RE-IMAGINING
The Marketing Concept in medical practice

The Surgical Audit
Improving patient outcomes

Doctor As Patient?
Managing the risks

Singapore
The Unlisted Collection
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Introducing CACHE by Terrance Hunt

Cache has been certified to the Australian AFRDI Rated Load 151 standard for chairs that intend to be used in a public space by people heavier than 100 kilograms.

Available at kezu.com.au
I love that Etihad Airlines T.V. Commercial featuring Nicole Kidman.

The images are of an incredibly luxurious first class cabin – a spacious, comfortable, 5 star mini hotel room with butler-service and wings.

As we are being enticed with movie star service and opulence, Nicole’s voiceover states:

“Occasionally people come along who are not content with simply moving things along...they want to take things further, tear up the plans and start again, then take another brave step.

They will see the future and knock down the walls to reach it; and insist that the dream is possible, overcome all indecision and take a running jump in to the unchartered.

Bored by re-invention of the superficial kind, they want more. Because their goal isn’t to improve on what’s been done before, but to totally re-imagine it”

We are living in an age where the true meaning of marketing, the Marketing Concept, if you will, has never been more prevalent in the strategic thinking behind corporations product and service development.

The Marketing Concept is the philosophy that businesses should analyse the needs of their customers and then make decisions to satisfy those needs, better than the competition.

Just imagine, or re-imagine, (to borrow from Nicole), what a medical practice would look and feel like, the services it would offer, the relationship it would have with its patients and the community if its principals adopted the Marketing Concept.

Imagine a medical practice ‘re-imagined’ – where the slate was wiped clean and it was built from scratch to satisfy the needs (wholistic and extended) of healthcare consumers.

Imagine a competitive environment that made this way of thinking a necessity, where customer service and experience dictated your viability, your survival – I believe you won’t have to imagine for too long as we are fast reaching over supply in some specialties in certain cities, towns, suburbs.

There are a brave few in Australia who are daring to ask patients what they want, need from their practice.

These pioneers are embracing change and, armed with sound business principals and strategies, are re-imagining the medical practice – their dual aim is to provide a better service and hence stay ahead of the competition as well as to create a business model that provides a quality lifestyle for their family.

Our delegates at last weekends’ Private Practice Growth Strategies workshop in Sydney heard from one such pioneer, Dr Stephen Morris, Obstetrician & Gynecologist. You can benefit from his strategic thinking by reading his article on page 6.

We hope you enjoy this, our 18th edition of The Private Practice Magazine, and invite you contact us should you wish to discuss any of the tips and ideas detailed within.

Happy Reading
The benefit of getting a medico-specialist financial adviser?

Medicos and other healthcare professionals are not like everyone else. When it comes to financial advice, you have particular needs, issues and concerns that need to be clearly understood from the outset. Which is why we’ve gone to considerable lengths to assemble a network of medico-specialist financial advisers – with extensive and successful medico experience. Like-minded professionals who will not only provide you with solutions but also educate you – so you can make fully-informed decisions. There’s a medico-specialist financial adviser in every state and territory of Australia.

Examine our network of medico-specialist financial advisers
The business of medicine as we know it has changed. People have choice. They expect service, and quality.

People don’t only shop for their clothes, food, real estate and entertainment - they shop for their doctors and their medical care, too. You may ask your colleague or best friend for advice on where to take your visiting parents out for dinner on Saturday night. You’d just as likely ask which obstetrician she used.

For many, it’s not only about receiving a medical service. It’s about receiving a good quality, friendly service in a caring, compassionate and positive environment, with their wellbeing the focus.
Dr Stephen Morris is an obstetrician gynaecologist, who completed his undergraduate degree at the University of Sydney. He undertook his residency at Royal Prince Alfred Hospital, and was a senior registrar at Monash Medical Centre in Melbourne, where he obtained membership with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Following this, Dr Morris worked overseas for four years, commencing with two years at the National Maternity Hospital and the Rotunda in Dublin, followed by a year at Queen Charlotte’s Hospital and The Royal Free Hospital in London and a year at Hospital Cochin in Paris.

On his return to Australia, Dr Morris worked as a staff specialist at the Royal Prince Alfred Hospital, before commencing private practice as a Consultant Obstetrician Gynaecologist in 2002. After a number of years leasing numerous medical rooms throughout Sydney, he knew he wanted to do things better.

“It became apparent to me, over the years, that the large majority of health professionals who specialise in pregnancy related health, are located in suburban areas or hospitals, making it difficult for many working women to access specialised care during pregnancy and early motherhood” says Dr Morris.

Stephen initially leased a suite in BMA House on Macquarie Street, Sydney, a well renowned and prestigious address for medical practitioners. Stephens’ move into the city meant “a higher referral base of nearby GPs, and the opportunity to care for women needing quality obstetric and gynaecological care around their busy work lives, based in the CBD” says Stephen.

After leasing the suite for approximately two years, Stephen, overtime, managed to purchased all four suites on level 9 of the building, giving him the whole of the floor to set about creating his vision.

In 2011, Dr Morris launched ‘Dr Morris – Sydney Mother & Baby’- a holistic women’s health practice, dedicated to caring for women before, during and after pregnancy, with the convenience of a CBD location. “My aim was to deliver the best possible standard of care for women through their pregnancies, by providing them not only with high quality obstetric care, but also the services of a very experienced team of midwives, and a lactation consultant”. In addition, patients have exclusive access to an extensive range of antenatal and postnatal education programs.

The business went from strength to strength, and continued to expand it’s services. “Our most recent additions to Sydney Mother and Baby are a complimentary breastfeeding drop-in clinic, available twice per week for women having difficulties breastfeeding, baby massage classes for new mothers and a mothers group for women with minimal family support in Sydney”, says Stephen.

In mid 2015, Dr Morris launched a separate entity to Dr Morris | Sydney Mother & Baby, ‘Sydney Medical Specialists’. Sydney Medical Specialists is a fully serviced, architecturally designed, medical practice, with state of the art facilities and equipment for doctors.

When asked what his vision was for this new medical facility, Stephen says “After the success of Sydney Mother and Baby, I saw an opportunity for other doctors to have a similar set up for themselves – a beautiful and welcoming space for their patients, access to an abundance of city based GPs, and a patient base centred on working professionals that require care in the CBD”.

The practice is positioned on the first floor of BMA house, opposite the Royal Botanic Gardens. “The model for the practice is really of convenience to busy specialists who want to expand their patient base – it basically allows them to walk in and to consult in a prime CBD location, with state of the art equipment and luxurious surroundings – the hard work in set up has been done for them!”

The practice model means that doctors are not billed for a percentage of their billings like many other practices, but are charged a flat sessional fee that covers all their expenses, from the suite itself, through to secretarial support, a bio on the website and all operational costs, such as utilities and stationary.

Dr Stephen Morris has re-imaged the practice of obstetrics and gynaecology, applying the Marketing Concept to patient services.
KEY ELEMENTS FOR A SUCCESSFUL PRACTICE

STAFF

"I think it goes without saying, but getting the correct staff for your practice cannot be stressed enough. I selected each of the midwives for Sydney Mother and Baby based on their immense knowledge and experience, and having worked with them at the hospital, and seeing first hand their impact on patients" says Stephen.

He also knows the importance of getting administration staff right. "The administration or secretarial staff are the first point of contact for both potential and existing patients. The difference between a really satisfied patient and a disgruntled one can often lay with your front of house. It can also mean the difference between gaining or losing a future or potential patient".

Stephen also recognises the importance of fostering good staff, with recognition of hard work, providing ongoing training, and team building days. "Twice per year we have a team building activity, which is always a lot of fun. I also find that communicating with your staff regularly, both in terms of individual feedback and team meetings are really beneficial for the whole team – it provides a sense of a common goal, and also allows you an opportunity to praise hard work which can easily be forgotten if you don’t make a concerted effort to do it. You really do notice the difference in performance where positive reinforcement is given".

MARKETING

Like any service in our modern era of everything being done on smart phones, having marketing in place has never been more important; "I never realised how important marketing is. You may have a fantastic service to offer people, however, if they can’t locate your services, or know what you’re offering, then your business just won’t reach its potential".

Both Sydney Mother and Baby and Sydney Medical Specialists have modern websites that are frequently updated. Stephen also uses social media, which is useful for patient updates on practice news and health information, such as when a vaccine is back in stock at the rooms, and also for potential doctors wanting to lease a suite at Sydney Medical Specialists. "My staff manage the social media with input from myself where required. I was hesitant to use it at first I must admit, however, I’ve since realised that practically everyone uses it, so if you don’t, you may be missing important opportunities. Patients also really enjoy the interaction with staff, and appreciate the information that is provided to them".

INFRASTRUCTURE

For both Dr Morris – Sydney Mother & Baby, and Sydney Medical Services, Stephen relies on a solid infrastructure of support, predominantly good accounting services, IT support and medical software support. "The daily running of the practice really relies on these elements operating smoothly. When they don’t, staff get stressed, which has a flow on effect to the patients".

Stephen utilised the solid and reliable infrastructure of Sydney Mother and Baby for the set-up of Sydney Medical Specialists. This provided the advantage of his staff having prior training and experience on the systems, and pre-existing positive relationships with the parties involved in the service delivery."
WHAT IF YOU WERE THE PATIENT?

Paul ter Bogt is a Corporate Authorised Representative of Financial Services Partners.
Medico-specialist financial advisor, Paul ter Bogt demonstrates the make-up and value of the optimal insurance portfolio.

Every day you see the financial impact that injury and illness has on your patients, often caused by them not being able to return to work. But what if it was YOU in that situation? Here Paul ter Bogt from Financial Services Partners shows how receiving specialist financial advice around personal and business insurance can help to secure your, and your family’s, long-term future.

Many of the medical professionals that we see have been so busy completing years of training, building their practice and caring for their patients, that they have unknowingly put themselves (and their practice) at significant risk through not having the right insurance cover.

And unlike many other professions, we know that even quite minor conditions can cause medical professionals to be off work for an extended period.

Think for a moment about what would happen to your family if you couldn’t work for a few weeks? Or a few months?

What would happen to your practice... your employees... your patients?

With so much riding on your ability to earn an income, how would you cope financially?

That’s why it’s absolutely vital that every medical professional in private practice seeks specialist advice around the appropriate amount of personal and business insurance needed to secure their financial future.

THE VALUE OF SPECIALIST ADVICE

Almost all medical professionals we see have at least some personal insurance in place, however we find it was often taken out very early in their career and hasn’t been looked at since.

And given how their earning capacity and financial situation has changed since then, not having insurance that has kept pace with their career means they are exposing themselves to significant financial risks.

We also find that the insurance they do have is quite ‘standard’, and doesn’t take into account the specific occupational risks faced by health care professionals.

These areas include patient injury, needle stick injuries and misconduct claims, along with unknown claims that can arise after they’ve stopped practising or retired.

Helping you to navigate this complexity is where a medico-specialist financial adviser can really help, especially when you have dependants that rely on you to generate an income.

A tailored portfolio of personal insurance is a cost-effective way to cover all those expenses that would arise should something happen to you, such as medical and hospital costs, mortgage payments, regular income for your dependants and funeral costs.

SECURING YOUR FAMILY’S FUTURE

Getting financial advice now will help to reduce the risks that may have built up over time, with a medico-specialist financial adviser using a mix of personal insurances to protect you, such as:

• Income protection insurance (also called salary continuance), which pays a benefit of up to 80 per cent of your gross annual income as monthly payments should you be unable to work due to sickness or injury.

While you recuperate, you can use this benefit to cover your ongoing debts (such as mortgage, credit cards and personal loans) and living expenses (such as rent, food, household bills and school fees).

• Trauma insurance which pays you a lump sum if you’re diagnosed with a specific illness or injury, such as major diseases (like cancer, stroke or heart disease) or serious physical conditions (like severe burns, deafness or blindness).

You can choose the benefit amount that you’d like to receive, which can be used to pay for your medical treatment, reduce your debts and fund your family’s lifestyle while you recover.

• Total and permanent disablement insurance (also known as TPD) pays you a lump sum, or equivalent instalments, if permanent disability prevents you from working in your current occupation.

Given the specialised nature of their work, having the appropriate TPD policy in place is especially important for medical professionals, should they be unable to work in the occupation for which they’ve spent years training.

A TPD benefit will not only help you to pay for medical treatment and meet ongoing expenses, it will also help you to adjust to those more permanent changes in your life, such as moving into a new line of work, making modifications to
INSURANCE

your home and for ongoing medical care.

- Life insurance, which pays a specified amount directly to your beneficiaries or your estate, either as a lump sum or instalments, if you die.

Having the appropriate life insurance in place to protect your most important asset – yourself – is so important.

ADVICE ABOUT BUSINESS INSURANCE

We also find, just like with personal insurance, that many medical professionals in private practice have some type of business insurance in place.

However, this is usually not anywhere near enough to protect their business, in the short or long term.

This is where the advice of medico-specialist financial adviser can help to secure the future of your practice, through putting in place business insurance, which may include:

- **Key person protection insurance**, which seeks to reduce any financial disruption to your practice by insuring the vital role that you play within it. This helps your practice retain its value and continue running should something happen to you in the short term, while also ensuring your family is protected in the long term if you are permanently disabled or die.

- **Business expenses insurance**, which covers all those fixed expenses that still need to be paid when you’re unable to work. We often see medical professionals that believe workers’ compensation or income protection can cover business expenses, which is why many practices don’t have this cover in place.

- **Buy/sell agreements** that, if you have a business partner, use a life insurance policy to fund the future purchase or sale of shares in your practice. These agreements are usually triggered by a specified event (such as disability or death), with the proceeds from the insurance policy helping with the ownership transfer of your practice.

- **Business debt repayment insurance**, which effectively pays out your business debts if you become permanently disabled or die. This gives you (or your estate) some time to decide what will happen with your practice, while allowing your business to continue paying those day-to-day business expenses like your lease or mortgage, and equipment and employee costs.

Advice for specialists, from specialists

The personal and business insurance needed by medical professionals is complex, with ‘standard’ insurance policies often not covering the risks that they face.

An experienced medico-specialist financial adviser can put together an insurance package that protects you and your family, through recommending the level and quality of cover that is tailored to your financial situation and specific occupational needs.

They can also review your insurance portfolio regularly, so you and your family remain fully protected as your situation changes.

To find out more about how you can protect your wealth through insurance, contact The Private Practice-endorsed adviser in your State.

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GIFTING THROUGH YOUR ESTATE
Michelle Gianferrari discusses how to make your ‘giving’ count.

Seeing the benefits that your profession delivers to patients and the advancements to your specialisation or scientific area of expertise as a result of medical research can often be the catalyst for your own giving or philanthropy. In many ways, philanthropy can bring about immense change not only to the communities and projects in which they help to fund, but also for those that give.

Whilst many people give directly to charity as a one off or even regularly, they may not realise that there are more efficient and structured ways to give, which can provide long term funding to the causes they choose to support. Structured giving means planning when, how and where to give for maximum community impact and is often incorporated into an estate plan which can allow individuals to also gift estate assets more effectively.

Considering giving through your estate plan can also help to determine what you can give and also how other assets in which you have an interest in will be treated in the event of death.

Structured giving is different to just writing a cheque, and is a great way to leave a gift that keeps on giving. Setting up a charitable structure is an achievable goal, and is a tax-effective way to provide a sustainable income stream for a chosen charity, foundation or cause. A charitable structure bearing your family name can also become a lasting legacy with a demonstrated reflection of personal values.

There are many ways to give

Setting up a charitable structure to support your philanthropic passion is an achievable goal. Once you’ve determined the right structure, you can also choose from a range of ways to give, such as scholarships or awards, through your estate or during your lifetime, individually or involving family.

Gifting through your estate

Establishing an endowment is a simple way that you can leave a philanthropic legacy, either during your lifetime or through your will. A Public Ancillary Fund can allow individuals and families to set up named endowments within an existing trust structure. Usually this can be established with an initial donation from as little as $20,000 and is required to make annual grants of 4% of its net assets. An endowment in a Public Ancillary Fund can allow you to:

• recommend the causes you wish to help – you can indicate the areas, organisations or specific projects you would like your endowment to support.
• establish a named legacy – you can name your endowment, use your family name, the name of a business or association, in memory of a loved one or remain anonymous. You can chose to set up and contribute to the endowment during your lifetime or through your will, with the knowledge that you are creating a sustainable legacy that will have a lasting community impact.

Many Australians are involved in charitable giving, with an estimated 87% giving to charity during their lifetime, and an estimated 7.5% of Australians with a will choosing to include a charitable legacy within it.

* Giving Australia, Giving Australia: Research on Philanthropy in Australia, Prime Minister’s Community Business Partnership, Department of Family and Community Services, Australian Government, 2005.
Gifting during your lifetime
Another charitable structure is a Private Ancillary Fund (PAF), which has emerged as an increasingly popular structure through which medical practitioners can give back to the community. In a similar manner that a self-managed super fund is established for effective control of investment decisions and flexibility, so too is a PAF – allowing you to create your own charitable foundation and determine your level of involvement.

As well as allowing you to share your wealth throughout your lifetime, a PAF is also an effective bridge to a lasting family legacy, as several generations can be involved in the charitable activities of the trust.

The amount of funding available from a PAF relies on contributions and investment returns. This is where a charitable foundation has an advantage over direct donations to a charity. A PAF generates revenue for distribution while aiming to grow capital. Rather than providing a finite amount which may cease at any time, setting up a PAF means you can put your funds to work and provide much-needed ongoing income to the charities and sectors you’re passionate about.

Once established, a PAF can be ‘topped up’ through bequests from your estate, which are not subject to capital gains tax, and incorporated into your will to ensure it serves your intentions in perpetuity.

For medical practitioners wishing to set up a PAF, we generally recommend an initial investment of $500,000, but can advise on other appropriate options for smaller amounts. Expert assistance is also recommended to set up a trust deed, secure tax office approval, develop an investment strategy and distribute the funds.

GIVING TO SUPPORT HEALTH AND MEDICAL RESEARCH
Philanthropic investment acts somewhat like venture capital where funds injected can help to instigate new research or further any early-stage or basic research that can be very promising but at the same time risky. When such research has progressed and concepts proven, government and commercial funding become more viable. Australian philanthropists donate more than $400 million annually towards health and medical research. These funds play a vital role in supplementing government and commercial investment in the sector.

Structured forms of philanthropy, such as an endowment or private foundation, play a vital role in the areas of advancement of health, medical research and science. Australia’s excellence in these fields is renowned worldwide, yet the research base remains highly vulnerable to inconsistent funding and its distance to collaborative partners abroad. Capital intensive and long-term focused, research programs can only thrive with sustained funding, be it from multiple sources, including private and public grants. Philanthropy, vital to the progression of health and medical research in Australia, can provide this much-needed stable funding base.

BRINGING FAMILIES TOGETHER
Charitable giving decisions are very personal and often not considered until an estate planning discussion is held. Understanding the most suitable options can be instrumental in achieving appropriate tax management outcomes now, but also at death. It can also be an ideal way of sharing and passing on family values and social responsibility to the next generation.
LONG-TERM LEGACIES IN ACTION

The notion of perpetuity is a powerful one. For example, the Ramaciotti Foundations were established by Vera Ramaciotti in 1970 with an original investment of $6.7 million. Under Perpetual’s management, this investment has grown to over $52 million (as at March 2015), and has distributed close to $55 million to medical research over that period. Last year alone, it distributed over $1 million in research grants and awards.

More recently, the Samuel Nissen Charitable Foundation was established as a PAF by Mrs Rowena Nissen, to honour the legacy of her late husband, Samuel. Mrs Nissen was particularly keen to establish a PAF structure, while still alive and healthy in 2002, to ensure that the capital from her estate could also be invested to make a difference.

Earnings from the Foundation have since been distributed to a range of worthy causes each year, supporting disadvantaged children, as well as the advancement of medical treatment and research. In the area of medical research, the Foundation has been flexible in its approach to funding, supporting everything from a post-doctoral position, advancing prenatal research to solar simulation equipment for the study of sun-related diseases. Since Mrs Nissen’s death in 2006, the Foundation has distributed approximately $4 million, demonstrating the legacy she created in her husband’s name has already had an impact.
de-capitation?

Margaret Faux explains the challenges to the implementation of capitation payments for chronic illness.

Moves to introduce capitation styled payments for general practitioners who provide services to patients with chronic illnesses are gaining momentum. Minister Ley was on message recently, warning that Australian’s would ultimately suffer if primary care reforms targeting chronic disease were not implemented. And health experts at the George Institute were again reported as recommending a capitation payment model for chronic disease, where GPs would be paid per patient for a year in lieu of the current fee for service arrangements.

But capitation may be easier to spell than implement. Introducing capitation payments potentially presents significant legal challenges, and even if these barriers are able to be overcome, changes to GP item numbers in the Medicare Benefits Schedule (MBS) will inevitably create a whole a new raft of other issues and problems, if for no other reason than because GPs are not the only healthcare providers who treat patients with chronic illnesses.

Capitation does not feature significantly in Australia’s health funding landscape largely due to the fact that at law, the relationship between a privately practicing doctor and a patient is governed by contract law. In practical terms this preserves the small business nature of private medical practice, secures the right of patients to enter voluntary private arrangements with the doctor/s of their choice and ensures that Australian citizens cannot have a required relationship with a doctor forced upon them without their consent. It also provides that Australian doctors are free to set their fees for their private professional services as they see fit and cannot be subjected to any compulsion to charge in a particular way or at a particular rate. The 2009 High Court case of Wong v Commonwealth decisively settled the scope of the constitutional placitum which Justice Michael Kirby described as “a rare constitutional guarantee” because of its unique character in protecting both doctors and the patients that they serve.

This does not mean that the constitutional guarantee is a blanket barrier to controlling health expenditure or doctor’s fees, it’s just that by definition, capitation doesn’t sit well with the constitutional right of doctors and patients to enter private arrangements, free from excessive intrusion by the government.

So whilst capitation as a way of reimbursing doctors for chronic disease services may be a great idea, its implementation will present significant legal challenges requiring creative interpretation of the constitution so as to preserve the rights of patients and doctors to come to their own arrangements if they so wish. In addition, any implementation will need to deal with the fact that Medicare does not pay doctors - never has. Medicare rebates are payable exclusively to patients, and can only be transferred to doctors with the patient’s consent. Bulk billing is the most common example of this transaction. So if the federal government were to change this arrangement under a capitation model that directly pays doctors a set amount in such a way so as to create a legal or practical compulsion upon them, it may risk constitutional invalidation.

Margaret Faux is Managing Director of Synapse Medical Services.
This was published on CROAKERY 7 September 2015.  
http://croakey.org/challenges-to-the-implementation-of-capitation-payments-for-chronic-illness/
This notwithstanding, incentivising doctors in a similar fashion to the way in which the Medicare Practice Incentive Program already operates, or mirroring the way in which some of the intensivist items in the MBS work (which is a mixed arrangement of capitation for certain services provided in a 24 hour period while still permitting fee for service for additional items not included in the capped amount), may provide opportunities for the introduction of this type of reform. Although the intensivist model is easily scammed.

But legal barriers aside, the current government’s blind obsession with GPs completely overlooks the fact that patients with chronic diseases are treated by specialists too. General physicians, geriatricians, cardiologists, paediatricians, endocrinologists, renal physicians, rheumatologists, rehabilitation physicians and psychiatrists are but a few of the many specialists who also regularly manage people with chronic illness.

In fact, last year during the co-payment debate a specialist client informed me of an internal bulletin he had received putting him and his colleagues on alert to be ready to take over the regular care of patients with chronic conditions, who it was feared might stop attending their GPs if co-payments were introduced. And because specialist services are paid at much higher rates, the financial impact of this, had it happened, would not have been insignificant.

For example, almost all patients with a chronic disease will meet the criteria for the relevant specialist consultation item 132 for which the rebate is six times the cost of GP item 23 at $224.25. The next two visits, each for the subsequent attendance item 133 will cost tax payers another $112.30 or the equivalent of another six GP visits. Then all subsequent visits will attract item 116, which can continue for the remainder of the 12 month referral period, each costing $64.20 or about double the cost of the same visit to a GP. If you assume one visit per month, the total cost to tax payers if specialists had picked up the chronic disease tab would have been $1,026.65 as opposed to $444.60 if the same services were provided by a GP. In the case of a geriatrician the rebates are higher again.

And it is not always the case that the GP is the gate keeper of care for the chronically ill. Patients may also fall into a well organised hospital based clinic after a significant event. Consider the diabetic with peripheral vascular disease requiring a hospital based procedure such as angioplasty. The patient may be simultaneously serviced by the GP, the hospital diabetes clinic and the specialist lead high risk foot clinic. Capping GP services might increase their attendances to the hospital, so that the GP becomes de-skilled and acts as little more than a referral service to specialist lead clinics.

The introduction of capitation needs to consider the whole system of health care for the chronically ill (from general practice to specialist care to nurse led clinics and allied health services) so that those with chronic illnesses are encouraged to attend multi-disciplinary clinics rather than public hospitals clinics, emergency departments or seek private specialist services. At the same time, Australia’s primary health workforce must be supported in its role as a gatekeeper, triaging and remaining intimately involved in the metering out of specialist services.

Minister Ley informs us that this is not change for change’s sake, but change that will actually make things better. It is hard to take the government seriously though, when yet again, just one predictable component across the entire spectrum of health service providers appears to be the target – our embattled GPs. There are currently 5,769 items in the MBS and focusing only on the handful claimed by GPs has the potential to tip the balance to hospital and specialist services, which are more expensive, and may not always make things better for patients with chronic conditions.

While all ambitious plans are challenging, the successful ones are multifaceted solutions. If the government’s approach to managing the chronically ill starts and ends with the GP it is unlikely to pay off.
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Improving outcomes through surgical audit

Dr Andreas Obermair presents the concept of audit as a strategy for dealing with complications.

THE IMPACT OF COMPICATIONS

All health professionals would agree that great treatment outcomes are our greatest priority. Unfortunately, not always things go according to plan. Poor treatment outcomes are an inevitable occurrence in a medical practice and can be one of the most insidious stressors we as clinicians have to deal with. While the primary focus must always be on the patient, the impact on the lives of the medical professionals involved can be far-reaching.
As a staff specialist at the Royal Brisbane and Women’s Hospital in Brisbane, Australia, I sought to explore the extent of influence such adverse outcomes have on the lives of my fellow obstetricians and gynaecologists, and at the same time survey which methods were thought to be most effective in dealing with it. Anecdotally, some of the reasons I was hearing as to why complications cause stress were,

“I feel very poorly equipped to manage my surgical complications.”
Obstetricians and gynaecologists normally do not receive training in bowel and urological surgery and usually are overwhelmed with the diagnosis and management of surgical complications to the bladder and the ureter or the bowel.

“Colleagues have a conflict of interest when they (mandatorily) report their local colleagues’ complications.”
Many doctors, but also their employers, follow an emotional approach to complications. Doctors are normally not assessed by their factual incidence of complications but assessed by their most recent one or two mishaps.

“When complications occur I often feel like a criminal.”
Accurate numbers on surgical complications are not available. Recently we compared the incidence of adverse events provided by a major tertiary public Australian hospital with the incidence of adverse events in the same hospital but obtained prospectively by a designated Quality and Safety officer. The public hospital numbers did not resemble the numbers obtained prospectively.

**THE RESULTS FOUND:**
When complications occur, sleep was affected of 80%, family and social relationships of 55% and physical health of 48% of respondents. The major sources of support were from colleagues (83%), family (82%) and medical defence organisations (73%), with professional bodies perceived as providing least support. Nearly 80% of respondents felt the need to talk to someone they trust during times of complications. Overall, 100% of respondents used at least one QA tool (62% used two, 26% three and 9% four QA strategies).

SUPPORT IS ESSENTIAL AND URGENTLY REQUIRED

This survey shows that complications have a profound impact on the lives of Australian and New Zealand obstetricians and gynaecologists, impacting on sleep, physical well-being and relationships of the majority of respondents.

These findings are consistent with evidence in the current literature. In a survey of Memorial Sloan Kettering surgeons in 2011, 42% of surgeons were found to have burnout, and 27% had some psychiatric disturbance.

When complications develop, support is sparse. Currently, support is offered by colleagues, family and friends, MDOs as well as from social and professional networks. The finding that participants engaged in at least one QA activity shows this can alleviate some but not all of the distress experienced. Current QA tools often do not allow a formal comparison of one’s own performance over time or a comparison with the practice of colleagues. Many practitioners (73%) desired access to such benchmarks, and 89% stated that knowing at least their own rate would help them to improve their clinical skills and cope better with stress (56%).

In assessing the respondents’ self-help response to managing the impact it was found that more than 43% of respondents used their own, custom-built pre-operative checklists, despite many mandatory checklists now available and used in hospitals. This could indicate that current checklists may not sufficiently cover the range of potentially avoidable risk factors and that respondents needed and wanted to further reduce the risk for their patients especially in the operating theatre. By contrast, patient satisfaction surveys are utilised by only 18% and could provide an additional source of reflective information for practitioners.

THE SOLUTION

It became apparent to me that there was a crying need for a confidential, web-based surgical audit system that could provide measurable, clinically meaningful and accurate feedback to clinicians that could allow clinicians to compare their outcomes with those of their colleagues’. It would have to offer a platform where sensitive information could be collected, processed and returned to its user in trusted confidence.

Studies consistently have found that audit changes behaviour, leading to improved health outcomes with improvements greatest if the performance at baseline is low. A survey to explore the attitudes of general practitioners to audit found that the majority benefited, including increased knowledge and job satisfaction, enhanced performance and improved teamwork.

DEVELOPMENT

Together with a team of medical and technology specialists, I set about designing clinical audit software for O&G specialists that would provide the data essential for a productive and successful audit. It had to offer the following features and capabilities:

- A platform where sensitive information is collected, processed and returned to its user clinicians in confidence
- The information can be used as a learning opportunity for its users, and no one, other than the surgeon who entered their data,
can identify a user or their outcomes

- No clinician can ever be identified or reported
- Accessible 24/7 anywhere in real time for immediate reporting
- Provide specific and measurable feedback on patients’ outcomes

Users would need to be able to:

- Search records for specific timeframes, locations, operations and generate reports.
- Access reports on number of procedures, patient factors, surgical details for all major gynaecological procedures, obstetrics outcomes and colonoscopy
- Generate reports on the user’s incidence of generally accepted standard KPIs of treatment (e.g. intraoperative visceral injury, readmission to hospital, unplanned return to operating theatre, etc.)
- Access reports on results on outcomes separated by location or department (e.g. public vs. private) and per time period as well as reports on KPIs such as conversion rates from laparoscopic to open hysterectomy, mesh erosion for pelvic floor repair, etc.
- Calculate CUSUM by tracking the cumulative incidence of adverse events over time to see if the outcomes are improving, worsening or steady and can ascertain Kaplan Meier survival curves: track and compare the probability of recurrence (endometriosis – pelvic pain, pelvic floor symptoms, etc.).
- Generate comparative reports on the incidence of outcomes in comparison with colleagues, department peers in both national and international locations.

THE SYSTEM

It finally came together and I’ve been gratified at the response to our system, SurgicalPerformance.com. To date hundreds of O&G specialists from all parts of the world have joined me in documenting their surgical outcomes, entering more than 25,000 cases that are now available for aggregate comparison by users.

Reflection and reports on the value of using audit as a strategy to help in dealing with adverse outcomes

This tool has enabled surgeons to reflect on their outcomes honestly and in complete confidentiality, without the need to hide unfavourable outcomes. Feedback from subscribers confirms that having readily accessible high-quality data at their disposal does reduce emotional stress and promotes a rational perspective. It also enables clinicians to benchmark complication rates against colleagues as a method of self-improvement.

In addition, the ability to measure surgical outcomes enhances conversations with patients about what to expect from surgery and makes patient interaction more fulfilling.

This tool also enables clinicians to benchmark complication rates against colleagues as a method of self-improvement.

www.surgicalperformance.com

CONFIDENTIALITY AND SECURITY

- **Complete confidentiality:** No user can see other individual users’ data. Surgeons’ individual outcomes are not made available to third parties. Only non-identifiable data is used for research.
- **Secure access:** Access is through a secure login and password only.
- **Rapid SSL (Secure Socket Layer) Certificate** is used to encrypt all data transfer to protect users’ security.
- **Meets Australian Commission of Safety and Quality in Healthcare Standards (ACHS) for Australian Clinical Quality Registries.**
- **Qualified privilege** granted by the Australian Commonwealth, which means that data cannot be subpoenaed by legal processes and the courts.
Healthcare businesses are more than twice as likely to be breached.

Geoffrey Brown, seccomglobal.com
Recent studies have confirmed that the healthcare sector has 3.4 times more security incidents than any other sector. Additionally, healthcare organisations are more than twice as likely to suffer data theft than any other sector.

But why is healthcare considered such a valuable target for hackers? The simple answer is that personal health data is highly financially valuable. As a general estimate basic Personally Identifiable Information (PII) is valued on the black market at around $1 per record while Personal Health Information (PHI) records can be sold for from $20 to $60 each.

Analysis of the past 10 years of data breaches by Trend Micro (as catalogued by the nonprofit Privacy Rights Clearinghouse) has revealed that Healthcare has the highest number of data breaches of any sector. These breaches are attributable to external attacks from hackers and internal security failures.

As a result cyber attackers are far more willing to invest in stealing medical records than healthcare institutions are willing to invest in protecting them from being stolen.

A Raytheon Websense report indicates that the average healthcare business only spends about 3 percent of its IT budget on security, even though the (not-for-profit) Healthcare Information and Management Systems Society recommends they spend at least 10 percent.

Not surprisingly, attackers are using the best of breed cutting edge technology tools. According to Raytheon/Websense, healthcare organisations are four times as likely to be hit with advanced malware – particularly the CryptoWall ransomware (450% likelier), Dyre Trojan (300% likelier), and stealthy Dropper (376% likelier), which opens backdoors and drops other assorted payloads.

Also, while outside attackers barrage them with malware, medical institutions also have malicious insiders to worry about. According to a report released earlier this year by Trend Micro healthcare has a larger insider leak problem than any other sector, attributing 17.5% of its breaches over the past 10 years to it. Insider leaks were the primary source of identity theft cases (44.2%) and healthcare was hit harder by identity theft than any other sector, accounting for 29.8% of cases.

Although these reports are based on US studies, the Raytheon Websense report cites, the U.K.’s National Health Services has been fined £1 million for its data security transgressions. Australia suffers many of the same problems across our HealthCare sector

The increasing volumes of data and the need to transmit/share information contributes to the overall complexity of the problem. The vast array of hospitals, labs, imaging centers, medical practices and pharmacies in multiple locations share data and computing resources.
According to the report, from January 2005 to April 2015:
• 41% of breaches were caused by lost devices – laptops, tablets, phones
• 25% of breaches by hacking and malware
• 17.4% of breaches were caused by unintentional disclosure (not including lost devices)
• 12% of breaches were insider leaks.

Criminals value the data very differently from the individuals from whom it was stolen. Trend Micro surveyed 1,000 customers about how much their data was worth. They valued passwords most, but only at $75.80. Health information and medical records were next, at $59.80. (American customers valued it more highly than European and Japanese customers, at $82.90.) Payment details were worth $36.60, purchase history $20.60, and physical location data only $16.10.

Operational business impacts caused by data loss may include inability to access patient information, loss of patient confidence, brand damage and being held hostage to criminals demanding ransoms.

Additionally there are legal responsibilities that may place the information holder in violation of the Australian Privacy Act resulting in fines of up to $340,000 for individuals and $1.7M for corporations.

Adequately addressing both the external as well as internal (malicious/accidental) cyber threats requires a high level of ongoing sophisticated technology capability and human behaviour management. Contemporary solutions are available both as self-managed or (increasingly) as “in the cloud” managed services. Overall business protection requires implementation and ongoing active management covering protection, detection and response capabilities.

To protect your business (and your patients!) you need digital protection to cover:

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DESCRIPTION</th>
<th>Indicative monthly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disasters</td>
<td>Natural, accidental and malicious events. Data Back Up/Recovery. Systems. 3 copies of data, 2 locations of data, 1 external location. Backed up every 15 minutes. Systems and data restored within 30 minutes</td>
<td>$700</td>
</tr>
<tr>
<td>Network and servers</td>
<td>Firewall protection against malicious attacks such as Ransomware, Denial of Service, trojans and viruses</td>
<td>$300</td>
</tr>
<tr>
<td>Devices</td>
<td>Protection for computers, laptops, tablets and phones for antivirus protection</td>
<td>Free</td>
</tr>
<tr>
<td>Web site attacks</td>
<td>Enterprise level protection securing web pages</td>
<td>$200</td>
</tr>
<tr>
<td>Human behaviour monitoring</td>
<td>Accidental or malicious inappropriate digital behaviour detection and monitoring</td>
<td>$10 per device</td>
</tr>
</tbody>
</table>

For a typical small to medium size medical practice to achieve an enterprise grade of digital security for their business, an investment of around $1,300 per month will provide ongoing worlds best practice ongoing protection and peace of mind.

For assistance contact Geoffrey Brown on 1300 FIREWALL (local) or +61 02 9688 6933 or email: info@seccomglobal.com

theprivatepractice.com.au
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Examine our network of medico-specialist financial advisers
Rafic Habib introduces the ‘Software As A Service’ model.

Cloud technology is emerging as the most secure and cost effective way to do business for small to large corporations, by offering what is conventionally a complex solution with a large up front capital expenditure for a small monthly fee.

So what exactly is cloud computing? Let me put it simply using the famous words of Larry Ellison, Oracle CEO:

“It’s not water vapour. All it is, is a computer attached to a network.”

There has certainly been a movement in the medical space towards cloud computing and the use of virtual servers, with many practices recognising the benefits over traditional hardware options. And there are undeniably some advantages of this technology over owning your own server, including reduced operating expenses, a more secure datacentre and the ensured backup processes of your provider. It also removes the soft costs associated with owning a local server such backup device maintenance, as ongoing repairs, and cooling and electricity. Although this is not ‘water vapour’, it is not a true cloud. It is “Co-Location.”

Which brings us to the topic of true cloud software, not simply cloud computing.

There has been a shift in the modern mindset from hardware to software across every industry from retail, to manufacturing to education. Why should the medical industry be any different?

WELCOME TO THE SOFTWARE AS A SERVICE “SAAS” MODEL

In today’s modern medical world, I’ve found that practices aren’t overly interested in the server platforms, RAM and hard disk space. What they want to know is “Can I easily manage patients, streamline administration, and improve financial visibility?”

Essentially, they want to ensure their practice runs as efficiently as possible with little disruption to patients, personnel and profits.

The last thing they want is to be wedded to an IT guy and the associated headaches of maintaining an IT system. They want to access data when and where they need it, be it in the clinic, on the road or in their lounge room across their desktop, laptop or mobile device.

I would like to suggest, that we as an industry need to work harder on mobility and give clinicians visibility over their practice from anywhere in the world. And not only the opportunity to view elements of their practice at their convenience, but the ability to manage it remotely – be it working on letters or post operation reports, ordering and reviewing pathology and radiology requests or reconcile billings and accounts.

I propose that we take the ‘hardware to software’ mindset to the next level.

I’m calling on the industry to collectively focus their thinking about expanding business intelligence and clinical intelligence.
in the practice followed closely by a conscious effort around integration of clinical applications and clinical devices.

At the most basic level, I propose we interrogate the financials, learn more about referral base behaviour patterns, follow income trends and identify your income sources. I believe this has the potential to dramatically impact the day-to-day decisions of running a successful medical practice. How would you be affected if I was to tell you right now that your biggest referrer is costing you the most time but not giving the best return on investment?

ENGAGING PATIENTS AS INFORMATION PROVIDERS

Taking this a step further, can we provide patients with the opportunity to help streamline aspects of the process by engaging with them as information providers?

Clinic to Cloud recently performed an informal survey of patients or doctors around accessibility. We asked them whether they would like the option of a patient portal that would allow them to login remotely and complete their registration with the practice ahead of their next visit. The overwhelming response was a resounding “yes please”.

What does this mean for your practice? A patient portal feature can have the potential to significantly reduce administrative work, minimise patient backlog and increase consultation numbers.

THE FUTURE OF PRIVATE PRACTICE

The introduction of the corporate element into the private medical practice is an important move that will help practitioners increase the profitability of their business. Furthermore, streamlining aspects of the business has the ability to reduce some of the personal and professional strains that often come hand in hand with the demands of the job.

Nearly everyone I’ve met in the healthcare space are motivated by a passion that is well beyond the money. When I started out in the health sector approximately 15 years ago, I was working away on building a brand and referrals and getting the trust of the doctors and the industry. I learnt that the only way to truly earn the respect of the industry is to reciprocate effort and demonstrate the same level of duty of care that practitioners show their patients.

I am not a medical practitioner and maybe I will never truly understand the level or responsibility and intensity required to be one. However, I believe that the use of the right resources and technology can certainly help improve certain aspects. At the end of the day I look for ways to increase the capacity for practitioners to earn more or live better – hopefully both!

It is unacceptable in today’s digital age that a clinician wouldn’t have the same remote access and visibility across their business that anyone else running a business enjoys from a smartphone.

The discussion today should be more focused on the possibilities of a software in the medical practice, and less so around the IT requirements needed to run the software. This shift is both necessary and long overdue.
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Design AND Build
or Design TO Build

Mike Watson is Director of Innova Design.
Once you have found the ideal location for your new practice you will have to start the Design and Fitout. This has the potential to cause cost and time problems if not handled carefully.

There are 2 ways of managing this process;

1) Design and Build

There are two schools of thought and in this article I’d like to look at the arguments for both and come to a conclusion.

Design and Build, also known as “Turnkey” involves entering into one contract with one service provider who will manage the whole design and build process from start to finish for you. Their scope of works also normally includes managing the approvals process for you. They should directly employ interior designers/architects and Project Managers and offer you one point of contact and responsibility throughout the process.

They will quote a fixed price and completion time for the project and be held responsible for achieving that.

The major benefit of this system is the time saving, as after appointing the successful consultant you can agree on the parameters with them – scope/cost/time/reporting frequency and simply touch base with your one point of contact once a week to ensure everything is on schedule.

Its important to remember there is no tendering process in this system. The successful consultant will generally use sub contractors he has worked with successfully before and are suitable for the project. He will normally charge a Design fee and a Project Management fee, both percentages of the total project cost.

You might ask where is the incentive to reduce the total project cost if the consultants fees are a percentage of it ? – this is why it is important, if using this system, to establish a project budget up front and keep the consultant responsible for it.

If using the Separate Contracts model you will be contracting to at least two entities. One to manage the approvals process for you and carry out the design functions and a second to actually carry out the building works.

For the first function it is normal to appoint an interior designer or architect experienced in healthcare design. They will quote a fee (normally based on the hours they anticipate will be spent on the project). This is open to variations so it is wise to make decisions quickly and not require modifications and redrafts that will take extra time and add to the cost.

This fee will normally cover services up to providing a set of drawings which can then be sent out to various head contractors for quoting the building works.

Using this method you may well get a lower price for the building works but a higher price for the design than if using the Turnkey method.

If separating the contracts, it is difficult to ensure that the design you have paid for will meet the budget you have set when it goes to builders for tendering. If it doesn’t, the only recourse you have is to change the design you have paid dearly for. There is a school of thought that separating contracts results in a lower construction cost. This is not necessarily so and even if the original quotation is lower there may be many variations on the way if the builder is not experienced in health care.

So in conclusion - to ensure your budget and timeframe are met, pass the responsibility of variations back to your consultant and limit your own time involvement, use a Design and Build company to provide a Turnkey solution.

Mike Watson urges you to consider the contract options for your practice design and build.

CONCLUSION

If your time is an important factor then the Turnkey solution offers the least "hands on" approach required. Ensure a budget and time frame are clearly established and accepted and you receive regular progress reports.

Mike Watson

Mike Watson urges you to consider the contract options for your practice design and build.

If your time is an important factor then the Turnkey solution offers the least "hands on" approach required. Ensure a budget and time frame are clearly established and accepted and you receive regular progress reports.

Mike Watson urges you to consider the contract options for your practice design and build.

If your time is an important factor then the Turnkey solution offers the least "hands on" approach required. Ensure a budget and time frame are clearly established and accepted and you receive regular progress reports.
A Weighty Issue
As our population gets heavier, a new generation of furniture is growing to support them. **Stephen Lacey** takes a look at the fabulous Cache chair.

The figures are nothing short of frightening: According to the Australian Institute of Health and Welfare (AIHW) almost two in three, or 63 per cent, of Australian adults are overweight or obese. And further, it is estimated that by 2020 this figure will have risen to a startling 75 per cent of the population, suggesting a frightening progression of the disease.

As a health professional dedicated to caring for our ‘growing’ population, you may have overlooked the question of how you choose to furnish your hospital, medical centre or surgery.

The fact is, many of the current medical furnishing solutions are woefully inadequate when it comes to catering to the overweight and chronically obese. This inadequacy doesn’t just result in reduced patient comfort, it could lead to the possibility of failure and a subsequent damages claim if it is being utilised within your facility.

In the past, bariatric furniture (that is, furniture specially designed for the obese or overweight) tended to be clunky and heavy, making it difficult to reposition, and presenting its own health and safety workplace issues for staff. Stacking away such furniture when it was not in use, or needed to be transported, was seldom if ever an option due to the poor design and sheer weight. And there was also the question of less-than-attractive aesthetics: much bariatric furniture looked like something from the industrial revolution; a fact that surely must have caused embarrassment for those who were forced to use it.

Aware of these limitations, Terrance Hunt created the Cache Chair for American furniture manufacturer, Source International.

To come up with the design, Hunt went back to basics and redefined the very notion of what bariatric furniture could be.

Firstly, Cache doesn’t look like bariatric furniture. In fact apart from the wider widths in which it is can be specified (there are three sizes to choose from) it looks like an elegant piece of furniture that wouldn’t be out of place in a domestic or corporate setting. Hunt has ensured there’s no compromise when it comes to aesthetics.

Secondly, Cache offers a flexible range of options. There are two different styles; ‘In and ‘Out’ named according to the shape of the chair back. Plus Cache can be ordered with or without arms, and in a huge variety of finishes and upholstery options.

Most importantly - especially when it comes to the mobility of the modern workspace - the Cache chair is totally stackable.

The Australasian Furnishing Research and Development Institute (AFRDI) has tested the Cache chairs and certified the widest version to hold up to 185kgs.

Environmental concerns have also been addressed by Source International, a company that has always prided itself on sustainability. Cache has been certified by the GreenGuard Environmental Institute, ensuring it meets stringent chemical emission requirements and Green Building criteria for indoor air quality.

Source International heavily focuses on recycling. All components of Cache products can be recycled post use.

The Cache chairs have a lifetime structural warranty, minimizing the contribution to landfills.

KE-ZU, one of Australia’s leading contract designer furniture suppliers, is implementing a local assembly and upholstery program with Cache chairs, meaning short lead time projects will not be a problem when it comes to supply. Meantime, you can start working with the KE-ZU sales team on larger projects or roll-outs with samples of most models readily available for evaluation.

“’We're really excited to be part of the Cache program,” says KE-ZU founder and CEO Mark Swanton. “We’re always seeking out innovative product designs from around the world to help create our portfolio of seating projects and Cache will become a valuable addition to this portfolio.”

Swanton says he has received frequent requests from both public and private institutions for chairs with a static load certification for at least 135 kilograms. “Cache is the first in our designer range of bariatric seating where a chair for the obese appears no different to a standard model apart from width. The importance of beautiful design to cater to this market is becoming increasingly popular.”

Cache is available from KE-ZU nationwide. For enquiries call 1300 724 174 or visit www.kezu.com.au
TO MARKET, TO MARKET...

Many doctors and practice managers are unsure how much they should be spending on their marketing. *The Private Practice* Magazine asked Vividus to draw back the curtains on this somewhat secretive topic.

Private practices are made up of lots of moving parts that work together to provide a beneficial service to patients. Likewise, successful healthcare marketing involves strategically developed systems, rather than a hap-hazard collection of ideas. Any budgeting question must therefore begin with your annual review of your strategic marketing plan.

The first step is to analyse your practice, similarly to how you would diagnose/treat a patient. This is your SWOT analysis: – Look at your Strengths and Weaknesses (internal) and your Opportunities and Threats (external). Also take a short time to list out the key success stories and challenges from the last 12 months – what worked well and what didn’t.

The next step is to set SMART (Specific, Measurable, Achievable, Realistic, Time) goals for the coming year, after all a marketing plan is designed as a one-year process.

**HOW TO SET SMART GOALS**

Most practices fail to thrive because they’ve never really established clear specific SMART goals. In an effective marketing plan, particularly when you begin to shape your marketing system, you’ll need to evaluate both short- and long-term goals.

Most marketing goals are not planned further than 1 year out as the market is continually changing and you’ll need to make sure you have the flexibility to change with the changing needs of your target market. This also means that you can keep your goals specific and measurable.

However, you will still need to consider your long-term goals as you intend to apply and use your marketing system for years to come.

Once you’ve identified your business baseline and your goals, you can assign a budget to successfully go after those goals.

**DEFINING YOUR BUDGET**

If you want the best return on investment, you should predetermine a budget that’s appropriate to the level and specific type of goals that you’ve established in your Marketing Plan.

Jason Borody explains how to scientifically calculate your marketing budget.

Jason Borody is Director of Vividus Marketing.
There are many different ways to establish your marketing budget:

**Task Budget Method**
This is the most effective way of establishing your budget. During the marketing planning process, define the types of strategies and tasks that are necessary in order to achieve your goals. Then look at the associated costs that will be incurred implementing those activities.

When you tally up the total costs needed to support the strategies to reach your goal, you have your marketing budget.

In theory this is a great approach, but in reality, when you add up the costs, the number is often greater than you expected. If this happens, you can always go back and readjust some of your goals to be less aggressive and more realistic, so that the budget necessary to support those modified goals fits with what you can afford.

**ROI Budget Method**
If you have access to good data regarding Return on Investment (ROI) performance of different strategies in similar situations, then you can utilise what we call an ROI based budget.

Start by establishing financial goals that you would like to achieve. Determine a reasonable return on investment ratio and work backwards to get your budget.

E.g. To achieve a growth goal over a year of $300,000 of incremental revenue, and assuming a historical ROI of 4:1 based on past financial data, you would take the goal of 300,000/4 and effectively set your budget at $75,000.

The big question is how do you find good trackable data on performance? This can be difficult unless you’re working with a company that has a pretty long track record in healthcare marketing and they may be able to give you that kind of perspective.

**Percentage Budget Method**
Many businesses outside of healthcare use a percentage method of budgeting. They identify a percentage of revenue that they will assign to their marketing budget. Be aware that this approach has some significant cons. You may be able to set a specific budget number, but the downside is that it’s an arbitrary number that may not align with your goals.

Many accountants will suggest a percentage, but whether it’s enough for you to use in achieving your goals is yet to be seen. We estimate Australian healthcare practices have an average marketing budget of between 0-3% of revenue per year. To some, 3% may seem like a high percentage of revenue to devote to marketing, to others it may be low.

If you look at practices actively marketing and actively generating revenue from their marketing efforts, the percentage is usually 5-10% (or higher). It all depends on your practice goals and competitive market place. The big issue with this method lies in its arbitrary setting separate to goal considerations.

**Opportunistic Budget Method**
No plan, no budget and as opportunities arise, you spontaneously decide whether or not to support the activity. This method often sees practices spending money on unnecessary local advertising.

**‘All You Can Afford’ Budget Method**
With this method, you’d like to do more but you can’t afford it, so you pick and choose the activities that you can afford and hope for the best. In
this case you either need to go back and re-evaluate your goals, or you need to consider the difference of looking at marketing as a revenue centre versus a cost centre.

**Investment Approach**

Regardless of which method you select to determine your marketing budget, you need to remember one important principal. Marketing is a revenue centre and not a cost centre. This is an important concept as most of the time, we focus on budgeting for and minimising cost centres. Cost centres require you to increase profitability by keeping costs down as long as it doesn’t compromise the quality of your care.

For revenue centres the process works in reverse – since revenue centres drive money into your practice they need investment fuel to drive profitability. If you try to apply a cost centre rationale to your revenue centres, all you’re doing is cutting off your oxygen and you’re left wondering why it’s hard to breath.

Marketing is an investment or a revenue centre, its purpose is to drive revenue into your business and your marketing budget needs to be supported to the level of your goals.

Also keep in mind that marketing is tax deductible, so you can generously donate those same dollars to your government as non-recoverable taxes or invest in your business and its future success, the choice is yours.

At Vividus, we find that our healthcare clients greatly benefit from professional assistance reviewing and re-assessing their marketing plans on an annual basis. We work with them to provide customised advice including marketing metrics and budget recommendations. We specialise in healthcare marketing for medical specialists, dentists, medical centers and pharmaceutical businesses. We understand the laws and codes that regulate medical marketing in Australia, and develop content and SEO strategies that are compliant, professional and effective. For more information, contact Vividus on 07 3283 2233 or info@vividus.com.au.
Medicos and other healthcare professionals are not like everyone else. When it comes to financial advice, you have particular needs, issues and concerns that need to be clearly understood from the outset. Which is why we’ve gone to considerable lengths to assemble a network of medico-specialist financial advisers – with extensive and successful medico experience. Like-minded professionals who will not only provide you with solutions but also educate you – so you can make fully-informed decisions. There’s a medico-specialist financial adviser in every state and territory of Australia.
THE SCIENCE OF PROPERTY INVESTING

Neil Smoli is Managing Director of Aviate Group.
Australia’s medical professionals have done an outstanding job, especially in recent years, in communicating a simple but effective message to the public when it comes to their health. The phrase “talk to your GP” has become part of the everyday vernacular. In terms of the medical industry’s value proposition, this message clearly defines the service that doctors and other medical specialists provide.

Financial health can also be viewed as a specialised field, as there’s no doubt a person’s financial position influences their health and wellbeing. Just as people are encouraged to speak to their GP regularly to ensure their physical health, so should they speak to experts if they are thinking about investing in property. After all, prevention is the best cure, and by implementing a secure wealth creation strategy when your earning capacity is at or reaching its peak, you give yourself the best chance to prosper financially in the future.

Sometimes the most difficult step is the first. Getting started. Therefore one of the most important questions would-be investors should ask themselves is “am I ready to invest in property?”

To answer this question properly, the process starts with you. Your personality will determine the property investment strategy best placed to deliver security and success.

We’re not talking about self-analysis. Instead, investors should seek specialist expertise in forming an investor profile specific to them. Consider a person seeing a new doctor for the first time. The doctor, before making any diagnosis or prescribing any medication, needs to understand the state of the patient’s health. There’s their file, a comprehensive series of questions, perhaps some initial tests to be administered.

Only then can strategies for improvement be put in place. A doctor must understand a patient’s health status now to inform the best path forward. Investor profiling is a similar process.

Prior to purchasing an investment property, you need to be clear about your objectives, motivations and importantly, you need to understand your tolerance for risk. These factors determine your investor profile and only through seeking professional advice can you ensure this profiling is accurate.

At Aviate, our investor profiling focuses not only on your current situation but also your future goals. For instance, we perform an extensive investment analysis on every property we recommend that accounts for all costs, both upfront and ongoing, required to hold the property for the long term.

We then cross reference this with the information we gather from you to ensure the property is feasible for you as an investment. This ensures there is a clear plan in place to work for your success.

This approach is uniquely thorough but something we consider essential. It’s the most comprehensive and secure way to determine if an investor is truly prepared. But what characteristics generally define a person ready to invest in property?

Someone ready to invest will typically place great value on their security, is discerning when it comes to finances, capable of removing emotion from an investment decision and is relatively affluent but careful not to pay too much for an asset. Your investor profile draws out these details.

If this mindset rings true, you may be ready to invest in property. Then it’s a matter of assessing where you’re at - understanding your means.

This begins by calculating your total cost of living expenses, leaving no stone unturned. This will include mortgage, car expenses, clothing, insurances, entertainment, food. Often it is time poor professionals who are least able to identify exactly where their income goes. But it’s an essential exercise as your existing budget will shed light on how much you can commit to repayments. These calculations are a key part of Aviate’s investor profiling.

It’s about covering all bases and ensuring your affairs are in order. For instance, you should ensure you have adequately insured your existing assets, have an up to date will and enduring power of attorney.

Then it’s a question of money. Investors who value security will want
to ensure the property they purchase will be tenanted either at, or immediately after, settlement. Research shows one to two-bedroom apartments in inner city locations are best positioned to appeal to the highest quality calibre of tenant.

Therefore, generally speaking, an investor would need a secure annual income of around $80,000 or above and equity of around $120,000 available to settle on a property of about $500,000. While this is obviously a generalisation, and everyone’s financial health is different, you can tell by these numbers that property investment is not exclusively the domain of the wealthy.

More important than a high income is the ability to take a disciplined approach to budgeting, and to recognise that your future financial health may require decisions to be made today.

Professionals able to satisfy the general criteria outlined above are most likely ready to begin an investment property journey, or to expand their portfolio. With the right mindset, and the right specialist advice, the foundations for a healthier financial future are there to be built upon.

After investor profiling clarifies their means, needs and motivations, many professionals turn their attention to this next question, which is especially poignant in the current climate. Is this the right time, from a broader economic perspective, to invest in property?

It’s understandable: contradictory media reports declare the market is hot one day and cooling the next. And there’s the never-ending speculation about the housing bubble that some commentators seem obsessed with.

This leads to the next logical question, “If I don’t own an investment property and I don’t buy one now, will it be more difficult to invest later?” The answer is – again – determined by your investor profile. Your personal situation and circumstances are the key.

Certainly, there are some commentators who have suggested that investing in property is the wrong move in the current climate. The argument goes like this: the property “boom” has peaked, the economy is slowing, the banks are cracking down on lending to investors, interest rates can only go up and new developments are springing up to more than satisfy demand.

This view – held by some self-proclaimed experts – oversimplifies the issue by assuming all properties are created equal. That the investment fundamentals for a three-bedroom house in Western Sydney are the same as those for a one-bedroom apartment in West End, Brisbane.

But in reality such a view fails to recognise that every property is unique. Consider two apartments within the same building, one on the ground floor adjacent to the garbage area and the other, say, the penthouse. In performance terms, there’s no comparison.

This fundamental heterogeneity applies for property as an investment asset class.

If the performance of two apartments in the same building is incomparable, how can we lump different suburbs together, never mind the entire Australian property market?

The point is, at any given point in time, there will be markets that are not suited to an investment property purchase. Markets in which there is too much price heat, where investors risk overpaying.

Likewise, there will always be markets that are suited to investment. Those that are operating under the radar, where a combination of investment fundamentals are aligning to present outstanding opportunities. Markets destined to become the next hotspots.

Making the distinction between an investment appropriate market and the hotspot du jour is not clear cut. It requires genuine expertise based on actual research and real data.

Warren Buffet famously said “Be fearful when others are greedy and greedy when others are fearful”.
If you hear doom sayers proclaiming their fear of an impending property bubble, it probably indicates that it’s the best time to buy. The question then turns to the property itself: which city, which suburban market, which development, which apartment therein. Again, to answer this question, expert advice is the best – and only – place to start.

Right now, in the current climate, smart investors are using the right research to find the right properties in the right geographical pockets. Their property investments are made through experts with a proven track record of analysing the many factors that determine success.

Getting it right the first time is crucial. Research is paramount to identify markets that are yet to, but set to boom – and then continue to perform over the long term. But this requires a level of due diligence and a basis of knowledge that typical investors, professionals in different fields, simply do not possess.

At this point a word of warning is appropriate: regrettably, like in most industries, investment property is not immune to less ethically-inclined operators. We’ve all heard the term “spruiker”, so it’s important to deal only with investment property specialists with the proper accreditation.

For example, Aviate has passed the strict due diligence of Australia’s most respected financial institutions including ANZ and Macquarie Bank, and is certified by the Property Investment Professionals of Australia. Investors who prioritise their security should only partner with groups with the highest level of professional accreditation.

Once you have sought the right advice, undergone the investor profiling process, and are otherwise ready to invest, other questions of course arise. Professionals – particularly those in medicine - are by their very nature inquisitive people.

Most people will have a natural curiosity as to how an investment property group arrives at a specific recommendation. That is, “how do you identify a property, among the myriad options available, that is destined to outperform the rest of the market?”

To answer this question, you need to understand what is meant by the term “off-market property”.

Some developers engage property groups to find buyers for their projects instead of using traditional real estate agents to market their developments through mainstream channels.

When this happens, the development won’t turn up in online searches or in the real estate section of the paper. Instead, the strategy to sell these off-market apartments targets individual – and ideally pre-qualified - investors.

Often it is smaller boutique developments that are suited to an off-market approach. This is because there are fewer apartments to sell. A far-reaching advertising campaign is not needed and a waste of money.

The key point for investors to understand is that marketing costs, regardless of which approach the developer takes, are expressed as a percentage of the sale price of the apartments in the development. If a property is available off-market, there is no need for a big marketing budget, so investors can often secure off-market properties at or below the independent valuation price.

This is one of the reasons Aviate recommends only apartments in smaller, boutique, off-market developments to investors. Boutique developments are also more attractive to a higher quality demographic of tenant. The apartments are more time and cost efficient to rent.

Obviously there’s a lot to consider if you’re thinking of investing in property. The questions outlined here are really just the tip of the iceberg. Like any specialist field, investing in property requires extensive education, research and experience.

Therefore perhaps the most poignant question for time poor medical professionals to ask themselves is “do I have the time to undertake all the work necessary to ensure I make the right investment property decision?”

If the answer is no, the next step is clear: talk to a specialist. Better financial health awaits.
Running a medical practice is a complex business – practice owners face a variety of risks which need to be appropriately managed with a mix of risk management strategies and an effective insurance program. While no two practices are the same, in my ten years of working with doctors, there are a number of recurring themes – the top 10 risk and insurance mistakes made by practices:

Chris Mariani counts down the top 10 risk & insurance mistakes made by medical practices.

Chris Mariani is Director at Medical and General Risk Solutions.
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| 1   | Legal/ accounting structure | There are a number of issues which frequently arise from the chosen business structure:  
• I often ask clients ‘draw me a diagram of your structure and show me the money flow’. Many clients can’t do this as they don’t understand their structure. I then ask the client to show me their insurance policies and often they have failed to name the right entities – so they’re leaving themselves exposed to uninsured claims.  
• A client once told me their accountant recommended they set up a separate ‘shelf’ company with no assets in it to employ the staff – on the basis of asset protection (i.e. he could simply close down the company if a staff member brought an employment claim against him). This approach failed to deal with the reputational risk – he was in a specialist market with a limited number of skilled technicians available, all of whom knew each other. Adopting a strategy to close down a company and not pay a valid employment dispute claim (say the practice manager bullied the young technician) could result in reputation damage as an employer. Given he could have purchased employment practices liability insurance for less than the accounting fees, the structure was questionable. | • Do you understand your practice structure?  
• Are you naming the right entities on applicable insurance policies?  
• Does your structure provide the asset protection you are seeking? Consider your reputation as an asset as well. |
| 2   | Signing contracts | The two most common contracts in the medical space I see issues with are lease agreements and independent medical practitioner agreements. Many doctors fail to obtain legal advice and insurance advice on contracts. From an insurance perspective there are generally clauses under ‘Indemnities’ and ‘Insurance Requirements’. Often landlords will attempt to put in unreasonable requirements - recently a client hospital there were leasing a suite in to insure the doors and partitions in the hospital. Often independent medical practitioner agreements will contain unfair contractual indemnities which are often not covered by insurance. | • Seek legal and insurance advice on contracts.  
• Pay particular attention to the ‘Indemnities’ section and ‘Insurance Requirements’ section.  
• Indemnities often change the legal position of “you’re responsible for your mistakes and I’m responsible for mine”. This can trigger exclusions in insurance policies. |
| 3   | No Privacy Policy/ processes that comply with privacy legislation | It still surprises me by the number of practices that simply do not know they are required by law to have a written Privacy Policy and processes/controls to protect patient privacy. Of those that do, many have not updated their Privacy Policy following the changes in March 2014. An easy way to identify this is new legislation references the 13 Australian Privacy Principles (APPs). If your Privacy Policy still refers to the National Privacy Principles (NPPs), then it’s time to update your policy! | • As a healthcare business you are required to have a Privacy Policy and comply with privacy legislation.  
• Your privacy policy needs to address the 13 APPs. |
<p>| 4   | Failing to use the resources of AMA, colleges, MDO and insurance broker | Before you spend hundreds of dollars an hour on lawyers or consultants, can you get it for free or for a reduced cost? For example a number of the state AMAs provide employment manuals and templates, Privacy Policy templates, medical practitioner agreements, etc. These are either free or heavily reduced. If you are buying or selling a practice, or reviewing your processes such as informed content, storage of medical records, then seeking medico-legal advice from your MDO could be helpful. | • In many cases you can get advice, templates, documents ‘for free’ or for a reduced cost. |</p>
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<td>5</td>
<td>No formal risk management</td>
<td>This is particularly the case in specialist practice where there is no incentive to be accredited. Many clients I see have no process to identify and then risk manage the key risks in their practice (risk register). They have no central system to record patient complaints, adverse events and near misses (incident register). Risk Management is not an item on their management team meetings. They have no processes and procedures manuals.</td>
<td>• Have you identified the top 10 risks in your practice and how are you managing these? – a Risk Register • Do you have a central document that identifies all patient complaints, adverse events and near misses? An Incident Register</td>
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<td>6</td>
<td>Assuming the doctor/s medical indemnity will also cover the practice entity and employees</td>
<td>In private practice, each doctor buys their own medical indemnity insurance. Each MDO has a different approach as to whether a doctor's practice entity is covered (some require the doctor to wholly own the entity) and secondly whether the employees are also covered (e.g. one MDO excludes all registered healthcare staff such as nurses). Doctors tell me this is an area of great confusion for them, as many policy wordings and surrounding documents are in excess of 100 pages. If you are unsure, ask an insurance broker to review your personal circumstances and provide personal advice.</td>
<td>• Does your practice entity require its own medical indemnity cover, or is it covered under the doctor/s personal medical indemnity policies? • The four MDOs differ so you need to review your own circumstances – seek advice from an insurance broker.</td>
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<td>7</td>
<td>Buying insurances online or direct with an insurer</td>
<td>It's important to understand the difference between “General Advice” and “Personal Advice”. When you deal with an insurer directly, you will likely be receiving “General Advice”. This means the insurer is providing you information only, not advice. They are not considering your personal circumstances or needs and they can only sell you the product they manufacture. When you engage an insurance broker to represent you, the broker is licenced to provide you with “Personal Advice”. This means the brokers duty is to give you advice on your personal circumstances and to find the right cover from a range of insurers they deal with. The broker's duty is to you as the client and not to the insurer. They're experts in insurance, the same as your accountant and lawyer in their fields.</td>
<td>• Does your practice entity require its own medical indemnity cover, or is it covered under the doctor/s personal medical indemnity policies? • The four MDOs differ so you need to review your own circumstances – seek advice from an insurance broker</td>
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<td>8</td>
<td>Lack of financial controls and oversight to detect and prevent employee fraud</td>
<td>One of the least understood risks in a medical practice is employee fraud. At the Private Practice courses we’ve heard from doctors who have had first-hand experience – from employees paying their personal mobile phone bills using the practice bank account, paying wages to employees who don’t exist, to medicare fraud. KPMG report in excess of 30% of companies with employees between 1 and 500 experienced a fraud against their company in 2012 (KPMG A Survey of Fraud, Bribery and Corruption In Australia and New Zealand 2012)</td>
<td>• Implement dual authorities on payments. • Have an approved vendor list of suppliers and authority to add a new supplier. • Implement regular management oversight, monthly reporting. • Use an accountant that can benchmark your spending relative to other similar practices (e.g. is your stationary spend reasonable?).</td>
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| 9   | Major gaps in insurance coverage | Many practices I visit have not gone through a risk review/audit process, have not engaged an insurance broker who specialises in medical clients and as a result, they do not have the right insurances in place to protect their assets and liabilities. Some of the most common areas left uninsured are:  
• Lost revenue as a result of an issue with the rooms or key equipment. By example a client recently had a major water leak which resulted in the practice losing one day's revenue during the clean-up. Luckily we had arranged ‘business interruption’ insurance so the insurer paid their lost revenue. While only one day, many businesses are forced to close for weeks or months in the event of major fire or storm damage.  
• Management exposures – such as employment practices liability, employee theft, privacy fines and other statutory penalties, and responsibilities of being a director. These risks are easily insurable under a Management Liability policy, with good policies starting from $1,500 for a $1 million revenue practice.  
• Medical indemnity for the practice and staff as noted it item 6. The chances are if you are a multi-doctor practice (including where you rent sessional rooms to other practitioners) you will need a separate medical indemnity policy for the practice. | Engage a broker to do a risk review of your practice. Ask them about their experience in medical clients and what other client purchase and why.  
There are some insurances such as Management Liability which are only available via brokers, so it's important to seek advice on all of your practice risks. |
| 10  | No review process               | Many practices have no process to review their risks regularly (see point 5) and have not engaged anyone to help them identify their practice risks. For example I visited a client last year who had a large hard file medical records rooms which had no door or lock. The room was down the patient toilet corridor with unsupervised patient access. Given privacy legislation now enables a fine of up to $1.7 million against the practice entity and $340,000 against individuals, putting a door and lock on the room was a highly sensible risk management decision made by the management team following my recommendation.  
What obvious risks in your practice are you overlooking? | Implement an annual review process with your insurance broker.  
Make the practice manager responsible for risk management and make it an item on the management meeting agendas. |

If you have any questions, would like a risk review or need advice on your insurances, please contact Chris Mariani on 0419 017 011 or chris@mgrs.com.au for an obligation free discussion.

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FISCAL REPAIR REQUIRED

Chris Caton is Chief Economist of BT Financial Group.
September was yet another month to try the patience of investors. The ASX200 fell by 3.6%, its sixth negative monthly result so far this year. This leaves the market down by 7.2% year-to-date. For the September quarter, the index declined by 8% after a 7.3% decline in the June quarter. This was the worst quarterly performance for four years. And, of course, volatility remained high. In the month, there were 12 trading sessions in which the index rose or fell by more than 1%. The last time that volatility was that high was in December 2012. To put this in perspective, there were 12 +/- 1% days in total in the six months beginning March 2014.

The US market had a similarly poor month. The S&P500 index fell by 2.6% in September and by 6.9% in the quarter. It is down by 6.7% year-to-date.

The reasons for the malaise have not changed much in the past month. First and foremost are continued concerns about Chinese growth, and the implications for the commodity sector. I discussed these at length last month, and there is little new to say. These concerns don’t appear to have become worse in the past month, but nor have they been resolved.

There were some subtle nuances added to the list of worries in the month. Of these, the most important was the Federal Reserve’s decision not to begin the process of interest-rate normalisation. The Fed is caught in something of a cleft stick in this regard. Its mandate is essentially to ensure high employment and stable inflation. With the unemployment rate at just 5.1%, little more than half what it was at the height of the GFC, one could make a strong case that the economy simply doesn’t need near-zero interest rates. But inflation remains stubbornly low (words which, until a few years ago, I never thought I would type); so low that it argues for continued near-zero rates. The “tie breaker” is something that is not part of the Fed’s explicit mandate, that one can label “risk minimisation”. The Fed apparently convinced itself that to begin the process of increasing rates in September would add to the ongoing level of financial market instability. What it almost certainly did not anticipate was the negative reaction to its non-decision.

Why a negative reaction? Some would look at a decision not to raise rates as positive for growth, hence for earnings and hence for the share market. But some look at the decision and come to the conclusion that “the Fed must know something I don’t; things are worse than I thought”. These two schools, incidentally, have been described as the Tigger and Eeyore approaches. Those familiar with the Winnie the Pooh classics will relate immediately. For those unfamiliar, this is not the place to address the gaps in your education. In this case, the Eeyore view dominated.

The question, of course, is what is likely to happen next? One of my chief-economist colleagues, Dr Shane Oliver of AMP, has produced a table showing all the declines of more than 10% in the Australian share market in the past 26 years. The first thing to note is that there have been 16 of them, so they are not that uncommon. Most remarkably, there was a correction of 10% or more in each of the calendar years from 1996 to 2001, and yet in each of those years the share market finished higher than it had started. If one measured from the very bottom in each of the 16 episodes, the average rise in the market over the next 12 months was 21%.

Of course, an 18% fall (which it was has happened so far in this episode) is much worse than 10%. There have been only five larger falls in the past 26 years. Once these episodes troughed, the average gain over the next 12 months was 33%. The (probably more meaningful) median gain was 27%. So far, so good, but what if this episode is not yet over?

It may not be. Markets in correction often fall further than expected. I made the case last month, however that both the Australian and global share markets were now on the cheap side, and that the only reason to fear a significant further fall was if one anticipated a massive further slowdown in global economic growth. I made the point then that, while the global economy was still stuck in the slow lane six year after the GFC, there was precious little concrete evidence that it was about to drive over a cliff.

If I may plagiarise what I wrote last month, “while volatility is likely to remain high for some time, the fundamentals of corporate earnings and likely economic growth suggest that the market will be significantly higher a year from now”. Cheap markets can get cheaper, but they don’t stay cheap forever.
THE AUSTRALIAN ECONOMY IN ONE STATISTIC

Last month, I addressed the confusing signals being sent out by the labour-market data. That pattern continued in September. First, employment growth in recent years was revised downwards, but this is a relatively minor matter. It comes about because there have been downward revisions to population growth, include that of the working-age population. These population figures are used to “benchmark” the employment figures. Of more concern are the fluctuations in the unemployment data. The estimated unemployment rate fell from 6.3% in January to 6% in May, and appeared to have peaked. It then reversed direction, climbing back to 6.3% in July, and was apparently still on the way up. Now we are told that it fell again, to 6.2% in August. Unless and until there is clear evidence that unemployment has peaked, there remains the chance of a further rate cut. (Note that, for all that is made of the current high unemployment rate it has been below its current level for only about one-third of the time in the past 40 years.)

Some of the work of a rate cut is being done by the falling exchange rate, which began the month at 71.5 US cents and finished at 69.9 cents. A month ago, I suggested that we would “touch” 70 cents in September (bingo!). Unlike the decline from August last year to June this year, movements in the past three months (from 77 cents) have been “home grown” and have not merely reflected a rising US dollar. As a result, cross rates have finally come down significantly.

The Reserve Bank will almost certainly leave the cash rate on hold again on 6 October. It remains a reluctant cutter.

I have trimmed by end-of-year forecast for the ASX200 by a further 200 points, to 5300. The currency is already below my end-of-year forecast of 72 cents, but I am not inclined to change that forecast. Right now, for the first time in almost six years, the Australian dollar is no longer over-valued by my reckoning.

WILL THE ECONOMY AND THE MARKET TURN BULLISH?

It is not every month that Australia gets a new Prime Minister (although it hasn’t been uncommon in recent years!). Economists immediately get asked: will it make any difference? My answer is that it could. If it does, it won’t be because of any sudden shift in economic policy; that is unlikely to happen. But there is no question that one contributor to the slow-growth trap the economy has found itself in for the past two years or so has been a lack of confidence, by both business and consumers, and that the political situation has been a significant reason for that lack. If PM Turnbull adopts a more inclusive, consultative approach, and this is embraced by the business community, then this can only help. Note that the lack of confidence has not been the major contributor to the slowdown; that honour goes to the almost-simultaneous end to two booms, in mining capital spending and in commodity prices (note that this also means that the slowdown is neither the fault of the current Government nor of its predecessor).

It would also be helpful if the “debt and deficit disaster” blame game were to stop, and if the PM and his Treasurer could effectively sell the story that there is no short-term Budget emergency but that there is a long-run mismatch between revenues and spending that needs to be addressed by action on both sides of the ledger. Attempt to address this issue have not been helped in the past by a lack of bipartisanship, and also by a view that proposed fixes are “unfair”. It is, of course, natural that people would like spending that doesn’t affect them to be cut, and tax increases to be confined to those paid by “someone else”, but such attitudes have to addressed and softened. The job of medium-term fiscal repair desperately needs a persuasive salesman. Stay tuned.
Medicos and other healthcare professionals are not like everyone else. When it comes to financial advice, you have particular needs, issues and concerns that need to be clearly understood from the outset. Which is why we’ve gone to considerable lengths to assemble a network of medico-specialist financial advisers – with extensive and successful medico experience. Like-minded professionals who will not only provide you with solutions but also educate you – so you can make fully-informed decisions. There’s a medico-specialist financial adviser in every state and territory of Australia.

Examine our network of medico-specialist financial advisers
SINGAPORE and the UNLISTED COLLECTION
ESCAPE

Steven Macarounas shines a light on the funky side of Singapore.

Singapore has long been considered by some as a 'ho-hum' destination, lacking in the exotic excitement of its more truly Asian neighbours, worthy perhaps of a stop-over on the way to ones main destination or as a conference venue but not as a holiday spot in its own right.

I disagree! Singapore, since the mid seventies, has always been one of my most favourite countries to visit – you have to be ‘in the know’, prepared to research, ask locals where to go, what to do, where to eat. It certainly helps if you have local friends.

It also helps to have a sense of adventure and to be prepared to leave the main tourist strips, the high rise shopping complexes and monolithic hotel towers, instead I recommend immersing yourself in the quirky, charming neighbourhoods, brimming with colour and authenticity.

These areas and the funky Singapore experience have been getting more and more accessible with the whirlwind arrival on the scene of wundekind boutique hotelier and restaurateur Loh Lik Peng and his ever-expanding Unlisted Collection.

The son of a Paediatrician Father and Optometrist Mother, Loh was a successful corporate lawyer, who, during the Asian financial crisis of the late 1990s, oversaw the foreclosure of many Singaporean commercial buildings – the experience was demoralising and conversely inspiring.

Previously forgotten buildings (often boarded up) in what were considered undeserving areas, sparked Loh’s imagination.

He spotted potential in one particularly interesting building in Singapore’s red light district in Chinatown. It was surrounded by the city’s famous ‘shophouses’—narrow heritage homes consisting of a business at street level and home above—and nobody wanted it. So he decided to buy it, and despite no experience in the industry, he converted it into Hotel 1929 – Singapore’s first boutique hotel.

And with that ‘out of the box’ move, the seeds of an empire had been sown.

Loh followed that with the New Majestic Hotel also in Chinatown, just down the street, and Wanderlust Hotel in the Little India district.

Having perfected the boutique hotel model in his home town, Loh decided to go global, opening The Waterhouse at South Bund in Shanghai’s old docklands, and three more boutique hotels in London, including the new One Leicester Street in Chinatown and most recently in Sydney, the Clare Hotel in the gritty laneway location on the corner of Kensington Street and Broadway, and inside the former Carlton and United Brewery’s administration building.

Pictures tell a thousand words and I’ll let those in this article do most of the talking for me.
So back to Singapore; one of the food capitals of the world now has funky accommodation options in cool character filled neighbourhoods – not for those who prefer ostentatious six-star casino hotels but those who appreciate heritage listed buildings which have been sensitively restored and re-adapted into radical, cutting edge lifestyle concepts that culminate into an unforgettable hospitality experience.

Pictures tell a thousand words and I’ll let those in this article do most of the talking for me.

You will note that the design and furnishings celebrate a new culture of creative spirit in Singapore.

As Loh says “Design is always a collaborative process for me so I always work with architects and interior designers to achieve something original and fun. It’s very seldom that I give a detailed brief to the designers so they almost always work from a blank canvas at first, which is why none of my projects have a signature look as such. The only personal touch you will often see in my projects is that they are almost always in conservation buildings (which I love) and often have a vintage barber or dentist chair, which I collect.

I try to make sure the design is relevant to the building, the location and the country we operate in. We try to be as local as possible and we try to ensure our neighbours are proud of having us there. To me this is very important so we try to use local designers and local artists in all our projects”

A true sign of his genius is that in this food obsessed nation, brimming with eateries of the highest standard, Loh has established a stable of restaurants, some within his hotels, that have become the darlings of the gourmet set.

My family and I recently ate at:

- **Meatsmith** – a Southern American menu of bbq and smoked meats, with Asian influences.
- **Esquina** – Spanish/Japanese fusion, high end tapas
- **Burnt Ends** – Fine dining bbq and cocktails with a casual Aussie flavour.

Each dining experience was magnificent, the food imaginative, delicious and memorable, the décor was character rich and in keeping with the Unlisted philosophy of modern/retro ambience.

The service and overall customer experience is directed by one of the most recent Unlisted Collection recruitments restaurant manager extraordinaire Emmanuel Benardos – hospitality is in his DNA and the personal service is simply unrivalled.

So, the Unlisted Collection has, in my opinion re-vitalised Singapore, turned what some travellers considered a staid destination to one that is fun and popping with whimsy and quirkiness – reason enough to consider Singapore as a regular holiday spot... it certainly is for me and my family. ☺️
EVENTS

The Private Practice 'Comprehensive',
Brisbane – 17-19 July 2015
EVENTS

EVENTS

The Private Practice 'Comprehensive',
Perth – 21-23 August, 2015
EVENTS

Day Hospital Development Workshop, Sydney – 29-30 August, 2015
EVENTS
