who is responsible for the incorrect claim and subsequent benefits paid by Medicare? Surely not you, as you weren’t even at the practice. Wrong – you are. Medicare has no authority to investigate or penalise Mary even if it wanted to.

Whenever a claim is made to Medicare with your provider number on it, you are responsible for it irrespective of what you were doing at the time or whether you believed that you had delegated the authority. Under the legislation there are no excuses – if an item number has been incorrectly assigned for a service you provided, you are the only one who will be held responsible.

This may sound heavy-handed, but it’s the law. And, unfortunately, not all doctors are aware that the buck starts and stops with them. Pursuant to the provisions of the Health Insurance Act 1973, only the practitioner who rendered the service is bound by the provisions of the Act and is therefore the only person who can be brought to account for services and items claimed under the Medicare scheme.

CLAUSE FOR CONCERN

Let me tell you a story told to me earlier this year by a lawyer working for a new general practice. The doctors who established the practice had asked her to prepare contracts so they could engage outside doctors to cover sessions for them. It was a progressive practice that believed it was appropriate to spell out contract arrangements.

One of the clauses in the prepared contract was standard and, the lawyer thought, unremarkable. It outlined that the doctor would advise the practice reception of the item numbers they were to claim under her provider number. The lawyer specialises in medical work so this might well have even been a cut-and-paste clause from any similar document prepared for medical contractors – and certainly not one to raise an eyebrow.

Surprisingly, one GP was outraged by this particular point and refused to agree to it. She said she had never been expected to do administrative work before and felt she should not have to itemise the services she provided to patients – this was for the front desk to sort out. The GP felt she was an employee being paid a salary, with no responsibilities beyond patient care.

In fact, the GP was a contractor. But even if she had been an employee, the responsibility to assign item numbers still falls to her as the doctor. After every consultation, whether you use online messaging or post-it notes, you must tell reception which item number is being billed.

FOR THE RECORD

At my own billing service, we’ve been asked by a prospective client if we would assign the appropriate item number based on her description of the consultation, as that would save her time. Alas, the answer we had to give her was, “No”. Another client, an anaesthetist, was quite happy to provide us with the item numbers that related to consultation and initiation, but instead of giving us the item number relating to the duration of...
anaesthetic, she was only noting start and finish times. She wanted us to do the maths to determine the corresponding item number – again, we had to decline. You see if we made an error in assigning the item number, she would be liable for the mistake. Doctors must inform us of the item number they wish to claim.

Errors are easily made and it’s simple to get an item number wrong. A doctor might mean to use item number 110 and hit 116, especially if they are using those item numbers many times a week. But if you are checking your billing records regularly, and I recommend you do, you will likely spot any errors, which can then be rectified in a timely manner. Claims can be reversed and Medicare benefits refunded.

It’s important to get it right because the penalties are onerous. Doctors have faced practise exclusions, been disqualified from the Medicare system for months and asked to repay sums as high as $300,000 – and many didn’t even know they were getting their billing wrong in the first place. They have been penalised for ‘innocent mistakes’.

The other advantage of reviewing your billing is that you can compare your practice against your profession. If you go to the ‘Provider’ section of the Medicare site and look at the statistics, you’ll very quickly see how your pattern of claiming sits against others. If you are an outlier, you can be sure that you will come under Medicare scrutiny.

A CASE IN POINT
The following case, taken from the Professional Services Review’s (PSR) 2005-2006 Annual Report, perfectly demonstrates the importance of getting billing right:

Dr E practiced in a large medical clinic as a general practitioner. Medicare Australia was concerned that, because Dr E had provided 28,102 services to 10,660 patients for a total benefit of $830,208 and may not have had the time to provide appropriate services to all patients. Dr E had provided services at almost twice the number of other practitioners at the 99th percentile. Dr E was in fact the busiest general practitioner in Australia at the time.

In addition, Dr E had breached the prescribed pattern of services provision of the Act (the 80/20 rule). Dr E had seen 80 or more patients on 32 days during the review period. Medicare Australia was also concerned that Dr E had provided 1046 care plans (MBS item 720) and 702 review of care plans (MBS item 724). Dr E’s rendering of items 720 and 724 was above the 99th percentile in both instances.

An extensive number of Dr E’s medical records were reviewed. Of Dr E’s item 23 consultations, 28 per cent were found to be inappropriate, as were 100 per cent of care plans, 100 per cent of reviews of care plans, 90 per cent of exercise electrocardiograms, 100 per cent of respiratory function tests, and 100 per cent of the removal of in-growing toenails. The Director met with Dr E on several occasions to discuss rendering of MBS items. Dr E acknowledged conduct during the review period constituted inappropriate practice and expressed an intention to significantly change the mode of practice. Dr E claimed to have been encouraged and reassured by more senior staff at the medical centre that Dr E’s work was appropriate.

Dr E’s case illustrates the effect poor mentoring can have on doctors early in their career. Dr E signed a negotiated agreement in which Dr E admitted to having engaged in inappropriate practice and agreed to repay the Commonwealth $115,000 and be fully disqualified from Medicare for six weeks. The Director formally reprimanded Dr E.

PROTECT YOUR PROVIDER NUMBER
I’m a regular reader of the PSR annual reports and one of the recurring themes is the attribution of doctor claiming errors to professional isolation. Here’s a sample of what has been said on the topic: “Practitioners referred by the Commission are often professionally isolated. They have little contact with professional colleagues and/or fail to keep their professional knowledge up-to-date. Others are manipulated by more senior practitioners or ‘employers’, or have deluded themselves. In the course of hearings, committees sometimes find impaired practitioners, mainly due to illness or substance abuse, and have referred these practitioners to the relevant Medical Board”.

Dr Tony Webber, recent Director of the PSR, has expressed particular concern about doctors working in corporate environments where the corporation may be putting pressure on them to claim incorrectly. He has suggested that there needs to be legislative change so that the PSR can investigate the corporation in these instances – the PSR currently has limited capacity to do so.

Until such a time as the law changes, it is important to note that your provider number is yours alone to protect.

Let’s leave the last word on this to the PSR, which has repeatedly stated: “A number of practitioners who work as independent contractors or employees in medical centres have claimed that office staff are responsible for itemisation on documents for Medicare benefit. This defence has been accorded little weight because the practitioner alone is responsible for the accuracy of the information provided for the purposes of a Medicare claim and this responsibility cannot be delegated or abdicated”.

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As we march into the 2012/13 financial year, you may be asking yourself if you've been paying too much tax and if there is anything you can do about it. While the answers will vary depending on your circumstances, it's always beneficial to revisit the issues to ensure that you're maximising your financial position each year.

To make sure that you are taking advantage of any possible tax savings, the process of tax planning essentially involves a review of your overall taxation affairs, including investment structures, income and deductions. This process is most beneficial if it is done throughout the new financial year, so don't leave it until the last minute when preparing next year's tax return.

ASSESSING YOUR SITUATION

Whether you are an employee or in business, there are several areas to review.

Superannuation: This continues to be a tax-effective way to provide for your retirement, as tax on contributions is limited to 15% in superannuation funds. Although there are differing rules governing the availability of deductions, depending on whether or not you are employed, generally, from 1 July 2012 you can contribute up to $25,000 per year and obtain some tax benefit, depending on your level of income. For example, if you are self-employed on an income level of $250,000 per year, a $25,000 contribution into superannuation will save you approximately $8000 in tax, (the difference between a 46.5% personal marginal tax rate, and the 15% super fund tax rate).

Salary sacrifice arrangements: If you are employed, salary sacrifice arrangements for either superannuation or other benefits are always worthwhile considering, as in some cases the tax savings can be significant. As sacrifice arrangements are only valid for prospective wages, a new financial year is a good time to review your arrangements to make sure that you are taking full advantage.

• Interest deductions: If you have investment-related debt, it is worthwhile reviewing your level of interest deductions at the end of the year. In some circumstances it may be possible to prepay interest to obtain additional tax deductions this year.

• Property Investments – Capital Allowances: The most popular form of tax deduction is that generated by tax law, as opposed to a deduction created by parting with your hard-earned money. Accelerated depreciation on income-producing buildings is one such deduction. If you own either a commercial or a residential property, obtaining a quantity surveyor report to determine the amount of additional depreciation that may be claimable in relation to the buildings is a low-cost avenue to obtain taxation concessions.

• Specific opportunities: Depending on your personal or business situation, there may be many other opportunities available to you. These may include prepaying business expenses and making compulsory staff superannuation contributions prior to the year’s end.

It is recommended that you contact your tax agent or business advisor for suggestions of ways to maximise your financial position. The key to successful tax planning is allowing yourself enough time to take advantage of available benefits. Hurried decisions in the last week of June often do not achieve the best outcome – early on in the new financial year is a great time to start investing some energy in your financial goals.
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With an ageing population and a move into the eHealth arena providing increased opportunities for doctors looking to enter private practice, the future of Geriatric Medicine is bright. Here we talk to four geriatricians with a passion for their chosen field.

We’re all aware of the fact that Australia has an ageing population, with the baby boomer generation entering retirement age having accrued more wealth, better health and a higher expectation of services than any previous generations. What doesn’t get discussed so readily is the effect this has, and will continue to have, on the medical specialty that serves our senior citizens – Geriatric Medicine.

Talk to any geriatrician and the sentiment seems to be that the effects are positive, with the specialty presenting exciting opportunities for doctors who appreciate diversity and are open to the possibilities of private practice.

Senior Geriatrician Dr Robert Prowse runs a private clinic within the Department of Geriatric and Rehab Medicine at Royal Adelaide Hospital, where he has worked...
for the past 25 years, and a monthly clinic in the country township of Port Augusta. He says the specialty has definitely changed and is becoming increasingly dynamic and diverse.

“No day is ever going to be the same when you are covering everything from cancer and cardiac problems to hip replacements and dementia,” he explains.

“There is a great deal of biological variability with our patients and, as you would expect, no one older patient is ever the same as the next – as well as having individual health problems we encounter people that have a great mix of social backgrounds and interests.”

Dr Prowse says these are the elements that make the specialty so fascinating: “My weeks will include a mix of half-days spent in the clinic, holding small group tutorials, doing some online teaching with a group of students in satellite schools within remote and rural areas, and completing administration work for the hospital’s Memory Trial Centre.”

Dr John Obeid, Consultant Physician and Geriatrician at Sydney’s Blacktown Hospital, also appreciates the stimulation that comes with the specialty’s broad spectrum. “Since I finished my training in 1998 I have worked in acute and sub-acute Geriatric Medicine, and I’ve always enjoyed the variation and complexity my work brings. Along with general medical problems you get to support older people with cognitive, gait and continence problems.”

Dr Obeid is also inspired by the fact that sub-specialists are recognising the importance of his chosen specialty.

“The complexity of the specialty and the fact that our population is living longer means the skills of geriatricians are so much more in demand than ever before,” he says. “Older people with cancer, for instance, have to be supported through their treatment and care in ways that differ to younger people. Geriatric Medicine used to be thought of as a purely public-sector specialty, but over the years patients have started using private hospitals for a range of surgeries and treatments.”

CARING FOR CARERS

For Dr Glenise Berry, working in Geriatric Medicine over the past three decades has been truly rewarding and is presenting plenty of new opportunity.

“I am particularly excited about the impact of eHealth and online facilities that are being developed all around Australia with a view to delivering specialist medical care,” says Dr Berry, who is Senior Visiting Physician in Geriatric Medicine at the Princess Alexandra Hospital, in the Brisbane suburb of of Woolloongabba. “Professor Len Gray [Professor of Geriatric Medicine, University of Queensland and Director of the Centre for On-line Health] and his team are currently garnering the interests of geriatricians remote communities that have not traditionally had access to specialists in Geriatric Medicine.”

Dr Berry says the ability to readily communicate with nurses in remotely located nursing homes will provide great assistance to GPs who are already overstretched, and to families who want to know their elderly relatives are being well looked after.

“Tailoring medicine to the individual can be very challenging with elderly people and will often rely on well-managed care provided by a network of people. It’s important that caregivers are given the support they need – whether patients are in nursing homes or are being looked after by family members at home,” adds Dr Berry. “We have to be mindful of the reality that people are living into their 80s and 90s much more than they ever did, so many men and women who have reached retirement age may be caring for their elderly parents and will often require support themselves.”

ADDRESSING KEY ISSUES

All three geriatricians have served time as Federal Councillors for the Australia & New Zealand Society for Geriatric Medicine (ANZSGM), which represents medical practitioners who to man such facilities. Older people deserve excellent diagnostics, medical care and planning, and it’s very exciting to think about being able to deliver services to urban, rural and care for older people and is one of the Specialty Societies of the Royal Australasian College of Physicians.

Dr Prowse, who is currently 13 months into his two-year term as
ANZSGM President, says he is inspired by the fact that the society takes a proactive approach when it comes to providing support for young fellows and encouraging doctors to specialise in Geriatric Medicine.

“ANZSGM recognises that, as a result of Australia’s ageing population, recruitment is crucial – we basically need two graduates to replace every retiring geriatrician,” says Dr Prowse. “The approach taken is that this is an exciting, complex, relevant and friendly area of medicine to be involved in, and there is a lot of support and mentoring available. Therefore, the society places great emphasis on ensuring processes for supervising Advanced Trainees are well in place and that senior fellows are not only visible in teaching hospitals but are on hand to teach and provide all the support necessary.”

Dr Obeid, who is a current ANZSGM Federal Councillor, agrees that Geriatric Medicine is one specialty where younger fellows can rely on support networks. “This is a complex and dynamic area of medicine, and it is filled with passionate men and women who are willing to share their knowledge and skills,” he says. “It’s very exciting to see that Geriatric Medicine is becoming an increasingly popular career choice for both men and women.”

Dr Berry, who spent the last eight years on the Council in an advocacy role, as well as being Chair of the Clinical Issues Committee. She also represents the ANZSGM on the National Aged Care Alliance (NACA) – a body representing stakeholders in Aged Care and was able to inform government after the Productivity Commission report on Aged Care in 2011 and influence the Aged Care funding reform announced in April. Advocacy in Aged Care is vital to ensure excellence in medical care of all elderly no matter where care is delivered acute, sub-acute, nursing home, general practice or the community.

According to Dr Berry, this level of involvement between ANZSGM and NACA resulted in the Government increasing the number of Aged Care packages throughout the community and raised awareness of dementia care and the need to fund further research into dementia.

“Although we recognise that increasing the number of packages available doesn’t address the whole spectrum of Aged Care, it is great to see progress being made,” she says. “It has also been rewarding to see those nurses working in nursing homes and in Aged Care within the community gaining Government recognition by having their salaries addressed. We can definitely see steps being taken in the right direction.”

A PRIVATE LIFE

Coming back to the geriatricians themselves, Dr Obeid says it is important for young fellows to consider entering into private practice.

“It’s becoming increasingly obvious that the public sector is straining under the weight of bureaucratic and funding pressures, and geriatricians must consider that there won’t always be jobs for them in the public sector,” he explains.

Dr Obeid believes there are a number of benefits to going into private practice. ”Within the public sector there is a quite a heavy emphasis on acute care and you don’t have a lot of choice around the work you do,” he says. “Private practice offers great flexibility – you can pick and choose what you want to do in accordance with your specific interests. The scope is great for those that enjoy variation in their work.”

Dr Prowse agrees: “Geriatric Medicine is a specialty that enables doctors to tailor their jobs. If you’ve had a baby and are just coming back from maternity leave, for example, there will be opportunities to work hours to suit your family, and you can build these hours up over time. You could also teach or move into the medico-legal arena.”
Due to obtain his Fellowship in August this year, Dr Anthony French is currently placed as an Advanced Trainee in Geriatric Medicine at the Princess Alexandra Hospital, in Queensland.

“I moved across to work with the Geriatrics and Rehabilitation team at the Princess Alexandra Hospital after spending three years at the Prince Charles Hospital [in Chermside],” explains Dr French, adding that he chose to specialise in Geriatric Medicine because of the wide spectrum of opportunities it presented.

“Geriatric Medicine specialists are in high demand in the public and private systems, giving great scope for innovation and career development over time, and allowing geriatricians to constantly modify and refine their practice to suit their interests,” he elaborates. “Collegiality is also an important factor in my choice, and geriatricians are a close-knit and supportive professional group. The care of the elderly is also a very rewarding and challenging area of medicine that offers high job satisfaction.”

At the completion of his training, Dr French will be starting in private practice to support two established geriatricians. “I’ll be helping to provide an inpatient Orthogeriatrics and Rehabilitation service at Brisbane Private Hospital, as well as an outpatient service out of St Andrews Hospital, in Spring Hill,” he says.

Acknowledging that a career in Geriatric Medicine is more than clinical practice, Dr French believes the biggest challenge he and his fellow geriatricians will face is maintaining currency of both knowledge and practice.

“This will always necessitate an interest in research and a commitment to continuing education and professional development,” he says. “There are more unanswered questions in clinical Geriatric Medicine, so increased specialisation within the discipline, combined with including research as part of everyday practice, provides significant intellectual stimulation and job satisfaction – and it also helps you to maintain high professional standards.”

Since the start of his training, Dr French has been involved with the ANZSGM, as the Advanced Trainee Representative of the Federal Council, and has chaired the National Advanced Trainee Committee.

“These roles provide many opportunities for input into policy development, development of training initiatives and web-based training,” he says. “Most beneficially they also provide excellent networking and career development, as well as opportunities for leadership and increased collegiality and support among trainees.”

Looking to the future of the specialty, Dr French says there is a lot to be excited about. “Two of the most exciting things happening at the moment are Geriatric Medicine’s increasing desirability as a medical specialty and the increasing diversity of practice opportunities, with the utilisation of technology such as Telemedicine allowing access to previously untapped areas of need in Aged Care,” he explains. “These aspects of the specialty are creating almost infinite opportunities for a very rewarding career – professionally, financially and lifestyle-wise.”
According to Dr Berry, the specialty has proven to be very flexible. “I have been fortunate during my career to have been able to name my hours when necessary. With the support of my husband I was able to combine my career and profession in a meaningful way with bringing up my three children – it was wonderful to have choice,” she confirms. “Even though I am now primarily working in the public sector, I have worked in private practice and still do private medico-legal work.”

There are challenges to working in the private sector, however, particularly from a business-management perspective. “You have to carefully weigh up the likely demands on your time and business skills, and work out how to limit your work. If you don’t seek out your niche, for instance, you might get overwhelmed,” says Dr Obeid, adding that it’s also critical to brief yourself around the issues of financial and practice management.

“Ideally try to find a mentor who can coach you on these matters so you don’t potentially lose focus on your core business due to the stresses that come with running a business,” he adds. “If I had the opportunity to attend one of The Private Practice’s courses when I was starting out, it would have saved me from hand-typing all of my own letters and bills for the first five years and taking quite some time to learn about efficient administration.”

On a final note, Dr Obeid says his advice to young fellows just starting out would be to sit down and think about the direction they would like their careers to take over the next 10 years.

“Always be alert to the fact that you might burnout if you don’t have a good knowledge of business principles and an appropriate understanding of how to achieve work/life balance,” he advises. “And be sure to get clued up on the long-term financial aspects of your business – you need to know what succession planning is so that when it comes time to retire you can actually make the most of every minute.”

---

**The ANZSGM Geriatric Physicians Private Practice ‘Comprehensive’**

From 20-22 July 2012, the Private Practice will be convening this dynamic ‘comprehensive’ on behalf of the Australian & New Zealand Society for Geriatric Medicine.

Tailored to address specific business, financial and lifestyle issues and challenges faced by the profession, the course will give attendees the chance to have individual access to speakers from a range of disciplines, including the law, accounting, financial planning and practice management.

Topics to be covered over the three days include:
- Medical Practice Business Planning
- Practice Set-Up and Management
- Medical Billing
- Banking and Finance, Products and Strategy
- Accounting, Taxation and Business Structures
- Estate Planning and Asset Protection
- Investment Planning, Products and Strategy
- Information Technology

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Running a medical practice brings its own unique set of challenges, including deciding on the best way to protect hard-earned assets. While Income Protection insurance should be considered, it’s also important to protect the very thing that generates your income – your practice.

By taking out Business Expenses Insurance, you can cover 100% of your share of eligible overheads for your practice if an illness or injury prevented you from practising medicine.

What is a business expense?
These are the reasonable and regular normal operating expenses of the practice you own and manage, which may include:
- Rent or mortgage payments
- Property rates and taxes
- Equipment or vehicle-lease costs
- Electricity, heating and water costs
- Cleaning and laundry costs
- Depreciation on office equipment and premises owned by the business
- Salaries of employees not generating income
- Costs associated with accounting services
- Fees for membership of professional associations
- Insurance premiums for your practice

By using this strategy, you could keep on top of your business expenses if you are unable to work due to illness or injury, and make sure you have a saleable asset if you’re unable to return to work.

How the strategy works
If you are self-employed, in a small partnership or operate your practice through a company, taking out Business Expenses Insurance can help to keep your business afloat and ensure that, in the worst case scenario, there is still a practice to sell should the need arise.

The maximum benefit payment period is usually limited to 12 months. You can also choose a waiting period before the policy will start reimbursing your practice’s expenses, typically 14 days or a month.

KEY CONSIDERATIONS
As your practice grows, you should consider insuring the people who play a key role in the ongoing success and profitability of your business.
• The benefits: If something were to happen to you or another key person, such as an associate, the insurance payment could be used to offset a reduction in revenue and cover the costs associated with finding and training a suitable replacement.
• How the strategy works: Many growing and established practices still depend heavily on the skills provided by the principal and other key staff. Where this is the case, the temporary or permanent loss of a key person could have a detrimental impact on your practice and patients. Also, finding a suitably qualified replacement can be very challenging.

A cost-effective solution is to insure key employees in the event of death, total and permanent disability and critical illness. Should any of these events occur, the insurance can provide a much-needed injection of cash to stabilise and protect the practice and keep servicing patients.
CASE STUDY

Tony and his business partner Andrew run a successful medical practice. They each generate a pre-tax income of $20,000 per month and are jointly responsible for meeting the total business expenses of $16,000. This leaves them both with $12,000 to draw as income every month.

<table>
<thead>
<tr>
<th></th>
<th>For the practice (per month)</th>
<th>Per partner (per month)</th>
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<tbody>
<tr>
<td>Pre-tax income</td>
<td>$40,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Less ongoing business expenses</td>
<td>($16,000)</td>
<td>($8,000)</td>
</tr>
<tr>
<td>Pre-tax income (after business expenses)</td>
<td>$24,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

Tony and Andrew both used Income Protection Insurance to protect 75% of their respective incomes. Tony has also taken out Business Expenses Insurance for $8,000 a month, which represents his share of the practice’s business overheads.

The table below outlines what could potentially happen if either Andrew or Tony became disabled.

<table>
<thead>
<tr>
<th></th>
<th>ANDREW Protection plan without Business Expenses Insurance (per month)</th>
<th>TONY Protection plan with Business Expenses Insurance (per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Protection Insurance benefit</td>
<td>$9,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Business Expenses Insurance benefit</td>
<td>Nil</td>
<td>$8,000</td>
</tr>
<tr>
<td>Total insurance benefits</td>
<td>$9,000</td>
<td>$17,000</td>
</tr>
<tr>
<td>Less share of ongoing business expenses</td>
<td>($8,000)</td>
<td>($8,000)</td>
</tr>
<tr>
<td>Pre-tax income (after business expenses)</td>
<td>$1,000</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

Andrew’s Income Protection policy would provide a monthly benefit of $9,000, which represents 75% of his income, net of expenses but before tax. However, because he doesn’t have Business Expenses Insurance, he’ll have to fund the business expenses out of his own pocket – potentially from his Income Protection policy.

As a result, he’s left with $1,000 each month, which won’t be enough to cover his personal expenses and tax liability.

Conversely, Tony, who also insured 100% of his share of the practice’s business expenses, will not need to use any of his Income Protection benefit – or any of his personal savings – to meet his ongoing business expenses.

Note: This case study highlights the importance of speaking to a financial adviser about protecting your practicent that you or another key person, dies, becomes totally and permanently disabled or suffers a critical illness. A financial adviser can address a range of potential issues and identify other suitable protection strategies.

To find out the types and amounts of insurance you may need to protect your practice’s key people and who should be insured, speak to a financial adviser who specialises in insuring the medical professions. A financial adviser can also review your insurance needs over time to make sure you remain suitably covered.

For more information, talk to your nearest Private Practice-endorsed financial adviser:

- **NSW:**
  - Warren Skinner
  - Fintuition
  - (02) 9362 5050
- **Victoria:**
  - Denis Durand
  - Durand Financial Services
  - (03) 9909 7553
- **Queensland:**
  - Scott Moses
  - Lane Moses Private Wealth
  - (07) 3720 1299
- **South Australia:**
  - Andy Murdock
  - Ora Financial Strategies
  - (08) 8211 6611
- **Western Australia:**
  - Wayne Leggett
  - Paramount Wealth Management
  - (08) 9474 3522
It’s a fact of modern-day medicine that many new patients will automatically check you out on the Internet prior to visiting your practice, and patients referred to specialists by GPs will do the same.

While people won’t necessarily seek to replace you with a web-savvy specialist, they will certainly form an opinion and may question which century you are living in.

Whenever I suggest to a colleague that their practice needs a website, the almost invariable reply is, “I’m busy enough – I don’t want to be any busier!”

The reality is that putting all of the information you normally give to your patients and referrers online will actually make your life easier, and it will save your front-desk staff from having to provide every detail over the phone time and again.

Providing information about you, your specialty and your scope of work is the starting point for new client relationships. It’s also helpful to add details about your location – including parking, public transport, access for patients confined to a wheelchair, local hotels for out-of-town patients and airports for out-of-state and international patients – and the hospitals where you perform procedures.

You can also add billing information, booking forms, new-patient registration forms and interactive forms that allow patients to digitally describe their pain point, for example.
REDUCING RISK

Probably of more importance is the information provided about the conditions you treat and the procedures you do. This does not replace what you tell patients in the office but it can save you and your staff having to repeat details.

It has been well documented that patients only take in a small percentage of what you tell them, especially if they’ve just been given a devastating diagnosis. If a patient needs more information, it can be helpful to have staff point them in the direction of relevant information on your website. It’s a great starting point, and if they have further questions they can always put in a phone call.

The information you make available online can also have an impact when it comes to risk management. Its availability does not absolve you of the duty to tell patients about the risk of certain procedures, but it goes some way to reducing your exposure in the event of a dispute about what was actually said if it is accessible publicly.

You’ll also have an electronic record in the form of an email, if this has been sent to the patient with documents attached, or a link through to the relevant section of the website. The format of this information can vary. Documents are standard but an increasingly popular and personalised medium is streaming video and online PowerPoint presentations. A picture tells a thousand words and it’s human nature to choose the easy option, so if you give someone the choice between the book and the film, they’ll often choose the latter.

SMART MARKETING

All businesses, however big or small, need to spend time and money marketing their services or products, and in this respect a medical practice is no different. This is certainly true if you’ve completed your specialist training and are just starting out but also applies when circumstances change and you are restarting after a break or changing locations.

It would be good to think that medicine is recession-proof but for some of us this is simply not the case. Businesses can employ a whole range of media for the purposes of marketing but the one that stands out head and shoulders above the rest is word of mouth.

While your referring GPs will ensure that people keep coming through the door to a degree, you can’t rely solely on these relationships. The fact is that what your patients and their friends and relatives say about you is invaluable.

If designed properly, a smart website can fulfil all of your marketing requirements and is considerably cheaper in the long run compared to other methods, such as advertising in the Yellow Pages.

Those who want to go one step further can supply regular referrers and repeat-visit patients with the latest news items and updates via RSS-fed newsletters or social-media networks, such as Facebook and Twitter.

DESIGN DETAILS

Once you’ve made the decision to have a website, the next step is to find a web developer. The obvious solution is to find someone just like you – a specialist. Look for developer who has created websites for specialists before or, better still, someone who exclusively works on sites for medical specialists. Have a good look at their portfolio and see if it matches your expectations.

You will need to provide most of the content for the site but if your developer employs medical writers then this can be of enormous help. Make sure the site will be completed within a reasonable time frame – six weeks should suffice – and for the right price.

Generally, you get what you pay for – a $1000 website is usually reflected in the quality but paying $10,000 dollars is absurd. A figure somewhere in between the two will provide a specialist practice with everything it needs.

Make sure you get good technical support built into the contract, either in the form of updates at the right price or a content-management system that allows your staff to make updates with a minimum of training.

Visiting a specialist is daunting for most patients, so offering a professionally developed and smart-looking website will go a long way to providing reassurance and a user-friendly experience.

If designed properly, a smart website can fulfil all of your marketing requirements.
Support Network

Your practice relies heavily on computer networks and software, but Rafic Habib asks whether you have support systems in place for those days when things go wrong.

As more practices become digitised and paperless, there is an obvious dependency on technology, and this dependency must be supported with processes and ‘service level agreements’.

A service level agreement (SLA) is a commitment from your vendor to provide you with support as needed in a timely manner. From an Information Technology perspective, the following components require an SLA:
- Practice management and clinical software application
- Computer network
- Telephone system

AT YOUR SERVICE

The argument for technology and paperless is solid. However, I still get asked that classic question: “Will I lose my data if the server crashes?”

My answer is yes, you will lose data if your server is not backed up and maintained. But how do you back up a room full of paper files?

The point here is that a paperless practice depends on a computer system made up of a number of complex components that communicate and deliver information. These components include medical software, server, backup system, UPS, Anti-Virus, firewall, computers, scanners, printers, pathology, Internet and digital dictation/voice recognition, to name a few. These things allow the practice to be efficient and, in doing so, decrease costs and increase productivity and efficiency gains.

One could argue that, on a busy consulting day, a paper-based system is quicker than a digitised, computer-based system. While there may be some truth in that argument, once you take into account the full picture and the functionalities a computerised system offers – the ability to manage appointments, send SMS reminders, sort patients by condition and provide accessibility from mobile devices from multiple locations – it becomes much more attractive.

In order for such a system to be successful, it must be maintained and serviced regularly. Only three to four years ago, the thought of providing someone with access to your network via the Internet was a foreign phenomenon to most practices, but now it’s normal to expect your IT provider to use remote access to provide prompt and timely support. You should also ensure that this access is used for proactive support and monitoring.

THE RIGHT FIT

Making sure IT works for you should be an important part of your business plan. More than likely you will find yourself making concessions in the way you practice to suit the system but, ideally, you want to system to fit around your practice as much as possible.

Choose a system that accommodates the way you practice and avoid anything that is not fully developed in terms of hardware or software (keep in mind that software development is a slow and painful process that is usually behind budget and, most importantly, behind schedule).

Once you’ve made your choices, ensure that the provider can back up claims with both support agreements and service level agreements that guarantee your business can continue with minimal interruptions.

The world of support has changed and paying exorbitant rates is a thing of the past. Good providers are now able to offer you fixed-cost plans for maintaining and supporting your practice. I highly recommend that you sign up so you can enjoy peace of mind.

Rafic Habib is Managing Director at ISN Solutions.
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If you want to reap the rewards of your hard work during retirement, Craig West says you have to get pro-active as soon as possible and take a long-term view.

Business-strategic succession planning wasn’t heard of 10 years ago, however business owners now understand that succession is significant to the success of their business.

In his top-selling book, *The 7 Habits of Highly Effective People*, author Stephen R. Covey cites habit number two as ‘Begin with the End in Mind’. He backs this up by saying, "If you want to have a successful enterprise, you clearly define what you’re trying to accomplish… the extent to which you begin with the end in mind often determines whether or not you are able to create a successful enterprise."

This applies equally to the medical practitioner who intends to build a valuable medical practice that remains viable beyond the date its owners maintain direct involvement.

**WHAT?**

As any financial planner will tell you, the average amount needed to fund retirement in Australia is at least $1 million. We are living longer than ever before and life expectancy is constantly increasing, which means we now need more money to retire on than previous generations – unless, of course, we wish to rely on a Government pension.

Beyond thinking of retirement, business succession planning must also be considered from the point of view of business continuity should anything unexpected happen to you. In the event of your death or serious illness, what would happen to your medical practice? Do you have plans in place to ensure that control or ownership of the practice is passed on to the successor of your choosing? And would your family be taken care of in the event of the practice being sold?

For many people, the value locked up within their medical practice is their second-largest asset behind the family home, and in some cases it is even more valuable than the family home. Yet most people invest more time, effort and money planning for the sale of their home than they do for the sale of their practice.

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Craig West is Chief Executive Officer of Succession Plus and President of the Australian Chapter of the Exit Planning Institute.
Investing the time and effort to develop a succession plan that ensures you realise the maximum amount of value from your practice when you retire, or if the unexpected should happen, is one of the most important financial decisions you may ever make.

WHY?
For many business owners, a confronting reality awaits them: 55 per cent of business exits in Australia result from failures such as bankruptcy, liquidation, divorce, death or receivership. A succession plan should ensure your business does not fall into this category.

It’s not unusual for practice owners to be surprised to find that their practice must grow, employ more people or raise capital as key steps towards funding an ideal exit or transition into retirement. In addition, underestimating the time required to realise a higher-value strategic transition that delivers maximum value is not uncommon.

Often people are forced into sudden business exits, without having sufficient time to maximise the value they might realise from their ventures. However, those with strategic succession plans in place will almost always realise greater value and less disruption than those who do not!

A succession plan is about maximising the value you stand to realise from your medical practice. If you do not have a strategic approach to business succession planning, any value you have been able to build into your practice may well retire when you do.

Over the years our work has confirmed that the vast majority of practice owners are not adequately prepared for their succession. Many have made no preparations at all and their succession plans are little more than pipe dreams. Many owners even avoid discussing succession plans, in the same way that some people avoid discussions about wills, death and taxes.

These practice owners will typically make their decisions in the last possible minute and the likely outcome will be a poor result for them and their patients, staff and suppliers. These people are not usually the type to start a practice with a view to increasing its value and selling it for the greatest profit after a thorough business valuation.

However, we have found that even the most hesitant business owners become enthusiastic converts to succession planning when they recognise that the best plans provide a strategic course to getting what they want and exponentially increase the potential for stronger, more valuable outcomes for all concerned.

WHEN?
Effective succession planning takes time and involves almost every aspect of your business. The simplest analogy is to ask whether you would consider approaching a real-estate agent today with a view to selling your property in a week’s time. While most agents could actually achieve this, without having any time to market, prepare the property and review their buyers’ database, the price they achieve will not be the real value of the property.

Most of the businesses we work with at our succession advisory firm, Succession Plus, require a minimum of five years to maximise the value and prepare themselves to extract that value successfully.

Not allocating enough time for either planning or implementing a succession plan is the single biggest mistake most business owners make. The first time many people start thinking seriously about a succession plan is when they turn 64 and decide to retire a year later.

At this point the only viable exit strategy is to do a quick ‘tidy up’ and put the business on the market. It’s no different from deciding to spruce up the house two weeks before the auction, appointing a real-estate agent and then heading off overseas and leaving the sale to them. Very few of us would ever consider such a hasty sales strategy for our properties, yet we do it with our businesses.

Succession planning needs to be considered from two very different perspectives. The ideal scenario is about establishing a plan that enables you to transition ownership and control of your practice to new owners at the time of your choosing, while maximising the value you receive for your years of hard work (planned).

The other scenario you must prepare for involves planning for what will happen to ownership and control of your business in the event of your death or serious illness (unplanned).

Succession plans that are rushed, for whatever reason, invariably end up facing a range of complicating issues, such as:

- Disputes among the parties about value
- Failure to properly transfer functional control and management
- Poor communication during the implementation
- Financial pressure on the buyers

A properly designed and implemented ownership transition
succession plan may operate over 10 years or more. This may seem like a long time but there is a lot to do. If the whole plan is rushed it simply won’t be possible to achieve a gradual, well-funded transition that doesn’t put people under financial or emotional pressure.

HOW?

Best practice is to follow a five-stage process that begins with simply reviewing your current position – by undertaking due diligence, benchmarking, structural review and valuation you can determine what exists in the practice today and where there are opportunities and challenges which may affect the ultimate exit strategy. In many cases there will be several areas within the business, both financial and non-financial, that need to be addressed prior to any exit plan being implemented.

Summarised below is the five-stage process we recommend at Succession Plus:

1. **Identify value:** Our business succession planning process is specifically designed around matching your wealth and retirement-planning needs with the value that can be extracted from your medical practice and personal assets, within a set timeframe. The first stage of our process is to identify what will be required in terms of retirement planning and financial needs going forward, as well as what exists currently in terms of practice value and personal assets.

   Our initial report includes a comprehensive review of both business and personal situations to ensure we can maximise the outcome.

2. **Protect value:** Our financial planning process determines the funding required for retirement or after exit, and the most appropriate structures to own that wealth. In addition, our plan needs to manage the risk of unplanned events in terms of accidents, sickness and even death. Our process includes the review of existing risk management and the implementation of legal agreements to govern the outcomes.

3. **Maximise value:** A dedicated adviser is assigned to each practice client to review strategic exit options and agree the most appropriate strategy given the client’s timeframe and financial position. This results in the development of a strategic plan for the practice that maps out initiatives over the next five years.

   Many of our clients have experienced dramatic improvement in performance through the adoption of an employee incentive plan such as our Peak Performance Trust. This is a specifically designed ESOP (employee stock ownership plan) for use as part of our business estate and succession planning process, which is implemented to attract, retain and motivate key staff within the business, ultimately leading to an increase in value.

4. **Extract value:** This stage involves implementing the agreed strategy once all of the restructure and maximisation projects are completed to ensure maximum value is extracted. Depending on the most appropriate strategy selected, this stage will involve transactional issues like legal advice, capital gains tax and taxation and accounting. A project manager will coordinate all aspects to ensure alignment with retirement-planning objectives.

5. **Manage value:** This process focuses on managing the wealth we have been able to extract (proceeds of sale, employee share plan, capital raising, mergers, etc.) to maximise the performance of passive income, minimise any risk areas, protect assets and utilise the taxation and retirement-planning benefits of self-managed super funds.

   Remember, the most successful succession plans are those that have been carefully considered over a period of time; are implemented gradually; and are constantly monitored and reviewed.

**Note:** This story is an extract from Craig West’s ebook, *Enjoy It.*, which can be purchased at [http://www.successionplus.com.au](http://www.successionplus.com.au)
Give your investments a healthy boost with our Healthcare Property Trust

As Australia’s population continues to age, there is an increasing demand for quality healthcare services. Healthcare expenditure is projected to increase from $121.4 billion in 2009-10 to $246 billion in 2033. The Australian Unity Healthcare Property Trust is uniquely positioned to capitalise on this spending (and provide solid returns) by investing in private healthcare-related property assets, such as hospitals, medical centres and aged care facilities.

Even at the height of the global financial crisis the Healthcare Property Trust remained liquid and delivered investors strong income returns.

In fact, the Healthcare Property Trust has had an outstanding performance track record, providing investors with consistent distributions for over a decade.

Healthcare Property Trust - Wholesale returns (as at 30 April 2012)*

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<tr>
<th>Since inception % p.a. (28 February 2002)</th>
<th>11.93%*</th>
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<tbody>
<tr>
<td><strong>Distribution</strong></td>
<td>9.18%*</td>
</tr>
<tr>
<td><strong>Total return</strong></td>
<td>11.93%*</td>
</tr>
<tr>
<td><strong>Growth</strong></td>
<td>2.75%*</td>
</tr>
</tbody>
</table>

*Past performance is not a reliable indicator of future performance. Returns are calculated after fees and expenses and assume the reinvestment of distributions.

To invest in the Healthcare Property Trust call 13 29 39 or visit australianunityinvestments.com.au/whpt

*The financial product is issued by Australian Unity Funds Management Limited ABN 60 071 497 115 AFS Licence No. 234454. This information is general information only and does not take into account the financial objectives, situations or needs of any particular investor. Investment decisions should not be made upon the basis of past performance, since future returns will vary. You should refer to the relevant Product Disclosure Statement (PDS) dated 17 April 2012 if you wish to know more about the product. A copy of the PDS can be obtained by calling 13 29 39 or visiting australianunityinvestments.com.au. You should consider the PDS in deciding whether to acquire, or to continue to hold the product. The property featured in this advertisement is the RPAH Medical Centre—it is owned by the Australian Unity Healthcare Property Trust.

Wayne Leggett is Principal at Paramount Wealth Management. Paramount and its advisers are members of Fortnum Financial Advisers and Authorised Representatives of RI Advice Group Pty Ltd ABN 23 001 774 125 AFSL 238429.

FUTURE FOCUSED

If you don’t like what you see when it comes to the daily performance of your investments, Wayne Leggett suggests that you stop looking.

My wife’s brother is a 60-year-old single man who had the misfortune to contract polio as a toddler while in hospital for a hernia operation. Although he was able to enter the workforce after leaving school and remained there for as long as his disability allowed, he was forced to give up work at a relatively young age.

He is fortunate in that now, largely through the efforts of my late father-in-law, he is a self-funded retiree. Being single and living alone in a small seaside resort, he finds he has an enormous amount of time to spend just thinking.

Some time ago he mentioned to me that he found every time he watched the news on television or read a newspaper, he became worried, depressed and anxious. In an off-the-cuff response, I flippantly suggested he stop watching the news and buying the newspaper.

The next time I visited my brother-in-law, a few months later, he said he had taken my advice and felt much better. Having not given what I had said to him any further thought since our initial conversation, I had to ask what advice he was referring to. My initial reaction when he told me was one of surprise. However, after pondering the consequences of him acting on my suggestion, it got me thinking how often we voluntarily put ourselves in situations from which we will only derive negative feelings – yet we do it anyway.

Extending this line of thinking, I began to realise that the same thought process has relevance in conversations with clients in my role as a financial adviser. Although it is thankfully infrequent, I occasionally encounter clients who tell me, “Every time I look at my portfolio, I start to worry”. My response is always, “Then, why don’t you stop looking?”

This triggers some incredulous looks, at least until I explain the practicality of my suggestion.

REALITY CHECK

The reality is this – until the world figures out how to remedy the financial woes of Europe, or comes to terms with the consequences of failure to do so, financial markets will continue to deliver uninspiring results. If you, or your financial adviser, have constructed an appropriate portfolio, you will be in the mix of assets suitable to your particular situation. Any portfolio with a substantial growth component will likely take some time before it makes for good ‘reading’ – and you have to accept that it may never return to the levels of returns taken for granted for 15 years leading up to 2008.

IN YOUR INTEREST

So, if we assume that the portfolio is suitably constructed but the continuing trend of extreme market volatility, giving back today the gains of yesterday, persists for some time to come, then frequent perusal of the performance of your portfolio will do little more than give you cause for undue concern.

Mainstream media has a lot to answer for in terms of its obsession with the constant reporting of financial market performance. The reality is that watching the rollercoaster that is today’s share markets will, or at least should, have no immediate bearing on investment decisions. Since the only
possibilities are that a ‘good market’ day may make you feel good but a ‘bad market’ day will probably make you feel bad, it would be sensible to avoid the temptation to be constantly checking.

An appropriately constructed financial plan is based on financial objectives and desired outcomes. In the main, it should ignore the noise of the day-to-day machinations of investment markets. If you have an inordinate focus on today, you run a grave risk of making decisions that may come with a high price in the future.

If you believe that what you have in place is in your best interests, you must have the courage of your convictions to stay the course and not too readily accede to your understandable desire to get out of the game.

As we celebrate, if you can use that term, the fourth anniversary of the GFC, even some of the more resilient of investors are starting to wonder about the wisdom of maintaining their portfolios in their present form.

At the end of the day, the lesson is that investing is like going sailing. If you are feeling sick from the motion of the waves, the only way to feel better is to focus on the horizon rather than looking over the side of the boat!

Disclaimer: The above information is commentary only. It is not intended to be, nor should it be construed as investment advice. The views expressed are subject to change at any time based on market and other conditions. To the extent permitted by law, no liability is accepted for any loss or damage as a result of any reliance on this information. Before making any investment decision you need to consider your particular investment needs, objectives and financial circumstances.
BUSINESS MINDED

The Private Practice has partnered with the General Practitioner Conference and Exhibition to offer a module dedicated to Finance and Medical Business Management. Nikki Drummond provides an overview.

The General Practitioner Conference and Exhibition (GPCE) is a triannual Primary Healthcare event held in Sydney, Brisbane and Melbourne. All three conferences feature a program that gives GPs unparalleled access to leading experts, medical researchers and scientists from across Australia.

Now in its 17th year, GPCE provides the Australian General Practice community with its largest and most innovative educational program and exhibition. The scientific program is accredited by the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and the Australian Association of Practice Managers for Continuing Professional Development points.

It comprises approximately 14 Active Learning Modules, made up of roughly 30 seminars and 150 workshops conducted over the three days at each of the state events.

KNOWLEDGE IS POWER

The GPCE is one of a range of Primary Care events produced by Reed Medical Education, which is dedicated to bringing the best research and clinical practice to professionals within the medical community in an unbiased environment.

Our goal is to deliver independent medical and health events focusing on areas where there is the greatest need for continuing medical education and where medical disciplines intersect. To this end, Reed Medical Education has teamed with the Private Practice to bring the latest in Finance and Medical Business Management to the Primary Care Industry.

This year at the Brisbane and Melbourne events, GPCE and the Private Practice will be launching an Active Learning Module dedicated solely to Finance and Business Management in Primary Healthcare.

The aim of this unique event is to provide information, education and resources to help healthcare professionals establish, manage and optimise the performance of their private practice and achieve and maintain their desired lifestyle.

This stream of education will address such areas as Business and Succession Planning, Finance and Banking Strategies, State of the Art Web and Practice Design, and Investments and Superannuation Strategies. Business and financial management is an important contributor to achieving better outcomes for both patients and doctors.

As Gregory J. Mertz writes (http://www.aafp.org/fpm/2001/0500/p27.html), "The dynamics of today’s healthcare environment make it increasingly complicated to ensure adequate physician incomes while running a high-quality medical practice. Physicians and
managers are faced with increasing overheads, discounted fees, a shortage of qualified and motivated staff, and growing service expectations from their patients. Efficient practice operations often elude even the most talented leaders, in part because tasks are performed out of habit rather than as a result of planning, and years of routine have institutionalised inefficiencies.”

From business conception to exit strategies, practice design and technological innovations, finance and business-management knowledge empowers the practitioner to optimise their practice.

Through the provision of this dynamic and interactive learning module, GPCE and the Private Practice will deliver to our delegates the skills and knowledge required for a business model that provides both the practitioner and the patient with the best possible experience.

To register online for this Active Learning Module, please visit www.gpce.com.au ©
In the first of our ‘Postcards from Practice’ features, Dr Louis McGuigan
discusses the realities of choosing to go private.

Before discussing what I feel about private practice in Rheumatology, it’s important
to give a summary of my training and experience before coming to private practice
in 1994. My training in internal medicine was undertaken in several large teaching
hospitals in Sydney before I spent one year in New Zealand after completion of my
advanced training in Rheumatology.

I then completed a Doctorate in Medicine on Immunogenetics and Ankylosing
Spondylitis before gaining a position as a
Staff Specialist in Rheumatology in one of
the units I had previously trained in.

In other words, I was all set up for an
academic/institutional career and I followed
this path for seven years. I enjoyed the
teaching, which over the years gradually
decreased from 120 hours per year to just
four hours per year. One might expect
this decrease was due to my unwillingness
to teach or poor ratings for my lectures/
tutorials, but neither is correct. It just seems
that face-to-face teaching is not the way
universities want to go these days.

I liked the clinical work but I must say
I found research and many researchers
frustrating and tedious. Moreover, I
really found hospital administration and
organisation inefficient and annoying. I
clearly remember one Friday night coming
home and being grumpy and my two
older daughters asking what was wrong.
When I said it was my “bloody job”, they
unanimously said, “Well change it then!”

They were smart kids and I realised that
if I didn’t take charge of my life then I could
not blame anyone else for my lot.
**TAKING THE LEAP**

In 1994 I started on my own with my secretary from the hospital, who had the same views about institutions. It was fairly lonely to begin with – I had enough regular patients to fill one filing cabinet and enough bookings for 10 days. At the end of the first week I nervously asked my secretary what our invoices were for the week. I was fearful that, with four children to support, I may have made a disastrous financial decision. To my great relief that was not the case and our practice has not looked back since.

Our practice, now known as Combined Rheumatology Practice (or CRP), has six rheumatologists, three large offices in different regions of Sydney, more than 6000 active patients (seen in the last 12 months), sees more than 450 patients per week and has a large clinical-trials centre run by one of our rheumatologists.

**MAKING IT WORK**

With this background, I would offer the following advice to anyone thinking about entering into private practice:

**Bring your ‘A’ game:** In other words, do not come to private practice unless you are well trained, competent and willing to work very hard. Remember the paradigm in private practice is that you work for the patient – they are paying good money either themselves or via Medicare or the health funds to get a result. They need to get better or have a very good explanation as to why they cannot. Private patients do not want to be an ‘interesting’ case.

**Be available:** Remember also that practices are built on the three ‘As’ – availability, affability and ability, in that order. If you are the new kid on the block you need to be available when your competitors/colleagues are not. That will get you a start with your referrers. Your ability, personality and communication skills will get you patients thereafter.

**Provide superior service:** Medicine is a service business. If you give service then you get business. We often think of service in the very narrow context of what we as doctors do for our patients in the 15-30 minutes we see them. However the experience for the patient is much more than this. It involves the ease of making the appointment, the politeness of your secretarial staff, the ease of getting to the rooms, the parking, the number of stairs, the waiting room, the atmosphere and how long they have to wait once they arrive for their appointment.

In other words, the 15 minutes with you will often be part of a two-hour journey and for elderly people it may be their only outing for the week. If you try hard to make it a pleasant experience your future will be assured.

**Apply your values:** If you do not have some ethos or objective for your practice you will be like a ship without a rudder. You must decide what kind of practice you want to give. This could be “excellence at any cost”, “good-value medicine” or “compassionate care”. Once this is decided then the cost structure of the practice, the type of staff and facilities required will naturally follow. Furthermore, when the practice needs to expand you will know the kind of practitioner you are looking for.

**Communicate clearly:** If you think you can get away without writing letters promptly to referring doctors in private practice, you are wrong. You live or die by your letters to your referrers. Many years ago, when I was doing a locum for a senior rheumatologist, I complained to his secretary about how much I hated dictating letters and how often I got way behind.

Her advice, which I thank her for every day, was to dictate the letter while the patient was there. I didn’t think this would work and believed patients wouldn’t like it, but I was wrong – patients love it! They know just how much has gone on in the consultation, they listen intently and usually correct any errors. Doing so also decreases questions dramatically and you are only ever one letter behind, and at the end of the day you are finished.

Almost all of our letters are sent on the day or the day after the consultation. As they are faxed, the referrers have the information promptly, again saving valuable time – they don’t have to ring for results and waste your secretarial staff’s time.

**Respond to all messages:** Patient and doctor messages can be a real headache. The motto in our practice is “Every message, every day”. If you don’t ring patients back they get annoyed and one day there will be a patient that will cause a disaster. Make sure you have a good system so no message gets lost, and ensure there is a record of your response. This is not just for medico-legal purposes but it is to document what you have done because, trust me, eventually you can’t remember.
Support your staff: You also live or die by your staff. Employ good people that share your ethos and train them well. Don’t expect staff to be able to do everything as soon as they arrive. Give them a good trial period before accepting them as full-time employees. Treat them well and never lose your temper, as you will regret it.

In our practice I have a chat to each staff member each year about their performance, their plans, their suggestions and the prospect of a raise. We have a staff meeting with all secretarial staff every three months and we attempt to improve efficiency via these meetings. Most of the developments in our organisation have come from suggestions that arose at these meetings.

We now also have a rule that if you cannot take constructive criticism then you cannot work at our practice. This applies to all of us – it’s a reality that some of the biggest problems will come from the medical staff.

Make your premises pleasant: If you are going to work at your office for 40-50 hours per week, don’t be a scrooge. Spend some money to make it comfortable and pleasant for you, your staff and your patients. The reward will be relaxed staff and patients who will appreciate your consideration.

Choose colleagues wisely: If your practice builds to the point where you need to expand and have more consultants, I would offer the following advice:

- Get someone who shares your approach to medicine and your ethos for the practice.
- Do not think that you are going to make money out of your colleagues – all you are doing is improving the service by improving access. If you try and make money out of your colleagues, they will become annoyed and resentful, and will eventually leave.
- Always try and get someone better than you. When the founder of the practice is challenged the standard of the whole practice will rise.
- Encourage the new colleague to develop an area of expertise that will broaden the appeal of the practice and add to the new colleague’s confidence.
- Make sure someone runs the business of the practice. If you don’t run the practice, it will run you. One person in the practice should have this responsibility. If you pass it off to another non-medical person then eventually you will be working for them.

Create financial security: Even the most well-run and profitable private practice will only give the owner a cash flow rather than creating wealth. You have to be smart to create wealth. In our practice we have used our ownership of our rooms to help generate future financial security by having our practice pay rent to the owning entity – our superannuation funds. In other words, we are our super fund’s tenants and the more successful the practice, the more rent we pay and the more our super funds make.

Some may not like this way of operating but it has worked for us and given us very good returns through the last four years of stock-market gyrations. I am no expert on these matters but if you want to try alternatives, remember that no matter how much you earn per hour it will never be enough and you must build yourself a passive income.

The reality is that private practice isn’t for everyone. If you think it’s a goldmine, a place to go when there are no academic or staff positions available or a place to dabble, think again. On the other hand, if you understand that private practice is a place where you can get reward for effort, fulfill your personal goals of service to patients and to the community, and build a future for yourself, your family and your medical colleagues, then it could be perfect for you.
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As an investment, healthcare has long been seen as an excellent ‘defensive’ option because it is less affected by economic cycles than other sectors, such as retail.

When combined with that other great Australian investment love affair – property – the opportunities for investors are significant.

Healthcare property in Australia, which encompasses medical centres, hospitals and aged care, is a fast-growing sector well positioned to capitalise on Australia’s ageing population.

Not only is the comprehensive baby boomer generation now moving into retirement, but as a nation we are continuing to live longer than ever before. This means the percentage of Australians aged over 65 is rapidly increasing – according to an Australian Bureau of Statistics document entitled *Population Projections Australia, 2004 to 2101*, this age group is expected to make up over 20% of the population by 2020.

Looking to the future and taking our ageing population into account, **Chris Smith** says healthcare property will continue to present a standout investment opportunity in the coming years.

**GOOD VALUE**

Australia’s ageing population will have an enormous impact on the economy over the next 20 to 30 years. Commonwealth expenditure on healthcare, for instance, is expected to grow from 4.1% of gross domestic product in 2009-10 to 7.1% in 2049-50 – or from 15% to 26% of total Commonwealth expenditure over the same period (*Intergenerational Report 2010, Treasury of Commonwealth Australia)*.

The Government’s *Productivity Commission Report* highlights the growing need to provide better services and facilities for our ageing population, both in medical services and in developments such as retirement villages.

In addition, the ongoing issues of chronic disease and obesity place heavy demands on Australia’s healthcare system. These demands will have to be met by both Government initiatives and the private sector.
As well as benefiting from these demographic changes in Australia, healthcare property also offers the advantage of long and stable tenancies when compared to other property sectors. From an investment point of view, this translates into steady income stream and capital value stability.

**SUPPLY & DEMAND**

The three healthcare-property sectors offer unique services and investment benefits.

- **Private hospitals**: With this sector continuing to experience solid growth, forecasts suggest that by 2021 private hospitals will treat 50% of all hospital patients, while day-surgery centres are also taking on services traditionally provided by hospitals. Up to 60% of all medical procedures are now undertaken as day procedures.

  Well-located, high-quality hospitals continue to be in short supply and are highly sought after by investors, providing strong support for prices.

  Yields for hospitals are typically in the range of 8.5% for well-located, high-quality hospitals, and up to 11% for smaller or older hospitals.

- **Medical centres**: The concept of the purpose-built medical centre developed in the mid-1980s from traditional, individual stand-alone doctors’ surgeries. Today they are more likely to be freestanding, multi-storey buildings providing a variety of services, and are therefore attractive to a broad range of potential tenants. Yields for well-located, high-quality medical centres are currently at around 7.5 to 8% for those valued at under $10 million, and 8 to 8.5% for those over $10 million, depending on each property’s characteristics. Medical centres priced under $10 million often appeal to private investors, which can keep yields in this price range tighter.

- **Aged care**: This covers assistance and support for the elderly and can include long-term care, nursing homes, hospices and in-home care. The three main drivers of the sector are:
  1. The ageing of the population, which increases demand for aged-care accommodation.
  2. A decrease in the care of the elderly within the family.
  3. A greater acceptance of aged-care housing as an accommodation alternative.

  Aged-care facilities usually include both high and low-care accommodation, and provide nursing care for patients who have a continuing need for nursing assistance. Historically, however, it has been difficult for investors to access this asset class as most hospitals are publicly owned.

**PROVEN PERFORMANCE**

The good news for investors is that it is becoming easier to invest in healthcare property, primarily through property funds. The launch earlier this year of the IPD Healthcare Index, which specifically measures the performance of healthcare property, is a clear sign of the sector’s growing importance.

This index has shown that while still a small sector compared to retail, industrial or office property, healthcare property has performed well over the past few years. It has shown a relatively consistent total return profile with a low peak before the global financial crisis (GFC) and shallow post-GFC trough (see chart).

Overall, healthcare property investments offer low volatility with very strong defensive characteristics; regular, long-term stable income paid quarterly; the potential for capital growth over the medium to long term; and an investment well positioned to cater for, and capitalise on, Australia’s large ageing population.

![Graph showing total return for all property versus healthcare annualised returns on quarterly periods to December 2011.](chart)

Source: IPD Research
BUILDING CONFIDENCE

Globalisation and confidence are the two key factors influencing the Australian property market today, writes John McGrath.

In the 30 years I’ve been in the property industry, I have never seen global economic issues have such a direct and meaningful effect on our property market. People are far more aware of what’s happening overseas these days, and Europe and the US are weighing heavily on the minds of buyers and sellers.

They’re worrying about the ‘what ifs’ – what if another financial meltdown occurred overseas, how would that affect us? These questions impact confidence, and without confidence the market doesn’t move.

Right now, interest rates have fallen, unemployment is not high and our economy is stable – but our property market is not responding. Interest rates, unemployment and the local economy have always been fundamental drivers of Australian property, but today globalisation is making overseas economic matters far more relevant.

When you add the uncertainty around interest rates and whether the banks will pass rate cuts on, a lot of people simply don’t have the confidence they need to go ahead and buy or sell.

THE FINANCE FACTOR

Confidence is all about psychology. Logically, buyers might recognise the exceptional value available right now but psychologically they’re struggling to make the decision to buy.

There is actually plenty of evidence that buyers are out there. At McGrath, we’ve noticed a significant spike in enquiry this year. In addition, figures from Australian Finance Group (AFG), the country’s largest mortgage broker, indicate buyers are getting their finance organised now for their next purchase. In NSW, for example, AFG lodged $842 million worth of new property loans in March – the second-biggest month ever since their index commenced in 2004.

But while buyers are getting their finance sorted, the lack of confidence is still causing many people to hesitate. They’re hearing a smattering of good news one day and doom and gloom the next, and this is causing real confusion in the marketplace.

Another worry for the property market is the banks signalling their detachment from the Reserve Bank of Australia’s moves on interest rates.

This is a significant issue. Consumers can no longer rely on the banks to move in sync with the RBA and this is making people nervous. According to AFG, one in four new borrowers are choosing fixed rates because they want some certainty with their repayments.
MARKET FORCES

I’m often asked in the media what the property market needs to move forward. A lot of people are sitting on their hands right now, waiting to buy or sell when they perceive the time is right.

The first thing I’ll say is that the market isn’t doing too badly. Despite the lack of confidence out there, people are still trading and the under-one-million-dollar price bracket is very strong. We also have RP Data numbers showing Capital City median prices are back in line with November 2011, which indicates steadying market conditions. Sydney home values actually made some ground in the March quarter, up 1.1%.

But to get the market back into a growth phase, we really need some positive news out of the US and Europe. There are some signals of recovery from the US but it’s just not enough right now to raise people’s confidence to buy or sell. A reduction in interest rates would also be helpful, as long as the banks pass them on.
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“We came to the course with the belief that we would walk away from our medical practice at the end of next year. We now think we will try to sell and get the proceeds into super!”

“Well worthwhile – lots of challenging strategies to consider.”

“It has been hard to find people whose advice you can trust and that is relevant to the knowledge you are seeking... I found a huge amount of valuable information that I can take away.”

“Opened my eyes to the deficiencies of my practice.”

“Very enjoyable; very approachable presenters.”

“We came to the course with the belief that we would walk away from our medical practice at the end of next year. We now think we will try to sell and get the proceeds into super!”

“Good overall! Now need to speak with individual advisers for personalised advice!”
Inspiring physicians and patients to jointly fight RA*

*Improved clinical signs and symptoms and inhibition of radiographic progression in moderate to severe RA*

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- **Rheumatoid Arthritis (RA):** Reducing signs & symptoms, and inhibiting structural damage, in adults with moderate to severely active RA; including patients with recently diagnosed moderate to severely active disease who have not received methotrexate. Humira can be used alone or in combination with methotrexate.
- **Polyarticular Juvenile Idiopathic Arthritis (pJIA):** Humira in combination with methotrexate is indicated for reducing the signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in patients aged 4 years of age and older. Humira can be given as monotherapy in case of intolerance or when continued treatment with methotrexate is inappropriate.
- **Psoriatic Arthritis (PsA):** Treatment of signs and symptoms, as well as inhibiting the progression of structural damage, of moderate to severely active PsA in adult patients who are candidates for systemic therapy or phototherapy.
- **Ankylosing Spondylitis (AS):** Reducing signs and symptoms in patients with active AS.
- **Crohn’s Disease (CD):** Treatment of moderate to severe CD in adults to reduce the signs and symptoms of the disease and to induce and maintain clinical remission in patients who have had an inadequate response to previous DMARDs, or who have lost response to or are intolerant of infliximab.
- **Psoriasis:** Treatment of moderate to severe chronic plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

**CONTRAINDICATIONS:**
- Severe infections including sepsis, active TB, opportunistic; concurrent anakinra; moderate to severe heart failure.

**PRECAUTIONS:**
- Infections (bacterial, mycobacterial, invasive fungal e.g, histoplasmosis, viral or other opportunistic); hepatitis B, latent TB; demyelinating disorders; haematologic events; live vaccines; immunosuppression; new or worsening CHF; renal, hepatic impairment; malignancy; hypersensitivity reactions; latex sensitivity; concurrent abatacept; elderly; pregnancy, lactation, surgery.

**ADVERSE REACTIONS:**
- Respiratory tract infections, leucopaenia, anaemia, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash, musculoskeletal pain, injection site reaction are very commonly seen adverse events. Benign neoplasm and skin cancer including basal cell and squamous cell carcinoma were commonly reported. Fatal infections such as tuberculosis and invasive opportunistic infections have rarely been reported. For others, see full PI.

**DOSEAGE & METHOD OF USE:**
- **RA, PsA and AS:** 40 mg sc fortnightly as a single dose.
- **pJIA:**
  - Paediatric Patients (4 to 17 years): 15 kg to <30 kg 20 mg fortnightly; ≥30 kg 40 mg fortnightly
  - 80 mg as two sc injections on Day 14, then Maintenance: 40 mg sc starting on Day 18 and continuing fortnightly.
- **Psoriasis:** Initial dose of 80 mg, followed by 40 mg fortnightly, starting one week after the initial dose.


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