The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

General practice ownership

DEMYSTIFYING THE BUSINESS END OF GENERAL PRACTICE IN NEW ZEALAND

Acknowledgements

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* HealthyPractice® is an online business support service run by MAS that provides GP-specific information and advice about employment, financial management, legal compliance and much more, as well as templates and support. The HealthyPractice® sitemap provides an overview of the information available.

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Foreword

New Zealand has a proud history of GPs establishing their own practices in the communities they serve. We all owe a debt to those pioneers who, by starting their own practices, established our modern-day general practice profession and networks.

These days, for some GPs, owning a practice is the realisation of a lifelong dream. For others, the idea is daunting or they simply don't know enough about it to really know what they think of it as a career option.

If you are considering establishing or buying into a practice, this guide aims to provide you with a place to start.

It touches on the many different facets of becoming an owner, such as what it involves, different business models, business planning and development, and the key professionals to have on your team.

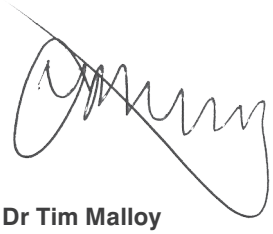
Becoming an owner or partner in a general practice is the solution for many GPs as it can provide great flexibility of lifestyle, the ability to direct and influence how your practice is run and, of course, financial benefits. Many other factors unrelated to medicine also come into play such as your family, personal aspirations, lifestyle and your philosophy on how best to fulfil your own ideals as a doctor and member of a community.

This guide is not the definitive text on practice ownership, because we all know what is right for one doctor or one practice is not necessarily right for another.

If you are considering ownership, you should also speak to your colleagues or mentors in general practice and, importantly, to a trusted business advisor about the financial and legal obligations of owning a business.

From a personal perspective, having had many years' experience as a partner in my own rural practice in Northland, I would say that the benefits and personal satisfaction of owning and running a practice vastly outweigh its challenges.

I would recommend and encourage you to consider becoming a practice owner. And if you do, I sincerely hope that you find this guide useful and that the case studies throughout inspire you in your career decisions.



Dr Tim Malloy
President

From a personal perspective… I would say that the benefits and personal satisfaction of owning and running a practice vastly outweigh its challenges.

Executive summary

General practice is evolving, with many new configurations of practice ownership. To enable general practitioners (GPs) to better evaluate whether ownership is something they would like to get involved in, The Royal New Zealand College of General Practitioners (the College) has developed this high-level guide, which aims to demystify the various aspects of being an owner and employer.

The resource provides an overview of the current landscape and funding mechanisms. General practices operate as part of the wider health sector, and the influences of external factors, including political, economic and demographic changes cannot and should not be ignored.

An outline of some common ownership structures is provided, as the set-up of a practice determines not only a business's success but also what will happen if things go wrong.

The most important message throughout this resource is that practice owners need to be connected to the right people: being a practice owner does not have to mean doing everything yourself. The College advocates getting professional advice on legal and financial matters, as well as employing key staff such as a practice manager, to make the most out of your investment. This also enables you, as a practice owner, to work at a governance level rather than a managerial level to grow your business in the direction you want.

This resource aims to cover the basics of strategic and business planning: analysing the practice, having a clear vision of what you would like it to look like and how you would like it to be operating (as a business and within its setting). It touches on leadership, teamwork, human resources, and creating your work environment. It also provides guidance on employing staff, technology and compliance.

Last, but not least, the resource concludes with advice on disaster preparedness and risk management – including loss of key staff – and how to close or sell your practice responsibly.

It is not the intention of this guide to provide definitive advice on every possible aspect of practice ownership. What is right for one practice might not be right for another. Instead, we hope it provides readers with an overview of what is involved. For those seeking more detail, it also identifies further reading and resources.

Introduction

Why become a practice owner?

The most widely cited benefits of practice ownership are autonomy, stability and financial reward. It also provides opportunities to develop new skills and can improve your understanding of and connection to the health system.

As a practice owner, you have greater control over your time, what services your practice offers, which providers you use, who you work with and your practice's working culture. For example, your practice could become a first-class training facility, promote patient empowerment, exemplify sustainable 'green' practice or have a fluid system where integrated care is provided by the whole clinic rather than an individual practitioner. You are able to have a say in how your practice is run and can include things that you enjoy doing, for example one morning a week of excising skin lesions.

Practice ownership … provides opportunities to develop new skills and can improve your understanding and connection to the health system.

Practice owners usually receive a return on investment over and above regular income. The College's 2015 workforce survey demonstrated that practice owners earn more than employed GPs, even when income is adjusted for hours worked.[1] The additional income received by the owner(s) compensates for the business risk and the cost of the use of personal capital in ownership.

Common concerns or reasons for apathy about practice ownership are that it detracts from the role of clinician, involves excessive working hours and is stressful. However, this does not have to be the case. These concerns are usually based on the traditional model of a single GP owning and managing the whole practice. In reality, there are a variety of ownership structures that split the management and governance functions and enable the shareholders/owner to maintain a focus on their clinical role; for example, a limited liability company with a governing board (the GPs) supported by an experienced practice manager.

As with any business proposition, it is important to assess the potential risks and rewards. Business ownership brings with it significant responsibility so should not be taken lightly. Business skills are generally not covered at medical school and are not extensively taught as part of the College's training programme. This can make the business side of practice ownership daunting for some; however, it is important to remember that professional advice is readily available (accountants, business advisors, practice managers, lawyers) and that these skills can be developed over time.

For many young GPs with a student loan, it can be helpful to learn about owning and managing a practice from your employer while working to pay off your loan. By the time you've paid it off and can spend that extra money on investing in a practice, you will have learned the ropes and hopefully gained a mentor.

With a large number of current GPs expected to retire over the coming decades,[1] it can be surmised that there will be increased opportunity to buy into existing

practices. This resource aims to provide the next generation of GPs with an overview of what practice ownership may involve so that they can make more informed decisions about whether they would like to take up this opportunity. Importantly, there are increasing opportunities to challenge the traditional ownership models, for example, the increase in practice co-ownership with nurses and other staff.

CASE STUDY

Less conventional route for new practice owner

New Zealand Doctor – 26 February 2014
BUSINESS
Liane Topham-Kindley

After almost 20 years in general practice, when many of her peers are opting out of practice ownership, Marie Burke has decided the time is right to buy in.

On 1 July last year Dr Burke took a shareholding in EastCare Health in Aranui, Christchurch, in partnership with long-time Christchurch GPs Jean Herron, Philip Frost and David Richards.

Up until about a year prior to that, she had never had any desire to own her own practice.

"I'd liked being a GP, I liked doing the clinical work, and the idea of running and owning a practice wasn't something I'd been interested in," the UK-trained doctor says.

But she began to consider the option as she became interested in having more say in how the practice was run.

"It hadn't been on my radar, but as time went by it became more and more on my radar," Dr Burke says.

Having scanned the *New Zealand Doctor* classified advertisements in search of the ideal practice, it was word of mouth that finally clinched the deal, and she initially started out at EastCare Health as a locum with a view.

Although older than most people buying into their first practice and bucking the trend to exit ownership, Dr Burke considers taking the less conventional route has been a good one.

"I think for me it was easier, because, I suppose from a financial point of view, you are a bit more stable. "I wasn't having to think I had to get more patients in the door, and I had a bit more experience under my belt."

Dr Burke says she has no regrets, but admits it has been a steep learning curve.

She has had great support from her three business partners and practice manager Maria Bayliss, as well as the bank and the accountant.

"It was good to have that support and advice."

Prior to moving to EastCare Health, Dr Burke was a long-term locum at Linwood Avenue Medical Centre, where last year Christchurch-based general practice company Better Health purchased a 50 percent shareholding.

She says the sale of practices to non-GP owners will likely increase in the future, but she does not like some corporate organisations' model of care that cannot guarantee patients a regular GP.

"I don't think it's a great model for complex medical problems," Dr Burke says.

One of the things she enjoys most about working at EastCare Health is the continuity of care.

Each GP is there every day. While for some people it doesn't matter which doctor they see, Dr Burke considers the better you know patients, the more likely you are to know when things just aren't right when they walk through your door.

New Zealand Doctor
More than medicine

CASE STUDY

Two new GPs take the bold step into practice ownership

New Zealand Doctor – 13 May 2015
BUSINESS
Liane Topham-Kindley

Two newly qualified GPs have taken a leap of faith and bought into the practice where they did their GP registrar training.

While few of their peers are investing in medical businesses, Loren Young (37) and Megan Bailey (33) became owners and directors of Blenheim's Springlands Health Centre on 1 April.

The two were excited to buy in as partners after enjoying their GP registrar training at Springlands.

For Dr Young, it was the fulfilment of a long-term goal. When she began her medical degree, after training and working as a nurse for five years, she always intended to become an owner/operator.

"For me it was a bit of stability," she says. "I like to be able to settle in one place and to be able to form relationships with a community and relationships with individuals."

She was also looking forward to owning her own business.

"I love the idea of being able to make a business grow. I grew up with a father who was an accountant and a business owner and I learnt a bit from him."

The story is quite the opposite for Dr Bailey. "[Practice ownership] wasn't on my radar at all," she admits.

She had planned a career in respiratory and emergency medicine but, after having two children, changed tack. While training in general practice, she found it was the specialty that interested her most.

"The one thing I didn't like about working in the emergency department was that you never found out what happened to the patients, so when I became a GP I realised that it really suited me.

"I can see whole families, I can see the grandma, I can see the new parents; it just took me a convoluted way to get here."

The pair has bought in just as one of the founding partners, Grant Johnston, is retiring. Dr Johnston established Springlands Health Ltd with Rod Bird in 1993. In recent years, GPs Helen Pike and Duncan McAllister joined them as partners and now there are the five partners.

"[Drs Young and Bailey] did their GP registrar training here and then worked as locums checking out their options," Dr Bird says.

"It was a really nice way to build up a relationship and for them to stay here and for us to decide if we wanted them as partners."

He adds: "We are very careful about who we get into partnership with. We have had a lot of people who have come as a locum with a view, but it hasn't worked out for a number of reasons."

Both Dr Young and Dr Bailey said in separate interviews that they particularly enjoyed the team environment at Springlands.

"When you are working as a doctor, everyone has a role and they are all equally important to ensure a primary health care team functions well," Dr Young says.

Dr Bailey pays tribute to Dr Johnston.

"It's Grant's legacy that he has set up such a great team environment with the nurses and administration staff all working well together," she says. "There's not a big hierarchy system."

Working at Springlands for a couple of years as a locum helped her understand the people and the practice.

Dr Bailey is married to a local man and one reason she invested in Springlands was to be part of the community.

In terms of working on an agreed price for a shareholding in the practice, Dr Young says she liaised with MAS. The traditional way of pricing a practice, using a price per patient, has been replaced by a "super profit" model, she says.

"It gives you an indication, but it also depends on what the practice is wanting and how much you are willing to pay."

Dr Bird says the GP registrar training programme has contributed to the success of the exit and entry pathways for partners.

"A decade ago, succession planning was looking grim," Dr Bird says.

"That was one of the reasons for us becoming a teaching practice. It has made a big difference."

New Zealand Doctor
More than medicine

General practice in New Zealand

General practice in New Zealand

General practice is the traditional provider of primary care. The key defining characteristics of primary care are that it is the first point of contact with the public health service, it provides comprehensive, coordinated health care to individuals and their families and care is longitudinal and ongoing. Finally, primary care is connected to the community it serves. Traditionally, GPs lived in the communities they served, provided 24-hour comprehensive care and generally spent their whole working life in one community. More recently, GPs have stopped providing after-hours care and maternity care and are much more likely to move practice after a limited number of years.

The general practice workforce

Until the mid-1970s, a typical GP was a solo male with one employee (often the doctor's wife) to act as the receptionist-manager. They owned their own practice, which was situated on their residential property, and had no formal general practice training after medical school.[2] Since then, the GP workforce has been feminised, new roles such as nurse practitioners have come into play and compliance requirements have risen to meet public health and safety standards and patient expectations. While practice owners still tend to be males in their late 50s,[1] the models of ownership have evolved to include partnerships, trust-owned entities, companies, corporate-owned practices and variations of these.

The general practice environment continues to evolve due to changes in workforce size and demographics. Funding alterations, such as the introduction of capitation in 2001, scope expansion, service expectations, political pressures, GP training, practice size, practice nurses and managers, enrolment and new accountabilities are all included in the changing general practice landscape. New generations of GPs bring different career expectations and perceptions about work–life balance. These macro-level drivers of change have led to innovation in the structure of GP practice ownership.

While the traditional model of a sole practitioner running a clinic from their home has declined, there has been increasing corporate interest in buying practices. At present, there is insufficient research to know if there is a best model of practice ownership, and most likely this will differ according to rurality, population demographics, what constitutes the definition of 'best' and other complex factors.

As a GP, and particularly as a practice owner, it is important to be mindful of the wider health sector and what influences it. There are many macro factors that are out of the control of individual GPs that can influence a practice. For example, political agendas (such as free visits for under-13s), new legislation (such as the Vulnerable Children Act 2014), the economic environment, the physical location (remote and rural locations face unique challenges and opportunities), social and demographic trends (such as increasing numbers of young Pacific families in Auckland and refugee intake), workforce supply and new technologies.

Increasingly, practices are being monitored on their performance at a practice level by district health boards and so a better understanding and use of a population health approach will likely become more important.

A population approach to general practice

In recent years, most of the funding for general practice has come through the public purse. While GPs often see themselves as responsible for the care of individual patients, public funding bodies such as the Ministry of Health and district health boards (DHBs) are interested in the health of a practice population. They are interested in practice policies and service deliveries that improve both the quality of care and health outcomes – including reducing inequalities. General practices, which provide comprehensive health care in a coordinated manner over a long period of time, are well placed to improve the health of the populations they serve.

Some practices use the information available to them to understand how they are serving their population and whether their efforts on a day-to-day basis make any difference to population health. To some extent, funding requirements, such as for immunisations and cardiac vascular risk assessments, are measured at a practice level. However, practices can do more to use their practice systems and other data sources (such as hospital data and laboratory data) to help understand the health of their practice population. Practices can monitor the incidence of diseases in their practice population, such as diabetes, cancer, heart disease or asthma, and check their progress with improving the quality of primary care in these domains. On a population basis, they can look at the proportion of patients with satisfactory haemoglobin A1c, the proportion of patients who have given up smoking or the proportion who have had breast or cervical screening.

Understanding the changes in the health status of the practice population not only gives great feedback to staff and the community as to how well the practice is operating but is also useful information when negotiating additional services with health funders. Increasingly, practices are being monitored on their performance at a practice level by DHBs and so a better understanding and use of a population health approach will likely become more important.

Primary health organisations

In 2002, primary health organisations (PHOs) were established to provide essential primary care services to enrolled members (patients) directly or through providers – predominantly general practices. This model aims to connect the various GP practices with other primary health services (such as allied health) to maximise the comprehensiveness and continuity of care – particularly for patients with long-term conditions. The Ministry has set minimum requirements for an organisation to become a PHO.[3]

At November 2015 there were 32 PHOs funded by 20 DHBs, which in turn receive funding directly from the government through the Vote Health budget. PHO service provision is negotiated by the PHO Service Agreement Amendment Protocol (PSAAP) and detailed in the PHO Service Agreements with the DHBs.† There is also some negotiation between PHOs and their providers.

† The latest PHO Services Agreement is available here: **www.psaap.org.nz/contract-documents**

While there are a small number of GP clinics that operate outside of the PHOs, the majority of general practices have a back-to-back agreement with a PHO. These agreements cover the service and legal requirements of the PHO's enrolled GP practices.

For many GP practices, there is little to no choice in which PHO to enrol with. For those that are able to choose, the following factors may be worth considering:

- Legal and contractual arrangements
- Services provided to practices, for example register management, IT support and standards monitoring
- Management of capitation funding
- Reports provided by the PHO to assist with patient management and quality comparison
- Performance management programmes
- Patient fee support
- Primary and community-based services
- Other patient services and projects
- Foundation Standard and CORNERSTONE® support
- PHO representation in the sector
- Continuing professional development for all practice staff.

Funding streams

GP practices have several sources of funding that vary according to the services provided and the enrolled population. The majority of funding for most practices is capitation (funding per PHO-enrolled patient). Capitation calculations include adjustments to account for patients that have higher service needs.‡ PHO funding is also assessed quarterly based on their practices' enrolled population.

Capitation

Patient enrolment in your practice and corresponding PHO determines the level of capitation funding your practice will receive from the PHO. 'Enrolment' is formally confirmed (ie signed) by a patient and indicates that they intend to continue using your practice as their primary care provider. More information about enrolment is available on the **Ministry of Health website**, and details about enrolment forms and requirements are available on the DHB shared services **TAS website**.§

FURTHER INFORMATION

The Ministry of Health provides the contact details for all PHOs on their webpage **About primary health organisations**.

‡ Capitation rates are published on the **Ministry of Health website**.

§ Alternatively, patients may be 'registered' and regularly use your service but may not yet be enrolled or may choose not to enrol (and therefore do not receive PHO-related benefits or entitle your practice to capitation funding).

Your practice may also see 'casual patients' who seek your medical services on an irregular or one-off basis and are enrolled with another practice in the same or different PHO as you. Your practice does not receive the capitation funding for these patients, but they may still receive General Medical Services (GMS) subsidies if they have a Community Services Card or High Use Health Card or are aged under six years old (as at April 2016).

To ensure your register remains accurate and up to date, your practice is required to re-enrol patients who have not personally contacted and received your practice's services within three years. HealthyPractice® recommends that practices set reporting on this to two and a half years to allow time for follow-up.

Key sources of funding are:	
Capitation	Capitation funding is based on patient enrolment of your practice and corresponding PHO.
Patient fees	Payments and co-payments set by your practice. Casual patients (not covered by capitation) are typically charged higher fees. Whilst you cannot randomly increase fees to fund personal projects, it is important to monitor charges for all services (for example, travel vaccines, minor surgeries) to ensure that you are covering your costs.
PHO funds for health promotion services	PHOs utilise practice registers and other key datasets to determine health promotion priorities (such as obesity reduction, smoking cessation, family violence reduction) for their population. It is recommended that you contact your PHO to see what services are available for your practice/patients.
Additional funding	Additional funding is also available through various government schemes, for example for rural practices and for practices with a high percentage of enrolled high-needs patients (Very Low Cost Access scheme). General Medical Services (GMS) subsidies where a general practice or after-hours treatment provider sees a patient not enrolled in a PHO or who cannot access the practice they are enrolled with during business hours or after hours (casual patient). Other sources such as Primary Maternity Services funding, Services to Improve Access funding, the practice nurse subsidy, Mental Health Service Payment, Special Sessional Scheme payments, sexual health funding and palliative care funding.
Third-party fees	Examples of third-party fees include Immigration New Zealand for medical examinations or private insurers.
Immunisation subsidy (IMMS)	The immunisation subsidy (IMMS) is for GPs who administer vaccines to eligible patients and submit claims to Sector Services under the Section 88 Advice Notice for general practitioners, PHO agreement or other approved agreement for **immunisation services**.
ACC	Contracts and cost of treatment funding – more information on ACC funding is provided below.

ACC funding

The **ACC 'For Providers' webpage** provides information on how to register with ACC, utilise their funding avenues (through ACC Cost of Treatment Regulations and specific contracts), and on supplier managers. To access ACC funding and services and/or apply for contracts, you must be registered as a provider (or vendor).

Contracts

Your practice may be able to apply for the following contracts:

- **ACC urgent care contract**
- **Rural general practice (RGP) contract**

Other contracting opportunities are advertised on the Government Electronic Tenders Service (GETS) from time to time,[II] for example, impairment assessment contracts for appropriately qualified GPs.

More information on these contracts, including how to apply or enquire about a contract, and the operational guidelines are on the **ACC website**.

ACC cost of treatment regulations

Registered GPs may invoice ACC under the Cost of Treatment Regulations, and ACC will contribute towards the cost of consultations and procedures required for treatment in relation to accidents and injuries. ACC can also request specific services (for example, requests for reports or clinical notes) and will send details of the service required and a purchase order. There are two parts to utilising the ACC Cost of Treatment Regulations funding:

1. **Lodging and managing claims** on behalf of patients, using Read Codes that correspond to specific injury types.
2. **Invoicing ACC** for treatment provided for accepted claims.

ACC supplier managers

Supplier managers deliver a face-to-face service to provider groups such as GPs to:

- keep you up to date with changes and what they mean for you and your practice
- help you solve any issues and problems you may have with ACC's policies and processes
- pass your feedback on policy and process issues back to ACC
- involve you in provider evenings and events about topics of interest in conjunction with local ACC branch staff.

II See the current tenders listed on the **Government Electronic Tenders Service website**.

Ownership structures

Nowadays, a variety of ownership structures exist, all of which have risks and benefits. The table below – which is by no means exhaustive – is specific to GPs; however, other health practitioners such as nurses are increasingly becoming owners and co-owners in general practices.

Top tip: Ownership structures aren't set in stone. It is advisable that your practice reviews its business structure periodically (every three to five years). Legislation changes (or ownership changes) may alter which business structure is the most effective and profitable.

Common ownership structures in New Zealand include the following:[4]	
Sole trader	**GPs who own their practice and trade as individual sole traders incur their own individual costs and employ all other staff.** This model offers total autonomy for the GP who also receives all income and equity benefits. Challenges to this model are that it can involve substantial time commitment to the business aspects and the GP can become collegially isolated and may find it difficult to take time off. These challenges can be mitigated through careful staff employment, and clinical networks. For example, the **Rural General Practice Network (RGPN)** offers locum recruitment services to enable rural GPs to take breaks or move to part-time work. See **Choosing the right structure** on the business.govt.nz website for more information.
Partnership	**Two or more owner GPs (or other health practitioners) trade as partners in a legal partnership that jointly employs all other staff.** Partnerships allow for distribution of the governance and management responsibilities associated with business ownership, as well as providing collegial support. There can be some difficulties in partnerships where ideas and vision for the practice are not aligned and in terms of liability. See **Choosing the right structure** on the business.govt.nz website for more information.
Unincorporated association or cost-sharing group practice	**GP owners trade as individual sole traders but share practice costs and employ all other staff.** The agreement of an association, often called a cost-sharing group, defines the governance of the association, the business relationship of the associates, how practice costs (direct, fixed and variable) will be allocated to each individual during their tenure with the group and what happens when someone decides to leave the group.
Trading trust	**All staff, including all GPs, are employed by the practice, which is owned and governed by a community trust, DHB or district council.** A trading trust has a trust deed and can confer wide powers and discretions on trustees, has wide borrowing and lending powers, can make provision for a corporate trustee and can contain adequate indemnity for trustees. Trading trusts can be complicated and legal and accounting advice should be sought on setting one up. Inland Revenue (IRD) provides some **further information about trading trusts on its website.**

Common ownership structures in New Zealand include the following:[4]	
Limited liability company/ amalgamated practice	**All GPs and other staff are employed by the practice, which is owned as a limited liability company by some combination of GPs, nurses, other health professionals and administrative staff.** A company is a separate legal entity. It is owned by shareholders and run by directors and, as a legal entity, may enter into contracts and sue or be sued. The **Companies Act 1993** applies, while the **Companies Office** is a useful resource and has advice on how to apply the legislation. A company can be established in a number of ways. For a new practice, this might involve investing capital in the practice in exchange for shares. It could involve one GP, who may also be the director and employee. Another way is for existing practice owners to each have their fixed assets and goodwill valued before selling them to the company in return for a proportionate shareholding. GPs without goodwill/assets can simply buy shares in the practice. The remuneration model can then be arranged separately. This model minimises risk to the owners, simplifies contracting, internal accounting and financial management (as all revenue is received and all expenses are paid by the group practice), makes compliance and quality management easier, utilises economies of scale and clearly separates governance from management (reducing potential conflict). Amalgamation of existing practices into one entity can help with patient retention and attraction. Possible challenges with this model include the devolution of decision making and potential for disagreement, technology challenges when merging and difficulties exiting the company. See **Choosing the right structure** on the business.govt.nz website for more information.
Minority/majority corporate (see **Note** below)	**This is where a corporate entity buys into a GP practice.** Key benefits of this model are financial stability, capital and connection to resources/services often provided by the corporate. Buy-in also means that the corporate entity may be involved in the governance of the practice as well. The corporate entity may have different priorities from those of a health professional, in part because they are not bound by the same professional standards. Some conflicts can arise where corporate entities have ownership interests in multiple GP practices. Compass Health,¶ for example, is aiming to overcome this through a set of guidelines for GP Ownership Service. For example, in Papatoetoe, **two GPs sold 50% of their shares in their two practices to South Link Health**.
100% corporate owned (see **Note** below)	**Corporate-owned practices in which GPs are employees**, eg **Green Cross Health**. The Australian Medical Association has developed an information package, **Corporatisation of General Practice – Decision Support Kit for Doctors (2010)**, to assist GPs considering moving into a corporate practice, which has some applicability in New Zealand.
Note: The term 'corporate' is used in an all-encompassing manner in this instance, ie it may include PHOs, pharmacies and any organisation that is not owned by a GP.	

¶ Compass Health is a PHO that provides a wide range of primary care services through general practice teams and a number of other health care providers throughout the Wellington, Porirua, Kapiti and Wairarapa regions.

Some PHOs and alliances are becoming more involved in general practice ownership for practice sustainability reasons and offer management services. For example, Compass Health is progressing ownership under a limited liability partnership model for practices needing 'rescue' as they are unable to continue to operate and provide services to their enrolled populations and for financially viable and stable practices that require or request investment from Compass Health.

As at the end of 2015, Compass Health and its associated PHOs had supported 17 practices through crisis situations, such as sudden retirement or exit from the practice, GP owner ill health and death, and Medical Council of New Zealand (MCNZ) intervention. Compass Health ownership is a temporary fix while it aims to find a solution by consolidating the practice with an existing neighbouring practice, interim managing/owning the practice before selling it to a new GP, recruiting a new GP or closing the practice.

FURTHER INFORMATION

Westpac and BDO Spicers presentation on **Amalgamation: The changing face of general Practice Ownership.** Presented at the General Practice Conference and Medical Exhibition 2010.

CASE STUDY

South Link buys a stake in two more Auckland practices

New Zealand Doctor – 2 September 2015
BUSINESS
Liane Topham-Kindley

South Link Health continues to make in-roads in practice ownership in Auckland, purchasing a stake in two neighbouring practices in Papatoetoe.

GPs Peter Vincent and Prue Waters, a husband-and-wife team, have sold a 50 percent interest in their practices to the South Island–based primary care network.

Dr Vincent's Papatoetoe Accident and Medical Centre and Dr Waters' practice, Hunters Corner Medical Centre, are located in Hoteo Ave, Papatoetoe.

South Link Health's practice ownership company, South Link Health Services, took over the shareholding in Papatoetoe Accident and Medical Centre last month and will officially take over the Hunters Corner Medical Centre shareholding on 1 January 2016.

The two practices have a combined enrolled population of 7500 patients.

SLHS already has a 50 percent shareholding in Takanini Care Ltd, a company that owns four practices in South Auckland (*New Zealand Doctor*, 24 April 2013).

The four are the co-located practices Takanini Care A&M Clinic and Takanini Family Health Care, and Counties Care A&M Clinic and Counties Family Health Care, co-located in Papakura.

Asked why the Dunedin-based entity is keen to pursue practice ownership in the North Island, SLH executive director Murray Tilyard replies: "This is about general practice in New Zealand, not just general practice in Otago and Southland."

SLHS is committed to offering GPs exit options from practice ownership as well as developing new models of care, new facilities and sub-specialisation in general practice.

Dr Vincent says the partnership with SLHS is about planning for the future for their current practices.

Both he and Dr Waters want to continue working full-time but believe they would be unlikely to find a GP who might, in the long term, be interested in overall management of the businesses.

"We explored a number of options but found that South Link was the best fit for us," Dr Vincent says.

"The price on offer was lower than the other corporate partners but there were no attached financial terms requiring us to maintain earnings into the future.

"South Link's focus was more on maintaining quality and the practice model that has served us well over the years."

Both GPs have been working from their practices for 30 years, and the long-term locum doctors have all been working with them for more than a decade.

Dr Vincent says the locums' preference was to continue the contracting arrangements rather than be practice owners. However, the arrangement with SLHS will allow them to buy into the practice in future if they wish.

The two practices are on the same block of land, but are two separate buildings and two separate business entities.

SLHS has either purchased outright or taken a shareholding in 26 practices in recent years but has amalgamated some practices and now owns a total of 17.

New Zealand Doctor
More than medicine

CASE STUDY

Nurse-owned medical practice welcome in South Canterbury

New Zealand Doctor – 4 February 2015
BUSINESS
Rachel Wattie

Two trailblazing South Canterbury nurses who have paved the way for change in the health care sector after buying out their GP boss have received unanimous support from the community.

For nurse practitioner Tania Kemp and registered nurse Chris Chamberlain, the transition to becoming owners of Pleasant Point Medical Centre, a 20-minute drive from Timaru, was easy since they were already the main face of general practice there, Mrs Kemp told *New Zealand Doctor*.

"The reason this could happen is because we had actually been in the driving seat anyway," Mrs Kemp says.

"The system worked well and the biggest thing was we knew we had the support of the community."

The medical centre's former owner, GP Anton van den Bergh, bought the practice in Pleasant Point in May last year and hired the two full-time nurses shortly after.

From the start, the two of them were the only ones present at the practice 24/7, but Dr van den Bergh was always available via telephone, and came in to run clinics once a week.

Now, the roles have reversed – Mrs Kemp and Mrs Chamberlain contract Dr van den Bergh, but their day-to-day roles are still the same.

GP Tim Malloy, owner of Northland medical practice Coast to Coast Health Care, told *New Zealand Doctor* the future of general practice lies in a collaborative model, and there's no reason why nurses shouldn't own practices.

A lot of practices are owned by corporates, who have zero clinical knowledge, and the question of ownership is "almost irrelevant", says Dr Malloy, who chairs the General Practice Leaders Forum and is president of the RNZCGP, but was commenting about this in a personal capacity only.

"From a clinical perspective, nobody works in isolation anymore," he says.

According to Mrs Kemp, the logistics of owning a medical practice are much the same for a nurse practitioner as they are for a GP.

Mrs Kemp charges patients the same fee as Dr van den Bergh did and, in her experience, patients don't expect to pay less for the consult because she is a nurse, she says.

Getting a loan from the bank was easy, because the practice was already an established business when they bought it.

"We haven't changed how it's run – we have just taken over ownership.

"Interestingly enough, the bank had no problems at all because they are my personal bank anyway."

Best Practice Advocacy Centre New Zealand guidelines are available for both nurses and doctors to subscribe to, and Mrs Kemp and Mrs Chamberlain can access this material via the IT tool HealthPathways. They use Medtech for all patient notes.

Pleasant Point is also an ACC provider, so the nurses can also tap into this funding.

The main difference between Pleasant Point and a GP-run practice, Mrs Kemp says, is that, when a patient comes in with a health problem beyond the nurses' scope of practice, they have to refer that person to either the GP, the emergency department or to see a specialist.

"There's a percentage of our client base who are always going to be over and above what I'm capable of dealing with."

Patients and test results, and any particular questions Mrs Kemp has, are discussed at weekly clinical meetings with Dr van den Bergh.

The nurses see all patients when they initially present at Pleasant Point but, if a patient insists on seeing the doctor, they can, Mrs Kemp says.

At first, some patients would ask to see Dr van den Bergh, but, once they realised Mrs Kemp could prescribe, the feedback was "very, very positive," she says.

"They have been telling us all along, 'thank goodness you are here'."

Campbell Murdoch, a GP at Palmerston's East Otago Health, has firsthand experience working in a practice that employed a nurse practitioner as one of the main health care providers, and he agrees with Dr Malloy.

"I would be very happy to work for a nurse practitioner – I don't think it's such a big deal," Dr Murdoch told *New Zealand Doctor*.

Until recently, East Otago Health just north of Dunedin had one full-time GP, one part-time GP and a nurse practitioner to care for about 2500 enrolled patients, Dr Murdoch says.

The nurse practitioner, Anne Fitzwater, retired earlier this year, much to the dismay of the community, he says.

East Otago Health is keen to hire another, but nurse practitioners are thin on the ground.

"The major issue here is the [patients'] reactions when she actually retired… The people who have seen her over the years missed her a lot – and they still do."

New Zealand Doctor
More than medicine

Before you buy

Pre-purchase considerations: look before you leap

As well as your own personal considerations, it is vital to obtain advice from legal and accounting professionals before you buy. Setting up, merging or joining a medical practice is complex and has long-term legal, financial and taxation consequences.

Due diligence before buying (or selling) a practice involves investigating all of the information associated with a transaction, including, for example, what exactly you are purchasing, why the practice is being sold and whether there are any contracts, employment agreements and arrangements that will need to be transferred.

Before deciding what type of practice ownership is right for you, some key considerations might be:	
Your career goals	Where do you want to be in 5–10 years' time? What do you consider 'success' to be?
Lifestyle	How many hours do you want to work per week? What sort of flexibility do you need?
Family and whānau considerations	How close is the practice to childcare or to school? What opportunities for employment are there in the area for your partner/spouse?
The potential business partners	How many and who are they? What about the other practice staff – are any key staff planning to leave?
Working life expectancy	How many years do you expect to be working in general practice and in this potential practice?
Business structure and income	Is there a partnership agreement? How will profit be distributed and how much will you earn? If you are buying into an existing practice, how is it currently performing? What contracts are in place already? Who will be responsible for ensuring that new contracts are drawn up and entered into, signed and set up in the PMS so that there is a smooth transition and uninterrupted supply of revenue from day one?
Desire for autonomy	What level of control do you want over the practice?
The community	How do you feel about the community you will be working with and become part of? Is there a need for your skills? Would you be retaining the existing patient base (goodwill)?
The location	Is the practice well placed for patient access? Is it highly visible? Is it well placed relative to your personal considerations? Is it well placed relative to other health services (eg pharmacy) and infrastructure (eg bus stop, parking options)? Is it co-located with other services and what are they?
The physical practice	What is the ownership/leasing arrangement? Does it need any work done (eg fresh paint)? How many staff does/can it take (eg is there a clinical area for a practice nurse, nurse practitioners or other providers)? Is there room for expansion? What sort of technology upgrades might be needed?
Working life	What is important to you in a workplace? What sort of peer support will you have?
Your competencies	What are you capable of and what do you need to develop?

Other employment options

For information about other employment options, such as contracting or being an employee, please see the College's resource for trainees **Getting a job in GPEP2 (2016)** in Appendix 1.

Picking your practice partners

When it comes to going into business with others, compatibility is as important as competence. As well as checking out the financial status and qualifications of your future business partner(s), it is also important to ensure you have similar ideas about practice working culture, professional attitudes and expectations, and long-term goals for the practice. Trust is central to any joint business venture. This applies to non-GP and/or non-practising partners as well.

> My advice to those considering a partnership is to **get legal advice** – not just about what should go in the contract but about whether or not to go into partnership at all. Go in with your eyes open and fully understand the implications of your liability. – Dr William Grove, 16 March 2016, Interview

Similar advice applies if the practice you are buying into has a governing board. Ensuring you have cohesive values and long-term aspirations will reduce the chance of having problems later on. It is worthwhile reviewing a practice's business plan and/or board minutes before making a final decision.

Major benefits of taking on practice partners are that:

- they tend to stay within a practice for longer periods (compared to employee GPs), which benefits continuity of patient care and provides stability from a business perspective
- partners have both a financial and intellectual incentive for the practice to be a success
- they may have advanced business skills
- they may have a special medical interest, meaning that the practice can provide additional medical services.

The potential negative implications of taking on practice partner are:

- having to negotiate with and/or justify significant decisions to a partner rather than being able to act autonomously (which could cause disharmony)
- disagreements about direction, services, hours or remunerations, which can all create tension, even if the actual issue is resolved.

Starting a new practice versus buying into an existing practice

Whilst it is possible to successfully start a new practice, this requires a lot more initial capital investment and work (for example, to purchase equipment). A new practice usually must attract patients away from existing practices. This can be difficult, can cause tension with local colleagues and reduces the likelihood of the practice being financially viable.

For a first-time owner, it is generally safer and more beneficial from a learning standpoint to buy or buy into an established practice. As a (co)owner, you can then modify aspects of the practice over time to reach your goals.

Buying into a practice provides greater certainty to the purchaser and their financial supporter(s) as you can see the patient numbers. This reduces that risk factor and ensures a reasonably measurable income right from the start.

FURTHER INFORMATION

Mason T, Hill J and Cosford S. **Planning partnership changes: a guide for GP partnerships**. UK: Neil Mason Associates; 2013.

CASE STUDY

College interview

Dr William Grove
PRACTICE OWNER, RIVERTON MEDICAL CENTRE

As a rural GP, I have been 'swimming against the tide' of practice ownership transferring to rural community trusts.

I understand that other practices in my area have had relatively high turnover rates. This could be attributed in part to their trust-ownership models in general, which, while well intentioned and philanthropic, does not promote particularly successful business models. In these circumstances, the practice manager largely runs the business, and the doctors are essentially employees.

Comparatively, I now own my own practice and employ an assistant, receptionist and practice manager, although I didn't start as a sole practice owner.

Partnership with a trust owning the buildings

I started work in Riverton, Western Southland, in December 1998.

A community trust was formed and came into being at the same time that I replaced my predecessor. With 13 years in practice in Riverton, he was the longest-standing GP in the region since Dr Trotter in 1912. The Riverton Community Medical Trust purchased the premises at the same time that I took over a 50 percent share of the business.

The model of ownership was a little unusual in that my (then) business partner and I owned the business while the Community Medical Trust owned the buildings. The rental agreement also included the contractual terms for provision of medical service (24-hour care to the community), so in many respects, I simply turned up to do the clinical work. This worked for me as, at the time, I was relatively new to general practice and focusing on clinical work.

My practice partner was quite experienced and did the majority of the bookkeeping and so forth. Back then, it was pretty simple, and there wasn't so much compliance so a practice manager wasn't necessary.

Sole practitioner with a trust owning the building

In 2001, when my partner left suddenly for Australia, I gave the stock on shelves and various assets to the Trust. At that time I felt very uncertain about the future, and divesting myself of any physical interest in the business allowed me to feel less 'trapped' and resulted in me staying on.

Selling the stock to the Trust relieved the fear, but it did mean that, every time the practice needed even minor fixes, like a new printer, the Trust had to be asked. This didn't really suit either of us as the Trust is volunteer based, and some Trust members were quite elderly.

My advice to those considering a partnership is to get legal advice – not just about the contract, but about whether or not to go into partnership at all. Go in with your eyes open and fully understand the implications of your liability.

In 2008, my wife and I moved back to the UK (where I had trained) for six months, and at that time, I employed a practice manager (I had done all the management myself up until that time) and a locum.

What it has been like being a practice owner

On my return to Riverton, I wanted to expand my interest in minor surgery, and the premises were not really fit for purpose as it stood, let alone for increased minor surgical volumes. Practice ownership definitely fosters personal interests and allowed me to do this.

In 2011–12, with the full support of the Community Medical Trust, I built a new medical centre, and in December 2012, we moved into the new building and the rental agreement with the Trust was terminated. The trustees figured my mortgage would keep me around!

I now own my own modern practice and employ a full-time assistant and a part-time practice manager. As the owner, I have total control over the organisation of my time. For example, I used to drop off my child early at 7.30am for school and wait to start work at the surgery at 9am. After speaking with the receptionist, who didn't mind, I simply

changed the hours of the surgery to open at 8am instead to suit me!

When I want a new piece of surgery equipment, I simply look at the books and decide whether the practice can afford it.

How do you arrange to take holidays?

Again, no trouble. I'm planning on possibly taking an extended break in the next few years. I will get in a locum or a long-term replacement who may eventually take over the practice. It's a valued practice in the town so I'm not overly worried about it.

Do you have a succession plan?

Riverton has now had a stable workforce for 17 years. My assistant has worked here for the last 14 years. We provide the backbone of the on-call system in Western Southland. I intend to continue working here until I retire.

I accept the possibility of simply having to walk away if I can't sell it. The structure (a company) with the practice manager and so on would allow the business to keep running with a locum and then an eventual replacement. Alternatively, the buildings could be leased out or sold back to the Trust, who would be keen to keep a doctor in town.

What makes a good practice owner?

I think it's partly dependent on what you're like as a person, and I suspect that if you make it through medical school in New Zealand, you are likely pretty independent. You would probably enjoy the autonomy that ownership brings and suit being the boss. I think I would now find it very difficult to be employed!

Achieving parity as an incoming partner

There are many different ways of calculating and allocating end income, so it is important that a prospective buyer understands how allocation works in a practice before buying in.

For example, in some practices, salary is based on 'tenths worked', and the dividend pay-out to partners is used to ensure final total income is proportionate to the percentage of income brought in to the practice (minus the same percentage of expenses).

Conversely, some partnerships assume that a new partner will contribute less in the first few years and therefore allocate them a lower share of the profits at the start. Over a period, the new partner in this model slowly increases their share of the business to reach parity, ie to be treated as a full partner.[5] For example:

Year 1	80% share allocated
Year 2	85% share allocated
Year 3	90% share allocated
Year 4+	100% share allocated

Finding a mentor

You may already have a mentor from your time in the GP training programme or a colleague that you typically go to when you need advice. If that person has experience as a practice owner, it is well worth asking them to assist you with your transition.

> "I would advise young GPs considering their options to seek independent advice from a practice owner or colleague they've worked with in the past." – RNZCGP National Advisory Council Member, 17 March 2016

If you don't already have a mentor, consider contacting past or current colleagues with whom you have a rapport. A second opinion is always valuable, whether you agree with the advice or not.

Finances

While the departing clinician will hold the knowledge about clinical governance, practice and management (ideally this is all documented in the practice's policies and procedures), it is likely that some business knowledge of the practice is held by a non-clinical staff member, such as the practice's manager or receptionist. Having a good discussion with this person about the practice (and developing a positive relationship with them) is another vital step to take before making any final decisions.

They may have a more contextual idea of where the practice is losing money, such as through unclaimed income streams. It may be helpful to make up a list of potential income streams and tick each one off as you identify it running through the financials.

"When buying into a practice, make sure you understand the business structure, and who holds the business knowledge. If it is the GP that is leaving, figure out how you will get this [knowledge] off them before they go."

Dr William Grove, 16 March 2016, Interview

Buying into a practice

Once you have made the decision to embark on your practice ownership adventure, you will need to arrange the finances.

When assessing your options, seek professional advice, and investigate different lenders, the Medical Assurance Society (MAS) and finance brokers, including banks. Advice will help you avoid unforeseen problems, and comparing the range of lending options will give you an understanding of base lending rates, fees and other borrowing costs.

Financing methods vary and may include:	
Self-finance	Once you've paid off your student loan, spending the 'extra' money that used to go into your loan on investing in a practice.
Equity	Providing a share of the practice to another party who then contributes capital.
Debt	External funding that you are committed to paying back over a set time, with interest.

A common model for buying into a practice in the UK is to have a portion (such as 10%) of the employee GP's income deducted from their wages resulting in the employee's stake in the practice growing each year.

Valuation of a practice

Two common methods for valuing a practice are the rule of thumb, based on price per capitated patient (goodwill), and future maintainable earnings, based on a multiplier of earnings before interest, taxation and depreciation (EBITD).

Rule of thumb:
Practice value = % gross income (goodwill) + assets

Future maintainable earnings:
Practice value (goodwill and fixed assets)= future EBITD x multiplier

MAS has developed a resource, *General medical practice valuation methods*, that outlines these methods with examples – see Appendix 2. (Note that this resource is updated regularly, so please refer to MAS for current information.)

These formulae, however, are simply a guide for calculation, and in reality, the price a seller and buyer agree to will be based on their particular needs.

FURTHER INFORMATION

A useful article, although US based, is **Negotiating your buy-in to a medical practice and practice valuation** by Mark Abruzzo, named partner in a law firm specialising in health care law.

Starting a new company

The general checklist for starting any new company is as follows:

- ☑ Get professional advice from your lawyer and accountant.
- ☑ Decide on the name and structure of your proposed company.
- ☑ Go to the **Companies Office** website and register your business:
  - List the registered directors, shareholders and address of the company.
  - The site will prompt you to register with IRD.
  - IRD will confirm your company's registration.
- ☑ Select a nominated person to act on behalf of the company and register your tax agent's details (optional).
- ☑ As soon as you have incorporated, start doing everything in the name of the company.
- ☑ Arrange insurance for your business.
- ☑ Arrange ACC coverage (as an employer).
- ☑ Undertake some business training and learn about:
  - health and safety.
  - your tax responsibilities and financial reporting requirements.
  - your new legal responsibilities.
  - your employer responsibilities.
- ☑ Develop your new company's strategy and business plan.

FURTHER INFORMATION

IRD **Tool for Business**

CASE STUDY

New GP clinic entices non-owner GPs into practice ownership

New Zealand Doctor – 2 September 2015
BUSINESS
Reynald Castaneda

Reynald Castaneda meets with GP Api Talemaitoga to talk about his new practice Cavendish Family Doctors, its ownership model and starting a practice from scratch A recently opened general practice in Manukau is encouraging GP employees from other clinics to dip their toes into practice ownership.

The idea is that six GP owners will work at Cavendish Family Doctors once a week, while still being employed at their original practices, GP Api Talemaitoga says.

"This is an opportunity for you to run your own clinic and have a say," Dr Talemaitoga tells prospective practice co-owners.

There are currently three Cavendish Family Doctors GP owners – Dr Talemaitoga, Siro Fuata'i and Nua Tupai – who are in talks with three other GPs.

Potential practice GP co-owners would ideally be employees in a practice in a completely different area, to avoid burning bridges with their current employers.

Cavendish Family Doctors is housed in a building called Cavendish Clinic, which was initially designed to be a shopping centre.

Dr Talemaitoga says the new practice took years to develop, and followed an invitation to establish a general practice from radiologists based in the same building.

As the practice is co-located with radiology, an orthopaedic surgeon and a physiotherapist, it is envisaged it will become an urgent-care facility in the future, he says.

This is not the first time the three current practice owners have owned clinics.

Dr Fuata'i and Dr Tupai own Bader Drive Healthcare, nine minutes' drive away in Mangere. Meanwhile, in the South Island, Dr Talemaitoga is one of three GP owners of Normans Road Surgery in Christchurch.

Dr Talemaitoga, who moved to Auckland four years ago, works at his Christchurch clinic on Mondays and Tuesdays, then flies back to Auckland to work at the new practice on Wednesdays and Thursdays.

On Fridays, he spends time on his other roles, as an RNZCGP board member and the Pasifika GP Network chair, among other positions.

Dr Talemaitoga personally funds his Christchurch flights. "I try to be disciplined and book ages ahead."

Asked if this is sustainable, he says he enjoys keeping his Christchurch practice open thanks to his practice colleagues who are excellent to work with.

New Zealand Doctor asked why Dr Talemaitoga decided to become a practice owner in Auckland: "I started from scratch in Christchurch [20 years ago] and I am doing it again – some people just never learn," he laughs. "I like being busy."

Dr Talemaitoga says the practice is currently having issues looking for an experienced nurse – and the clinic owners are willing to wait.

"We've been looking for three months. We want a nurse who works independently because we are starting from scratch," he says.

"There are not enough experienced practice nurses looking for jobs… [This is because] GPs know that if you find an experienced nurse, you hang on to them."

With the new practice not having enough enrolled patients and being in competition with neighbouring cheaper VLCA practices, Dr Talemaitoga says it is looking for other ways to make the practice financially sustainable.

For example, the GPs have been in meetings with local businesses that are looking for health-check packages for their employees, he says. After these checks, relevant

patient information is sent to employers and the patient's own GP.

The practice owners' due diligence shows more than 60 percent of people who work in Manukau do not live within the area.

That said, Dr Talemaitoga hopes the practice's enrolled patient list will also grow.

The GP owners have plans to do mail drops and advertise in community papers in future, he says.

For now, the practice owners are hoping word of mouth – the 'coconut wireless' – will attract more patients.

What does practice ownership involve?

Governance vs management

Governance pertains to the chosen direction and policies of a practice. It provides leadership to the business in terms of what the aims and strategies are for being successful and how successes will be defined. Governance of a practice is provided by the practice owner(s) or on behalf of the practice owner(s), for example by a board. It ensures that a practice is effectively managed.

Clinical governance is an important element of the larger concept of governance and is a key responsibility for any GP organisation. Clinical governance reflects that a practice must be accountable for the quality of its services and safeguarding high standards of care. It involves ensuring compliance with specific legislation, together with any contractual obligations in this area.

Management pertains to the day-to-day operations and how to achieve the goals set by governance. This includes business management (finance, operations, quality and risk), human resources, IT management, compliance, facilities management, communication and liaison, PHO management and business development. It is important to note that, while a practice owner may choose to confer all management responsibility for day-to-day operations to a practice manager, the long-term strategy/vision must be crystallised by the practice owner.

Most GP practices operate as small businesses, which are governed and managed by the same principles as larger practices. Clearly, for smaller practices without a separate governing group, there will be considerable overlap between the governance and management role.

Key professional services

Just as in areas of medicine, there are different levels of knowledge and competence when it comes to legal and financial matters. While some health professionals may have the legal and financial expertise necessary to run a business, for the majority of practice owners, professional advice is the safest way to ensure that you get the best results from your investment.

Key times when professional advice is particularly valuable include starting out, assessing ownership of a patient base, filing tax returns and paying employees, complaints and liability issues, professional indemnity insurance, growing your practice and management of your practice in difficult times.

Lawyer

A lawyer who you know and trust for advice on buying, merging, joining or selling a practice, contracts, complaints, compliance, insurance and other legal and risk matters is indispensable.

FURTHER INFORMATION

Medical Council of New Zealand's **Statement on responsibilities of doctors in management and governance**, 2011.

Institute of Directors: A membership organisation that facilitates professional development of company directors through a variety of courses and resources.

bpac[nz]. **Clinical governance: a guide for primary health organisations**, 2005.

Scally G, Donaldson L. **Clinical governance and the drive for quality improvement in the new NHS in England**. BMJ 1998;317: 61–65.

If you don't already have a lawyer, the New Zealand Law Society offers a **Find a lawyer** service.

For Medical Protection Society (MPS) members, there is a **medicolegal advice service** that could also be useful.

Accountant

A common fear about practice ownership is of the personal financial risk; however, this is minimised through good practice management and by employing (or contracting) an accountant. Regular review of your practice's finances by a registered accountant will ensure that you are meeting your tax requirements as a small business and are advised of areas where there is excessive expenditure or areas of particular profit.

Whilst an accountant will be able to take care of the financial nuances and add value to your business, it is advisable that you get a handle on the basics. A helpful site for general business ownership advice is the Ministry of Business, Innovation and Employment's (MBIE's) **business.govt.nz** website.

A good accountant can make all the difference for your practice in terms of its profitability and sustainability. This is one reason why it is recommended that you employ a chartered accountant (CA) who has undertaken at least seven years of training to achieve the CA qualification, will complete mandatory professional development training, is bound by professional standards and a code of ethics and is regulated by Chartered Accountants Australia and New Zealand.

A bookkeeper, while valuable, is **not** a substitute for an accountant.

Business advisor

Another key professional you may wish to consider employing or consulting is a business advisor, who can identify issues and inefficiencies and new or underutilised funding streams, develop a business plan and help you implement that plan.

Business advisory services are often offered through banks, accounting firms (for example, **BDO**) and medical insurance companies (for example, **MAS HealthyPractice®**).

Utilising the expertise of a business advisor is particularly advisable when considering and choosing a business structure for your practice.

Practice manager

Larger practices, surgeries and health centres are increasingly employing practice managers to run the business side, including managing staff and budgets, developing a business strategy and generally improving the efficiency and smooth running of day-to-day business.

Practice management has become a specialty area of management, often done by managers, receptionists and administrators who have completed specific training. Management can be considered in tiers: operational, tactical and strategic.[6] The relationship between a practice manager and practice owner and the experience of both determine at what level of decision making a practice manager operates.

There are challenges to practice management that are unique to the health industry, such as the complexity of funding streams, tensions between public

"Get good legal and accounting advice in the planning stages of going into general practice, no matter the model you intend to work under. Ignore this rule at the peril of always being in catch-up mode."

– Doug Baird, 2005[2]

funding and private enterprise, compliance and government influence. The Practice Managers and Administrators Association of New Zealand (PMAANZ) has developed an educational pathway in conjunction with the New Zealand Institute of Management (NZIM) specifically for this purpose. **PMAANZ** also holds an annual conference for professional development, networking and collegiality. The membership website offers other areas of professional development, networking and support.

Practice managers in this pathway move through a Knowledge and Skills Framework (KASF)** consisting of Bronze, Silver and Gold levels. Practice managers may also complete an NZIM Certificate or Diploma in Practice Management (Health). Training covers business management while incorporating learning about the health industry and its economics. For example, a practice manager with Gold KASF will have an in-depth knowledge and understanding of:

- management (including management of emergency procedures, IT, leadership, change, strategic planning, risk and property)
- office management
- finance
- pactice management systems (for example, policy for security of electronic patient data)
- compliance (such as GP legal and risks, health legislation, economics, health and safety)
- human resources
- continuous quality improvement (for example, non-clinical Foundation Standard and CORNERSTONE® requirements, QI plan, achieving practice compliance and Ministry of Health targets).

Quality improvement and compliance

Legal and quality standards are put in place to ensure the safety of patients, health practitioners and non-clinical staff. As a practice owner, you take on additional responsibility in this realm; however, everyone in the practice has a part to play in ensuring standards are upheld.

There are two programmes available to help ensure general practices meet legal and quality improvement requirements: the Foundation Standard and *Aiming for Excellence* (met through the CORNERSTONE® accreditation programme).

The Foundation Standard (mandatory requirement) is distinctive from the *Aiming for Excellence* standard (optional) in that its focus is on quality assurance. Comparatively, *Aiming for Excellence* extends a practice through the attainment of advanced and aspirational standards that focus on quality improvement. Practices that are CORNERSTONE® accredited with *Aiming for Excellence* are deemed to have met the requirements of the Foundation Standard.

These programmes are kept up to date by the College to ensure that you are meeting the requirements of current legislation and best practice for quality improvement.

** Developed by ProCare and endorsed and distributed by PMAANZ. More information about practice management education is available on the **PMAANZ website**.

Key legislation

Some key legislation that you should be aware of as a practice owner (over and above being a health practitioner) include:

- Code of Health and Disability Services Consumers' Rights 1996
- Health Information Privacy Code 1994
- Health (Retention of Health Information) Regulations 1996
- Health Practitioners Competence Assurance Act 2003
- Health and Safety at Work Act 2015
- Health Act 1956
- Vulnerable Children Act 2014
- Holidays Act 2003.

Training programme involvement

As a practice owner, you have the opportunity to decide how involved you want your practice to be in the development of the next generation of GPs. GP teachers shape future colleagues who have the potential to become partners in business ownership. This is vital to the sustainability of the workforce as a whole.

Becoming a teaching practice benefits the greater good but can also offer many personal benefits including:

- inspiring your own lifelong learning
- keeping you in touch with new developments and providing alternative viewpoints (particularly relevant for rural practice)
- encouraging reflective practice and possibly improving practice efficiency
- improving job satisfaction
- potential financial benefit
- satisfaction through sharing what you love doing with an enthusiastic listener
- adding to your teaching skills through teacher training
- increasing the likelihood that a trainee will return to your practice as a locum, employee or potential co-owner (particularly relevant for rural practice)
- improving practice status in the eyes of patients.

Considerations: General Practice Education Programme Year 1 (GPEP1) teaching practices must be CORNERSTONE® accredited (or working towards accreditation).[††] You can find out how to become a teaching practice and what it involves on the **College website**.

[††] There is currently an exception to this requirement for some practices in the Midlands region, which is undergoing a transition from its own set of Core Standards (as at May 2016).

FURTHER INFORMATION

For more information about the Foundation Standard or *Aiming for Excellence*, go to the **RNZCGP** website.

The Ministry of Business Innovation and Employment has a tool, **Compliance Matters**, with filters for industry and business structure that aims to help business owners 'manage key business requirements'.

CASE STUDY

Business ownership – plain sailing or navigating rough seas?

New Zealand Doctor – 13 April 2016
BUSINESS
Fiona Mines

Dear Aunt Masie,

I am considering buying a solo practice but would like some advice about things I need to be aware of before taking the leap into becoming a business owner and employer. Could you please outline the key things I need to know?

Going Solo, Taranaki

As a business owner, you can expect a financial return on your investment, both by way of annual profits and by building a valuable asset. You may also enjoy other benefits that go with running a business, but it is probably not going to be all plain sailing.

General practice is complex, and accessing funding through PHOs, ACC and other government agencies requires good business and clinical processes, and systems that will meet their ongoing audit requirements.

In the near future, you will need to meet the Foundation Standard that covers both clinical and non-clinical criteria, and there is also a range of legislative requirements to meet as a business owner and employer – smaller practices will find it more difficult to meet these increasing compliance requirements.

As a business owner, you need to be aware of the following business legislation:

Health and Safety at Work Act – new legislation coming into effect this month imposing additional responsibilities on business owners, directors and people who influence the decisions of a business.

The Employment Relations Act 2000 covers all aspects of employment law. You will need to follow compliant employment processes as a minimum, but, as a solo GP, you will rely heavily on having a high quality and productive team to be successful – delivering outstanding service relies on great leadership and teamwork. On the flip side, dealing with poor performance or disciplinary matters can have a huge impact on any small business and you need to know your employer obligations of fair process in this area.

The Holidays Act 2003 – sets out the regulation with regard to holidays and leave; this includes public holidays and parental leave. Compliance with this legislation can be tricky, and we have recently seen government agencies getting their staff holiday pay calculations wrong.

The Wages Protection Act 1983 and **Minimum Wage Act 1983**.

The Vulnerable Children Act 2014 – the requirement to safety-check core workers initially, with gradual implementation to cover all workers by 2019.

The Privacy Act 2003 and **Health Information Privacy Code 1994**.

As a professional, you will need to be fully aware of the requirements of the Health Practitioners Competence Assurance Act (HPCA Act), which requires practitioners to work within their relevant scope of practice. Under this legislation, there is a requirement to monitor the registration and scope of practice of any health practitioner who works in your practice as well as to investigate any competence issues and report them to the relevant regulatory body.

Unfortunately, this is by no means an all-encompassing list of the legislation you will need to be familiar with (we haven't even touched yet on tax law and its requirements), but with knowledge in these areas, and in combination with good business support, you will, hopefully, be able to enjoy the full benefits of business ownership.

Fiona Mines is the HealthyPractice Adviser, MAS. MAS staff are happy to answer any questions you have on workplace health and safety or other practice dilemmas. Email your questions to **business@mas.co.nz** .

New Zealand Doctor
More than medicine

Good business

There are a multitude of methods for strategic business planning and development that you can consider. These are the steps you will need to take in one form or other:

1. **Practice assessment:** You have to know where you are to know where you are going.
2. **Strategic planning:** Based on your practice assessment and a broader analysis of where you are at, decide at the highest level where you want your practice to be in 10 years' time. This sets the vision and broad goals for your practice.
3. **Business planning:** This lays out the actions your practice needs to take at an operational level over the next three to five years to achieve your strategic goals.

Throughout your strategic business planning and development process, consider the needs of your patients, health disparities that exist in your community and how you might incorporate the principles of the Treaty of Waitangi to address inequity.

The College, in its **Position Statement on Equity**, encourages all GPs to assess their own practices to ensure treatment and management decisions contribute to improving health equity for individuals and communities.

Step 1: Practice assessment

Before developing a business plan, you must first understand the current state of the practice, including its patient service, fees, overheads, staffing and remuneration, operational efficiency, technologies used, patient lists (daily volumes) and financial systems. Your practice may have done much of this assessment as part of the Foundation Standard or CORNERSTONE® accreditation process.

A practice assessment can be done by an external consultant, for example, a business advisor, or internally, for example, by your practice manager. The assessment may be directed by your vision for the practice rather than extensively covering every aspect of the daily operations. For example, if you want to be a first-class training site, your practice assessment may focus on achieving CORNERSTONE® accreditation and training for staff who will act as mentors and teachers. Segmenting your practice assessment also helps break down the workload, which can be time consuming, and any actions that come out of the assessment may be easier to implement in an incremental manner.

Some methods for practice assessment include (most likely a combination of):

- observation, for example, of office operations
- interviews (with staff, patients and external health care providers and community partners)

"The College supports health services being better integrated with other community services, such as Whānau Ora, as a means of addressing inequities for at-risk families. GPs are encouraged to make links with integrated services, including Whānau Ora providers, and contribute where appropriate."

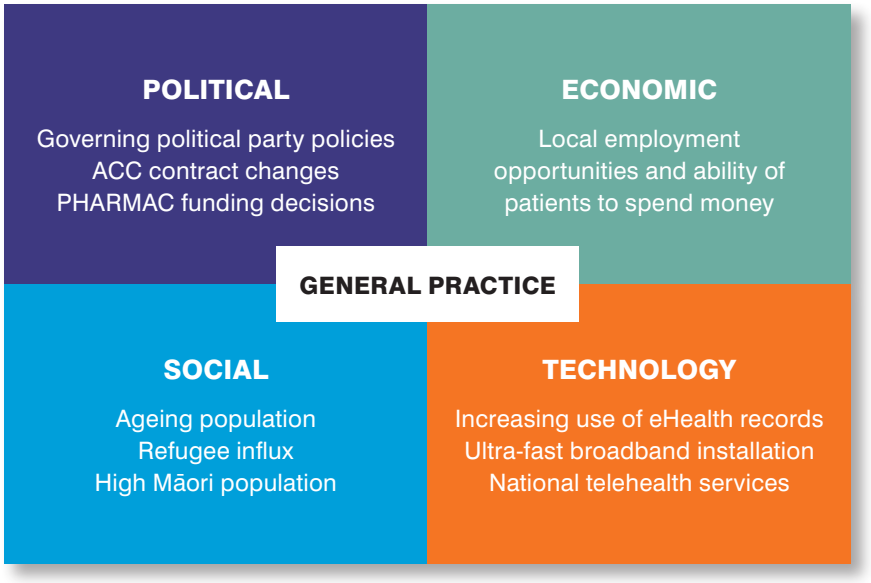
– RNZCGP Position Statement on Equity, 2012

- practice document collection and review, eg policies, forms, information sheets, business plans, staff contracts and protocol sheets
- visualisation of practice structure, for example, an organisational chart with roles and connections to external organisation
- surveys, for example:
  - staff rating scale for various aspects of the practice environment
  - patient satisfaction survey
- clinical audits
- benchmarking analysis, ie comparison between practice and best practice benchmark.

Once you have assessed where your practice is at, you can see which areas need improvement or to be changed. A strategic/business development plan will enable you to then address the areas of concern and, in the long term, allow you to achieve the vision you have for your practice.

Practice assessment in an industrial context

Practice assessment should also include an analysis of the wider influences on your practice – the macro-environment. A common assessment model is **PEST**, which covers political, economic, social and technological factors. Some examples of what this analysis might consider are given below:



Step 2: Strategic planning

While good practice management goes a long way towards a successful business, it will not compensate for a flawed business model or a lack of direction. Strategy is generally set by those in governance roles (such as the owner or the board) with input from the operational manager.

The word 'strategy' is sometimes used loosely and synonymously with planning. However the aspect of a plan that makes it strategic is the analysis of the wider environment and the crafting of the plan to best suit that environment and achieve your goals. It takes into account the current position of the practice, its clinical resources (nurse, GP and other health professional hours) and the local situation. Strategic planning also considers how your practice fits (or could fit) into the wider sector in terms of services offered and relationships with other entities.

The creative aspect to strategic planning is exploring where your practice could go in future based on where it is now. Once you have pulled together all of the information about your practice and the general practice environment, it becomes possible to identify patterns and see the possible directions.

Practice ownership provides an avenue through which to channel your particular passion, whether that be environmental sustainability, hauora Māori, Pacific health or a special interest such as minor surgery. Alternatively, you could analyse the health needs of your patient list to ascertain any gaps in the services provided. For example, if you have a population with high obesity rates, could you offer a nutrition and fitness programme and/or weight loss clinic? As a practice owner with direct or indirect involvement in governance, you have the ability to shape the overarching goals of your practice.

Strategic planning will help you achieve your business and patient outcome goals while covering costs and providing additional income. **It is the combination of analysis and creative thinking.**

Strategy toolbox

Some popular tools for strategic analysis and planning are:	
SWOT analysis	Identifying the practice's internal and external strengths, weaknesses, opportunities, and threats.
Market segmentation	Dividing your patient base into segments (for example, young families, older people and travellers) and using the **4Ps marketing mix** to target them.
Mind mapping	A similar process to brainstorming in which facts and ideas are mapped to a central idea or goal.

As a result of strategic planning, your practice should have a clear vision or mission statement, values and three to five key areas of focus. Ideally, this strategic plan will be well known and understood by staff.

FURTHER INFORMATION

Textbook: Kotler, P. Marketing. 9th edition. Pearson Education; 2012.

Strategic planning… is the combination of analysis and creative thinking.

CASE STUDY

New integrated health facility for Akaroa one small step closer

New Zealand Doctor – 25 May 2016
BUSINESS
Liane Topham-Kindley

After years of planning, talking and negotiations, Canterbury DHB has signalled it is serious about getting a new integrated health facility for Akaroa under way, inviting tenders for the building's design.

The original plans of a $7.5 million community-owned and operated integrated family health centre (*New Zealand Doctor*, 18 December 2014) have changed and the ownership model for a less grand facility is still being worked through, though the DHB has asked the local community to contribute funds to the cost of the development.

Canterbury DHB chief executive David Meates says that to enable the facility to include beds for aged residential care, a substantial one-off $2.5 million contribution from the community will be needed.

The Akaroa community has previously agreed with a proposal that a community-owned company, Akaroa Health Hub Ltd, will be the provider of the services in the new facility, Mr Meates says.

Spokesperson for the Akaroa Health Hub structure group, Joanna Goven, says the community is pleased the DHB is calling for tenders for the facility's design.

"We are relieved, because we finally have a commitment to action – we are relieved and very pleased," Ms Goven says.

The community is also committed to fundraising for the project. The original plans included a $2.87 million contribution from the community, but this has been reduced.

The DHB has committed to construction getting under way by November with a projected completion date later next year. The former Akaroa Hospital was demolished last year, and the new facility will be built on the hospital grounds.

It is welcome news for Akaroa GP Suzanne Knapp who has been working in temporary premises in the hospital grounds, since the hospital was damaged in the September 2010 earthquake (*New Zealand Doctor*, 6 September 2010).

"It's the first concrete sign that something is happening," Dr Knapp says.

"We certainly have had our fair share of highs and lows."

Originally, it was planned that Ngai Tahu Property would invest $5.75 million in the facility, with a community trust owning the land and buildings. However, last year, the company withdrew from the project, not prepared to comment publicly as to why (*New Zealand Doctor*, 11 November 2015). *New Zealand Doctor* understands there were difficulties with all three groups working together and issues around transferring ownership of the land, and governance and ownership of the facility.

Canterbury DHB ended up taking over management of the project and has planned a cheaper $4.5 million facility. It will house the medical centre and other community services as well as eight aged-residential care beds and four general practice beds for inpatients.

Work is being undertaken with the existing Akaroa health service providers including the general practice, resthome, hospital nurses, physiotherapy and pharmacy to integrate the services and design the model of service delivery.

Details of financing and ownership are still being worked through, but Mr Meates says, in a media release, that sufficient time will be provided for the community fundraising targets to be reached.

Because of the uncertainty around the project, Ms Goven says there have not been major fundraising projects to date. However, about $500,000 has been raised, and the community group will now plan for events in the future.

Although negotiations are still under way, it is likely that ownership of the general practice will be taken over from Dr Knapp by a business entity of the community trust.

Mr Meates says reaching the milestone of inviting tenders for design is a huge achievement.

"Especially in light of the unique complexities of this process and the other priorities competing for health resources in our post-quake Canterbury environment.

"Our positive engagement with the community to date gives me great confidence that this partnership approach is the best way forward."

Step 3: Business planning and development

Business planning is the operationalisation of your strategic plan.

Regardless of the ownership structure, developing and implementing a strategic and business plan for a practice is a key component to achieving both financial and non-financial goals. There are many business plan templates available online, for example, **Business NZ**, **Bplans**.

The essence of a business plan is to ensure that when you are working in a 'business as usual' fashion, you are also working towards your goals, whatever they may be. A plan will answer these key questions:

- Where do you want to go? (Objectives based on your strategic vision.)
- How are you going to get there? (Strategy actions at an operational level.)
- How much is it going to cost and what are the risks?

If you have bought into an established practice, it is likely that a business plan already exists, and you will have (or should have) reviewed this before investing.

Top tip: Business plans should not just be done once, then sit on a shelf until next year – they are a management tool that allows the practice's governing board/person to assess progress on a regular basis. It is also recommended that aspects of the plan be shared with your whole team to create a sense of purpose and teamwork for your business.

A business plan should outline your goals (direction setting) and objectives (achievable steps in the direction of the goals). One common system to developing good goals for your business, or for anything, is the SMART system developed by Blanchard, Zigarmi and Zigarmi.[7]

A SMART goal has the following qualities:
Specific
Measurable
Achievable
Relevant (or realistic)
Trackable (or timed)

Services offered

The combination of services offered by your practice affects the attractiveness of your practice to patients and the connectedness of your practice to other providers and the community, as well as the practice's funding streams.

Service provision should be decided at a strategic level factoring in your community's needs and wants and the practice vision. Obviously, capability and capacity are clear deciding factors in what services your practice offers. You may choose to invest in upskilling staff (or yourself) to enable your practice to offer a particular service.

For example, if you are in a sunny, holiday location, skin cancer services might be valued by the community. Similarly there may be some services that the DHB might want to see delivered in the community and that your practice could provide. Some services that you choose or want to provide may not be funded, in which case, you will have to consider a cost-recovery charging regime. This may make such a service less attractive to you and your clients.

FURTHER INFORMATION

Bplans; 2016. Park Square Family Medicine: **Family Medicine Clinic Business Plan** (example plan).

"A good practice provides access to a wide range of health care services to help address local health needs and inequalities."

– RCGP. It's your practice: general practice explained. Royal College of General Practitioners; 2011.

If your practice is rural, it could become part of the **PRIME (Primary Response in Medical Emergencies)** scheme, which aims to ensure high-quality access to pre-hospital emergency treatment in areas where there is a shortage of advanced life-saving paramedics.

As with any major business decision, it is prudent to check with your lawyer and/or business advisor to make sure a new service is legitimate. For example, authorised and delegated prescribers, including doctors, cannot hold an interest in a pharmacy due to the clear conflict of interest (Medicines Act 1981, s42C)[‡‡] and some services may alter your insurance cover (for example, allied health), so be sure to attain legal/insurer advice.

> "Rural New Zealand has characteristics and challenges that influence what health services are needed and how they are delivered. These include large distances and geographical features that affect the ease of access to health services. Small, isolated populations and higher levels of deprivation, which are closely associated with poor health status, are a feature of some rural regions and also in otherwise more affluent rural communities. Service delivery in rural areas must focus on providing comprehensive primary health care for rural communities."
>
> – RNZCGP; **Rural general practice in 2015**

Implementing your plan

All the planning in the world will not make up for poor implementation. To ensure that planned actions are put in place and completed, it is advisable to have and clearly communicate some form of implementation schedule that lists:

- what needs to be done
- who is responsible for its completion
- when it should be started and finished (considering other time constraints)
- how it will be achieved – the resources required (including staff time, finance, people, equipment, space and so on).

Some businesses prefer to create an action plan in the form of a table, while others may prefer tools such as a **Gantt chart**. Most likely, your practice manager will set up and monitor your implementation plan.

Tips for implementation:

- As in any business, you need to articulate your goals and vision so that you have staff buy-in. Effective communication of the plan and answering any staff queries about it will increase the likelihood of everyone getting behind it and following through.
- Ensure that staff have the skills necessary to complete actions.
- Monitoring the action plan and the practice's achievements, followed by evaluation of the plan's outcomes, are important to provide quality feedback to staff, to ensure that resources are being used effectively and to develop information for future planning sessions.

FURTHER INFORMATION

Hint Health; 2015. **How to decide what services to offer your direct care patients**. Online article.

[‡‡] The New Zealand Government is working on a new regime to regulate therapeutic products in New Zealand, which is intended to replace the Medicines Act 1981 and its regulations.

CASE STUDY

'Mother ship' takes first step in expansion on the Hibiscus Coast

New Zealand Doctor – 11 November 2015
BUSINESS
Ruth Brown

Silverdale Medical Centre, north of Auckland, is planning to open an offshoot centre nearby at Millwater Central, a new business development which has space for about 30 shops and services.

Currently in the process of getting council consents, the owners hope to open within the first six months of next year.

Silverdale Medical, which has 13,000 patients on its books, was established about three years ago when Red Beach Family Medical Practice and Silverdale Medical Centre integrated (*New Zealand Doctor*, 13 February 2013).

Practice manager Dale Te Iwimate says the new centre in Millwater will start with one GP, one nurse, a health care assistant and a receptionist. She hopes to have 1000 enrolments there within the first six months.

The area itself is expanding, with major new housing developments under way as well as the new shopping complex.

Ms Te Iwimate says Silverdale Medical will also look at other spots on the Hibiscus Coast where they can establish satellite centres.

These centres would focus solely on GP services with other, more specialist services offered at the large 'mother ship' premises on Polarity Rise in Silverdale, she says.

A development in Highgate in the next three to five years might be the place for the first such satellite, she says.

After that, it could simply be a matter of following where development is occurring.

Patients say they want small, intimate practices where they can develop a one-on-one relationship with their GP, she says.

Using the Polarity Rise premises as the base where patients get referred for specialist services such as skin cancer care, vasectomies and ultrasounds, the partners hope patients will get the best of both worlds, she says.

Also, in theory, patients will be enrolled to attend any of the affiliated clinics, but in practice, it is likely they will mainly go to their own local clinic.

Ms Te Iwimate says all GPs at the satellite centres will undertake some sessions at Polarity Rise to ensure they have support, education and professional development.

The new development follows a change in ownership for Silverdale Medical earlier this year (*New Zealand Doctor*, 24 June).

Silverdale was the first practice to partner with Southern Cross Primary Care. Back in 2011, the practice's owners sold a 20 percent stake in the partnership to Southern Cross with the idea that, over time, the partnership would likely become 50/50.

Another five practices joined Southern Cross' ranks, but earlier this year, Southern Cross confirmed it was selling back shares in almost all of the practices it part-owned. Silverdale Medical was one of the practices which exited the partnership.

At the time, Southern Cross Primary Care general manager Tracey Barron said the company was no longer pursuing an investment model.

Working towards your business plan

Financial reporting and management

CAUTION: Decisions relating to financial management are extremely important, so it is essential to seek advice from an accountant or financial advisor.

Understanding budgets and financial reports is vital to being able to critique expenditure and make strategic decisions (as well as being a generally useful tool in life). **Business.govt.nz** provides an introduction to finance and some useful business tools on its website.

Regular financial reports can be generated by accounting software packages (such as Xero and MYOB) and allow you to monitor how your practice is tracking to budget and your cash flow and enable to you make adjustments throughout the year.

Ways to ensure good financial management in general practice[8]

- Having consistent, accurate bookkeeping:
  - Preparing regular financial reports.
  - Monthly statement of financial performance (income statement).
- Annual statement of financial position (balance sheet).
- Performing a simple financial analysis.
- Reconciling bank statements monthly.
- Preparing a budget annually and comparing it to actual monthly (or quarterly) reports.
- Reviewing fee calculations annually to ensure adequate remuneration.
- Regular, effective communication between practice manager and business owner.

Glossary of key financial terms: Free online glossaries, such as that provided by the **Companies Office** or **Learn Accounting Free**, supply helpful definitions for accounting terms.

Insurance

While you will already have personal medical indemnity protection (for example, with Medicus), it is important that your practice is also covered. Insurance is essential to risk management as it transfers the risk to the insurer. You can do this by becoming a member of a discretionary fund (such as MPS) or by purchasing an insurance contract.

Ask your insurance provider (for example, MAS) for advice on the various insurance types that relate to practice ownership, such as:

- business risk insurance (rooms, contents and business interruption)
- employment-related protection (disputes, damages, costs and employee dishonesty)
- liability insurance (legal, statutory and employer's liability)
- income security and key person insurance (to protect the partners and key employees should they die or suffer a significant disability), which is essential for small practices.

Liability – what is it?

- **Unlimited liability:** The liable person (ie the owner) is personally responsible for all debts, putting their personal assets at risk.
- **Limited liability:** Shareholders' liability for losses is limited to their share of ownership of the company (except when company directors have given personal guarantees for company debts or where a company has been trading while insolvent or is considered to be trading recklessly). This is most commonly used in companies and trusts.
- **Joint and several liability:** Often used in partnerships where a partner can end up paying not only their share of the business's debts but also their partners' (if all other partners are insolvent or unaccounted for).

Taxation

The tax rate that applies to your practice's income (and your income) will depend on the ownership structure. Your responsibilities in ensuring taxes are paid may also vary according to your role in the company.

For example, as an employer, you (or the company) may need to file a personal tax return according to your income and the ACC earners' levy, tax on a bonus or lump sum payment and/or company tax according to profit. Alternatively/additionally, you may be eligible for an independent earner tax credit.

Professional advice from your accountant (or from IRD) on how much tax should be paid, and who should be paying it, is paramount. The IRD **Tool for Business** pages have information on tax responsibilities for different business structures:

Marketing

Part of owning a successful business is good marketing. This is a much broader concept than advertising and in its true sense covers every aspect of your business. The American Marketing Association (AMA) defines marketing as "the activity, set of institutions, and processes for creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society at large". It is likely that your practice manager will handle the day-to-day marketing of your practice.

The input required for an existing practice may be fairly minimal; however, you might want to consider engaging specifically in the marketing of your business if you:

- want or need to increase the size of your enrolled patient list
- want to differentiate your practice from a nearby practice

- want to charge more for services
- are offering a new service or want to promote a particular underused service
- are making changes to your practice that might affect your patients.

A fundamental rule of marketing is to know your market, which for GP practices means knowing your local demographics[§§] and who (at an epidemiological level) is on your patient list. Once you have done your market research, you can develop a marketing plan.

There are many marketing plan templates that can be adapted and screeds of advice available online.

Example: Mplans provides a great sample marketing plan for a dental office, The Tooth Fairy, that could easily be adapted to medicine.

A very simple system for thinking about or planning marketing is using what are commonly referred to as the four Ps (or 4Ps) of the marketing mix:

The four Ps of the marketing mix	
Product (or service)	What services can your practice offer to ensure your patients are receiving the best and most comprehensive care? For example, you or one of your partners may be qualified to offer sports medicine appointments.
Place	Is your practice physically located in a good place for patients, such as near a bus stop, near a pharmacy, easily visible and/or on the main road of your suburb or town? Place might also refer to whether you have a virtual address (website) that makes it easy for patients to find information they need about your practice.
Price	When setting prices for your prescriptions, appointments and services, you will need to consider the various government schemes that you decide/are eligible to become part of (such as VLCA, free under-13 visits). Having a good accountant and practice manager will make all the difference in terms of ensuring your practice sets its prices well and is financially viable.
Promotion	Promotion covers the advertising aspect of marketing and should be an investment, not an expense. Promotional activities should always have a specific communication in mind for a particular audience. Knowing the goal of your promotion will change which media you may want to use (local newspaper, your website, email, billboard, golf-club notice board) and how the message is phrased.

The Commerce Commission has developed a useful series of **fact sheets** to help health practitioners work within competition and consumer laws, including one on price setting and one on promoting your services. They note that, "In an environment where collegiality and collaboration is encouraged, you may need to stop and think about who your competitors are and whether you are at risk of breaching the Commerce Act."

FURTHER INFORMATION

The Medical Council of New Zealand's **Statement on Advertising**.

[§§] You can find out more about who lives in your area using Statistics New Zealand's **Business Toolbox**.

Practice management

As a practice owner, your time will be split between clinical work and the strategic, administrative side of running a practice (the proportions of this split depend on how you delegate tasks and who you employ). The more efficiently the administrative side is run, the more time you can spend with patients, utilising your clinical skills.

Office management covers internal policies and procedures, payroll, cash flow, general administration and all other non-clinical aspects of a GP practice. Many of these tasks involve skills that aren't taught through a medical degree. While some GPs have natural or learned business acumen, for many, the most effective way to ensure your practice is run efficiently and effectively is to employ a good practice manager.

Policies and documentation

As with any business, documentation of key processes and policies for common or challenging issues help ensure consistency of practice, are sometimes part of accreditation processes and help reduce vulnerabilities in your practice.

Services exist that aid the administration aspect of policy and procedure documentation set-up. For example, **GPDocs** and **HealthyPractice®** have many policy documents that can be customised by practices, as well as employment agreements, contracts for service templates and so forth. Alternatively, PHOs or other GP practices interested in working collaboratively may be able to share their policies and processes, which can then be tailored to your practice.

The *Aiming for Excellence* guidelines identify key policies that your practice should aspire to have in place, such as (but not limited to):

- how patient complaints will be managed in line with the Code of Health and Disability Services Consumers' Rights (the Code of Rights)
- privacy to ensure security of electronic health information
- health and safety to minimise risks to staff and patient wellbeing
- patient results tracking
- repeat prescribing
- incident management
- employment.

Patient debt policy

You will need a robust set of procedures around managing patient debt that is clearly communicated to all staff and patients. HealthyPractice® advocates prompt action, and debt collection agencies also encourage you to have terms of trade that include payment within 14 days.

The policy should determine the debt limit and what will be done if it is exceeded by a patient. Having a clear procedure in place before difficult situations arise is conducive to fair decision making.

Practice environment

Please refer to the ***Aiming for Excellence*** guidelines for information and standards regarding the practice environment.

A well-designed practice will enable good patient and staff flow, provide all staff (and predicted future staff) with appropriate work space, have sufficient storage and create a comfortable environment for patients. Having a strategic direction for your clinic will help ensure that your practice does not outgrow its space.

Consideration and good management of energy-efficient lighting, insulation, and heating/cooling systems can not only produce a more comfortable work environment but also reduce the overheads for your practice.

Some spaces to consider:

- **Waiting room:** An approximate guide is that there should be enough space for around six chairs per practitioner. Ideally, your practice environment will reflect your patient demographics as well, for example, having toys in the waiting room or having multicultural art or photos on the walls to create a welcoming atmosphere.
- **Consultation rooms:** As well as the usual room for an examination couch/bed, hand basin, patient chairs, desk and so forth, a window is recommended for natural light.
- **Nurse workstations and consultation rooms:** As the role of nurses expands, it is important to include clinical, storage, procedural/treatment and sterilisation spaces for nurses. A toilet near this room can be helpful too.
- **Non-clinical workspaces:** Administrative staff, including a practice manager, require their own space as well.
- **Reception desk and area:** This should be clear on arrival, provide privacy for patients discussing their financial and health needs and ideally have a view of the whole waiting room and entrance way.
- **Parking:** Both for staff and patients.

Practice furnishings and equipment

If you are starting a new practice or plan to upgrade or refresh your new practice, consider making sustainable choices. You can find out more about this in the College resource **Greening general practice: a toolkit for sustainable practice**. Some furniture your practice is likely to need includes:

- ergonomic office chairs
- patient chairs (consulting rooms and waiting room)
- (adjustable) examination couches
- lockable storage (equipment, supplies, medicines)
- refrigerator (for medicines)
- treatment carts/cabinets
- lockable filing cabinets
- staff tables and chairs
- staff kitchen appliances

- office equipment: facsimile (fax) machine, printers, copiers, scanners
- computers and software
- telephone (and possibly videoconference) system
- stationery (including personalised and practice-branded stationery, such as appointment cards, brochures and prescription paper).

Common clinical equipment

For a list of the essential and advised medical equipment that you or your practice should own, see the **Foundation Standard Interpretation Guide**, p63: Appendix 1: Medical equipment register.

Community engagement

A key component of the **Triple Aim approach to health care** is to identify the patient experience and patient outcomes. With any business, it is important to get feedback about patient experience. This can be at an individual level, for instance, many practices survey patients and ask for feedback. It is also important that practices engage more fully with their communities. A community advisory group will be able provide the practice with advice as to how services could be improved and better meet the local needs. Regular contact with key community leaders such as local councils, school boards, volunteer groups or local iwi can help ensure the practice is well regarded and seen as part of the community and to ensure that the quality of the service is continually improved. Other ways of engaging with the community include the use of newsletters and increasingly through the use of social media such as Facebook. Practices should have a communication and community engagement plan as part of their business model.

Culture

Culture is the character and personality of your organisation. It is a culmination of the traditions, beliefs, interactions, behaviours and attitudes of your workplace and can strengthen or undermine your business development.

A great working culture can attract talent, increase engagement and retention of staff and affect your and your employees' happiness and job satisfaction and overall performance.

Various aspects affecting workplace culture that you may wish to consider include:

- good leadership (including conflict management, influencing doctors' decision making, change management and communication)
- management and smoothness of day-to-day operations
- workplace practices such as CPD allowances, performance management, wellness promotions and traditions (for example, staff birthday cakes)
- policies and philosophies
- the mix of people that you hire (personalities, cultures, skills, everyday behaviours and interaction types)
- all staff sharing a clear mission, vision and values
- the physical work environment and how it is used
- the frequency, type and manner of communications between staff within and between levels (such as board to staff).

It is recommended that you take time to find out how your staff and patients view the culture of your practice. It is all too easy to mistakenly think that all is well in this area of your business due to not seeking feedback. Consider undertaking an anonymous survey of your team or ask a trusted colleague or mentor from another practice to help you to assess your practice culture.

Bullying, sexual harassment and inappropriate behaviour

In April 2015, the Resident Doctors Association released a report on *Sexual harassment, bullying and inappropriate behaviour in the hospital workplace* based on a survey of its members.[9] While this report focused on the hospital environment, bullying can also be an issue within some general practices.[10] These types of unwanted behaviours are not restricted to a junior–senior doctor relationship and could be between any two or more colleagues.

Part of the solution to this is in the creation and maintenance of a good workplace culture that fosters open, constructive feedback and a teamwork approach. It is also helpful to have an internal complaints mechanism for all staff to ensure incidences of bullying are documented.

Service contracts

There are a number of service contracts that may be necessary for your practice, usually managed by the practice manager:

CLEANING
practice facility, windows, linen

AIR CONDITIONING
heating and cooling

BUILDING
security, automatic doors, lifts, lighting, grounds

TELEPHONE
systems, software and support

COMPUTER
IT systems, software and support, testing of back-up, printers

CLINICAL
fridge, steriliser, equipment

WASTE DISPOSAL
sharps containers

EQUIPMENT
supply, service and support

OFF-SITE STORAGE
patient health information

MEDICAL CONSUMABLES

PRINTING FACILITIES

LOCAL COUNCIL COMPLIANCE

An existing practice will most likely have all of the necessary contracts in place; however, if you are starting a new practice, you may wish to first consult with your PHO, which may be able to assist with many of these services. Your mentor and colleagues may also be able to advise on available local services.

FURTHER INFORMATION

RDA; 2015. **Workplace bullying**.

RACS; 2014. **Guidelines to bullying and harassment: recognition, avoidance, and management**.

CASE STUDY

Youth, enthusiasm and 'hot-desking' combine in new Christchurch practice

New Zealand Doctor – 11 May 2016
BUSINESS
Fiona Thomas

Four young doctors in Christchurch are looking to use their enthusiasm for innovation to set up a practice with a difference.

GPs Eric Dy (38), John Ko (29) and Ben Chang (33) as well as oncologist Brian Ko (34), who plans to become a GP while retaining an interest in onocology, are all shareholders in Wigram Health Ltd. They will open a new medical centre this year in the town centre of Wigram Skies, a new development in the city's south-west.

Currently, the group is scattered between Doctors on Riccarton, the public hospital and nearby Hornby Surgery, which the group purchased from a retiring GP last year.

When the new centre opens, Hornby Surgery will close, moving the practice over.

The new practice is to be run around the concept of 'hot-desking' where medical staff, including doctors, nurses and physios, will move from room to room, with patients able to stay in one place.

Dr Dy says the idea came from wanting to give patients access that was second to none.

"A lot of people talk about being patient centred, but we actually want to do that."

To further their easy access model, the practice will be open from 8am to 8pm Monday through Friday and some weekend hours, and will embrace IT and telehealth as much as possible.

The building will house ultrasound and mammography facilities, a radiologist, physiotherapist and a Chinese medicine practitioner as well as having a pharmacist across the road.

While recognising the size of the project they are taking on, the four doctors believe their relative youth will be important in driving it to success.

"One of the benefits of having a group that's newish to general practice is we are all excited about new technology, rather than being reluctant to adopt it," Dr Dy says.

He says they are doing nothing new, rather taking ideas they have seen elsewhere and putting them into practice in their own way.

The group met through hospital and medical school connections, and decided to take the project on together because of a shared interest in health care accessibility.

They started discussing building a new medical centre in July 2014 and, from there, brought their plans together in time to sign on for the Wigram centre in October that same year.

The building itself, which will be ready to move into on 2 June with an opening date of 4 July, is designed to serve a population of 10,000 under a traditional model, but Dr Dy says this could be more under the model they will be using.

The practice will employ six doctors and one nurse practitioner-in-training to start with, leaving room for numbers to grow.

Dr Brian Ko says when the team started, people told them how difficult it would be. The group agrees it is hard, but feels their collective determination will get them over the line.

The hardest part has been convincing people they would be working with to change their mindset about how general practice should work.

Compared with that, the building was 'easy'.

Rolleston GP Phil Schroeder has been running his new medical centre in Rolleston, just south of Christchurch, for nearly two years using the 'hot desking' model (*New Zealand Doctor*, 8 October 2014).

In his practice, two-man teams of doctors and nurses work in tandem, coming in and out of the consultation room and letting the patients stay put.

The patients love this model of care, he says, as they don't have to move around the building, saving time and anxiety.

The downside is the cost, born from the space required to allow doctors and nurses to work within a system like this.

The team from Wigram have paid Dr Schroeder's practice some visits to see how he does things, and he wishes them luck in their venture.

Since the quakes, things in Christchurch have been more collegial than competitive, he says, and the aim is to obtain the best service for patients city-wide.

Their youth will be a big advantage, Dr Schroeder says, as they will be willing to try something new, which older doctors may not.

New Zealand Doctor
More than medicine

HR and staffing

One of the benefits of being a practice owner is that you have greater control over who you work with and establishing or influencing the culture. As well as the skills and services they provide, practice staff form the first and continuing impression of your practice for patients. For example, GP practice receptionists have identified with a caring role for both the practice and patients and contribute more than simply administrative support to a practice.[11] Recruitment and retention should not be a reactive process but a proactive one that is aligned with the practice's recruitment strategy (which may be part of the business development plan).

For information about recruitment, contracts, managing misconduct and your (and your employees') rights, we recommend MBIE's **business.govt.nz website**, which has free information and tools on staff and HR. The New Zealand Medical Association (NZMA) also has a comprehensive advisory service in relation to HR and staff issues – further information about this service is available on the **NZMA website**.

Practice managers should be trained in HR and staffing matters and should be able to complete the majority of HR work. However, employment decisions and monitoring clinical staff performance will most likely come under your role, as the practice owner.

Rural practices have access to assistance in attracting and recruiting locum and permanent general practitioners and nurse practitioners through the government-funded rural recruitment and locum support service administered by the **New Zealand Rural General Practice Network's (NZRGPN's) recruitment division (NZLocums).**

Employment laws and standards

Your practice entity must meet the minimum employment rights for every employee, available on MBIE's **Employment New Zealand website**. Key legislation you should know about as a practice owner are the:

- Employment Relations Act 2000
- Holidays Act 2003
- Health and Safety at Work Act 2015
- Wages Protection Act 1983 and Minimum Wage Act 1983
- Vulnerable Children Act 2014.

MBIE also provides a full list of clauses that you should include in an employment contract as part of their **Employment Agreement Builder** tool (as well as a list of mandatory clauses). Legal advice, as always, is advisable when you are first developing or negotiating your employment contracts.

A list of workplace legislation can be found on the **Human Resources Institute of New Zealand website**.

FURTHER INFORMATION

A recommended read on the substantial changes to the Health and Safety at Work Act is an article in *On MAS* magazine: Moore S. **Health and safety: a new decade**. On MAS. 2016. p13.

RNZCGP; 2014. Policy Brief – Issue 5: **The Vulnerable Children's Act 2014: safety checks required for children's workers**.

Employees vs contractors

Employees and contractors have different rights and obligations under the employment legislation. While most practice staff are likely to be employees, it can be confusing which laws apply for locums and in some business structures.

All employees are protected by the Employment Relations Act and enjoy a range of employment benefits such as paid annual, sick and maternity leave, paid public holidays and KiwiSaver and can negotiate the terms and conditions of their contract with their employer. The employer deducts PAYE income tax on the employee's behalf through payroll.

Self-employed contractors enjoy greater flexibility in their working arrangements and, to offset the absence of reduced employee benefits (no paid annual or sick leave, paid public holidays or KiwiSaver and no or limited parental leave depending on the contract), are generally paid between 10 and 15 percent more than employee rates. Contractors have less job security, however, and are not extended protection under the Employment Relations Act.

Contractors have the option of functioning as a sole trader or through a company structure, paying GST and working out other tax liabilities. The IRD website also has information about tax obligations.

Some contracted GPs are paid a commission rate (rather than a sessional rate). This varies but is often 55 to 60 percent (average 59 percent) of the income generated from the patients they see. Established GPs and GPs working in busy practices find this arrangement quite rewarding. When working for a practice as a short-term contractor or locum, sessional rates are usually higher than when working for a practice long term.

It's very important that you understand the actual nature of employment arrangements. There are significant risks for you as well as your practice if this relationship is misplaced. Employment contracts is an area where you, as a practice owner, should get sound advice from your accountant and lawyer, as well as informing your insurer of the final arrangements.

Fixed-term employees: There must be reasonable grounds for a fixed-term offer such as a project with a set timeline or substantial leave cover (for example, six months). Fixed-term employees have the same rights as other employees except that their employment has a known end date.

Trial periods: Another key employment option is a mutually agreed trial period for a new employee of up to 90 calendar days. Find out more about this on the Employment New Zealand website.

Parental leave: Paid and unpaid parental leave benefits are available to mothers and their partners according to criteria dependent on their employment status. The Employment New Zealand website provides a summary table of parental leave and payment eligibility.

FURTHER INFORMATION

Employment New Zealand; 2012. Webpage: **Difference between self-employed contractor and employee**.

IRD; 2015. **Tool for Business**: Are you an employer?

Recruitment process

Practice managers should have been trained or had experience in recruitment and will most likely be able to manage the recruitment process. However, as an important, potentially strategic decision for the practice, this will also require input and decisions from the practice owner.

Recruitment is known to be difficult in rural and provincial areas. The NZRGPN helps to maintain the rural workforce by recruiting replacement GPs, supporting existing GPs with breaks and back-up and ensuring experienced senior GPs are available as GP mentors and supervisors. The NZRGPN does this through its government-funded **NZLocums** – a rural recruitment and rural locums support service.

The usual recruitment process is as follows:	
Job analysis	Keeping your business development strategy in mind, what competencies and skills does your practice need? This step involves the development of the job description. The MAS HealthyPractice® resource provides templates.
Attracting applicants	Word of mouth, the *New Zealand Doctor* magazine, *ePulse*, online recruitment sites (Seek, Trade Me) and local print media are all tools you can use to attract applicants. Remember, the wording you use in your advertisement will help people to filter themselves out as well. Supplying a standard application form with your advertisement that requests the most important information can help you with the selection process by allowing easy comparison of applicants.
Selection	Interviews (structured), including questions covering clinical experience and cultural fit, and reference checking are tools you can use to narrow down applicants and make a selection. For clinical staff, you may check their registered scope of practice and annual practising certificate status with the responsible authority (Medical Council of New Zealand, Nursing Council of New Zealand). Safety checks are necessary for those working with children.
Job offer	See the previous section on **employment laws and standards**.
Registration to practice	International medical graduates or overseas trained nurses will require registration through the appropriate responsible authority.
Induction	This process is not only important to ensure your new employee feels welcome and has a buddy they can ask questions of but also ensures all legal aspects have been covered and that they have everything they need to start doing the job. A good induction will take more than a day, with introductions, check-ups and information sessions spread over the first few weeks. More information on induction and orientation is provided below.

Induction and orientation

MCNZ provides particular advice in its resource **Orientation, induction and supervision for international medical graduates** (IMGs) (2011) about the roles and responsibilities of IMGs and their employers and supervisors, from preparation and recruitment through to starting work and following up in subsequent months.

MCNZ has also developed a helpful **Orientation topic checklist** that can be adapted for what your practice should cover. Alternatively, the NZRGPN runs a monthly three-day orientation course for general practitioners or nurses who are new to the New Zealand health sector. This course is free to doctors recruited through the NZLocums service; however, any practice is able to book a new doctor or nurse onto the course (fees would apply). For information, see the **NZLocums website**.

Notably, general practice teaching practices are expected to provide orientation for trainees including information about:[12]

- patient population (specific demographics)
- teaching resources
- the practice's Māori health plan
- practice policies and information such as billing
- staffing
- appointments
- continuity of care
- rosters
- nursing
- after-hours services
- community involvement
- relationships with local Māori organisations, health providers and groups and other health care providers
- educational strengths within the practice
- support available, if required.

Most aspects of the orientation list above are adaptable for any new clinical staff.

Training and continuing professional development

It is your clinical employees' responsibility to ensure they are meeting their vocational continuing professional development (CPD) programme requirements (such as Maintenance of Professional Standards for GPs or various professional development and recognition programmes for nurses). However, as an employer, it is in your best interest to ensure that they have the opportunity to do so.

Consider assessing what resources and additional training your employees would benefit from following a performance appraisal, for example, via a staff questionnaire. The opportunity to develop skills is also an important aspect of staff satisfaction.

FURTHER INFORMATION

Human Resources Institute of New Zealand provides a helpful **generic guide and checklist for what an induction should involve**.

Alternatively, MAS HealthyPractice® provides role-specific sample induction guides.

Business NZ

RNZCGP; 2014. Policy Brief – Issue 5. **The Vulnerable Children Act 2014: safety checks required for children's workers**.

"Good orientation and induction strategies are an investment in the future – the better [a staff member] settles, the less likely it is that the service or practice will be looking for a replacement in six months' time."

– MCNZ, 2011

Non-clinical staff require continuing professional development just as clinical staff do, and the College recommends including CPD allowances and packages into practice budgets and planning. Investing in staff will improve the efficiency of your practice and contribute to the overall success of your business. PHOs offer regular continuing professional development for all practice staff.

Investing in staff – both clinical and administrative – will also mean that when it comes to filling more senior roles in the practice, you may be able to promote internally. As well as helping with succession planning, in some situations this also ensures you have a back-up if staff are unavailable.

CASE STUDY

Reducing vulnerability

Dr William Grove

I would say the single most important asset is the staff – in particular, having a good practice manager. Over the years, compliance, PHO data extraction, IT and so forth has become more complicated, and, nowadays, I'm not sure that I could take over the practice manager's role – they currently work three days per week.

This vulnerability is one of the biggest business risks and stress points for me, and I strongly advise ensuring that you have back-ups for crucial people's roles.

I have invested in training my receptionist to do some of the roles of the practice manager. Additionally, another practice uses the same PMS as us, and our practice managers meet semi-regularly. There is an informal arrangement that, if for some reason, one of our practice managers suddenly became unwell or couldn't do the job, the other practice manager would step in to train the replacement and provide cover in the meantime.

IT plays a big role in reducing vulnerability nowadays as well.

Performance management

Performance management is an ongoing process (see Figure 1), with a formal review at agreed intervals during the year. It is important to ensure employees clearly understand what is expected of them, and this is best done through regular discussion about their performance.

Good performance management will involve opportunity for communication from both sides about any issues or problem areas, a mechanism for improvement, staff understanding of the practice's goals, motivation, training needs and recognition of achievement.

MBIE's **business.govt.nz website** provides a checklist of the key tasks involved with each step of performance management.

FURTHER INFORMATION

Medical Council of New Zealand. **Recertification and professional development** webpage.

St George I. **Assessing doctors' performance**. Wellington: Medical Council of New Zealand; 2005.

RNZCGP. **Continuing professional development** webpage.

Nursing Council of New Zealand. **Continuing competence** webpage.

Figure 1. Key steps to effective performance management. – Ministry of Business, Innovation and Employment.

It is advisable to have in place clear policies and procedures to establish expectations. These are agreed documents with your staff that reduce the risk of misunderstandings, ensure fairness and consistency and provide a reference point to confirm that you're complying with legislation. They are also a means of maintaining the institutional knowledge of your practice.

As well as your normal reporting requirements as a doctor, you will have additional **responsibilities as an employer, under the Health Practitioners Competence Assurance Act 2003** (sections 34 and 45):

- You have a duty to notify the registrar of the responsible authority if a staff member is unable to perform required functions due to mental or physical conditions.
- If a health practitioner employee resigns or is dismissed for reasons relating to competence, you must promptly give the registrar of the responsible authority written notice of the reasons for that resignation or dismissal.

FURTHER INFORMATION

Medical Council of New Zealand; 2013. **Good medical practice**.

Medical Council of New Zealand; 2010. **What to do when you have concerns about a colleague**.

Council of Medical Colleges; 2015. **A best practice guide for continuous practice improvement** (a framework for use when developing or reviewing programmes set up to demonstrate the competence and performance of medical specialists).

Business NZ; 2015. **Performance management plans** webpage.

Employee remuneration and benefits

Remuneration

For clinical employees, the nature of remuneration may vary and include (among other things) hourly rates, sessional rates and/or salaries, as well as employee benefits such as five to six weeks' annual leave, professional subscriptions and CPD costs.

For contracted GPs, the hourly sessional commission rates (per patient) are generally higher than employee rates because they don't receive employee benefits.

These are some resources that may provide an indication for appropriate remuneration:

Medicine:

- Vocationally qualified GPs employed by DHBs generally fall under the **ASMS/DHB MECA**. Full details of the collective agreement are available on the **ASMS website**.
- **RNZCGP 2015 Workforce Survey Report**. Wellington: The Royal New Zealand College of General Practitioners.
- For more information on rates for GP locum and associates, view the MAS HealthyPractice® **GP locum/associate remuneration report** (December 2015), which is also available on request by contacting MAS.

Nursing:

- The **Primary Health Care Multi-Employer Collective Agreement** (PHC MECA) is in use in nearly 600 GP practices throughout New Zealand, and the majority of other GP practices use the pay rates and terms and conditions as a guide. The NZMA negotiates this agreement with the New Zealand Nurses Organisation on behalf of GP practices and provides ongoing comprehensive advice to general practices on its interpretation and application.
- The DHB MECA for nursing is available on the **New Zealand Nurses Organisation website**.

Practice management:

- Biennial remuneration surveys are completed by **PMAANZ** to gain a benchmark for practice managers and administrators.

Payroll: When paying employees, you also need to consider PAYE deductions, student loan repayments, KiwiSaver deductions, child support deductions, employer superannuation contribution tax and tax credits for payroll donations. You can find out more about how to pay these on the **IRD website**. Payroll issues like this will most likely be handled by your practice manager or administrator.

Employee benefits

Happy, healthy staff are more productive, and there are employee (fringe) benefits you may wish to offer as an employer to promote staff health and wellbeing:

- **Wellness initiative:** This could be in the form of financial support for items, memberships and events that promote physical activity and healthy eating. It could be providing a staff fruit bowl that is restocked regularly. It could be offering a Fitbit to all employees.
- **Employee Assistance Programme (EAP):** Partnering with EAP ensures your employees receive additional support when they need it.
- **Insurance benefits:** While clinical staff will most likely have health insurance packs already, you may like to set up an insurance deal with a provider for your non-clinical staff.
- **Professional development support:** This could be in the form of financial aid, time or flexibility.
- **Parking:** Simply ensuring your staff have somewhere to park can be considered a major benefit.

Employee benefits and bonuses are subject to taxation (fringe benefit tax) as are some employee allowances that are made in addition to salary/wages. It is recommended that you seek professional advice from your accountant or the IRD to clarify your responsibilities.

Looking after yourself

Looking after practice staff applies to you too. The College offers several **self-care resources** and can put you in touch with a colleague if you need to talk.

Top tip: Take real holidays. Holidays are an important part of your success as a practice owner. They help to revitalise and re-energise you and ensure that you are focused when you return to work.

- **Leave work at work.** When you go away, don't take any work with you and try not to be contactable (tell senior staff that it's on an emergency-only basis)
- **Take regular short breaks.** The odd long weekend can be more beneficial and enjoyable than one long stint.
- **Create systems that staff can follow.** This ensures that, when you are away, your practice will not suffer. Staff should be trained in handling almost everything that will go wrong.
- **Plan your holiday periods in advance.** This will maximise the possibility of finding a locum to cover your practice in your absence. Where possible, avoid the school holiday periods as these are traditionally popular periods, and locums get booked very quickly.
- **Find ways to actively relax and enjoy life.** In addition to holidays, do things you enjoy yourself and with friends, such as sailing, tramping or yoga. Take up a hobby or interest outside of medicine, for example, Mexican dancing or Vietnamese cooking!

If you do decide to become a practice owner, utilise peer groups and mentors who can support you in discussing issues so you are not spending your spare time worrying about things that others may have had experience in and can provide advice about.

Teamwork and integration

There is a growing body of evidence that shows developing effective teams (an integrated approach) is key to operating a successful general practice. Working at the same location and working together as a team are quite different. Good communication between non-clinical and clinical staff, as well as between clinical staff of different disciplines, improves the efficiency of a practice and is beneficial to employees and the employer.

There is also evidence that a teamwork approach to practice improves job satisfaction, quality of care and patient outcomes.[13,14]

The following were identified in a study by Pullon et al. as essential for good teamwork and interprofessional practice, as well as for running a good business:[15]

- Good systems for patient flow-through.
- Adequate space in which to work (especially for nurses).
- Uninterrupted and dedicated time for meetings.
- Open communication.
- Valuing of all points of view regardless of professional discipline or employment status.

Other key factors for promoting teamwork include interprofessional education, dedicated time for team development and reflection, cultural competence, appropriate leadership and organisational and structural support.

> "We have the doctors' and nurses' meetings every second month; we have all-staff-right-across-the-board meetings every other month. We have strategic planning once a year, everyone is very approachable. [In our practice] I think everyone feels they can say… about things that are worrying them. We have a stress monitor that we fill in at our staff meetings… red is the danger area so the practice manager monitors that… and she can start putting things in place." – Interview N, paragraphs 85–88, 92, nurse employed in private practice[15]

Leadership

As a practice owner, you are likely to have more opportunities to become involved in clinical leadership. Good leadership within your practice will contribute to the success of your business development and can have a positive impact on patient outcomes. There are several courses available that you could choose to undertake to improve your leadership skills:

- The **Institute of Directors** has a variety of courses.
- **Catapult Leadership Programme** (and tailored programmes).
- The UK **Leadership Academy** (by the National Health Service) – the foundation course is free to access and based online.

FURTHER INFORMATION

Finlayson M, Raymont A. **Teamwork – general practitioners and practice nurses working together in New Zealand**. J Prim Health Care. 2012;4(2):150–155.

Taggart J, Schwartz A, Harris MF, et al. **Facilitation teamwork in general practice: moving from theory to practice**. Aus J Prim Health. 2009; 15(1):24–28.

Elwyn G, Hocking P. **Organisational development in general practice: lessons from practice and professional development plans (PPDPs)**. BMC Fam Pract. 2000;1(2).

Technologies and information management

ICT manager

Well run, up-to-date information and communications technology (ICT) can contribute significantly to the efficiency of your practice. As well as installing, monitoring and fixing the standard office equipment, ICT management can include teleconferencing and videoconferencing facilities, voice over internet protocol (VoIP) services, secure messaging, data security systems and disaster recovery processes (file back-up). For large practices, an ICT manager may be a valuable addition to the practice staff team. For smaller practices and for practices with a practice manager, it may be necessary to contract ICT services to an external provider. If you are setting up a new practice, changing PMS software or trialling the latest technology, consider seeking specialist ICT advice and management.

Service-level contract

For most practices, ongoing ICT maintenance, support and upgrades are best done through a service-level contract[II II] (SLC) with an ICT company that has previous experience with general practices and their ICT needs. Support can often be done remotely with just the occasional onsite visit. You may like to ensure your SLC covers:

- servers, hubs, modems, workstations and printers
- agreed response times for urgent and routine matters
- preventative maintenance activities
- a confidentiality agreement
- management of data back-up and trial restoration of data files
- monitoring of error logs
- maintenance of documentation of configuration and service performance
- installation of program updates.

A common misconception is that ICT is always a challenge. However, some PHOs offer supportive IT services to their providers, and it is generally in the best interests of technology companies to make their product hassle-free for the user.

CASE STUDY

HealthOne

In Christchurch, Orion Health, Pegasus Health and Christchurch DHB partnered together to commission **HealthOne**, a new and evolving health information-sharing system used by authorised providers enabling access to patient medical records (with their permission) from various locations.

To access this innovative system, providers must be on the **Connected Health Network**, then the HealthOne team visits to install the required software. Once implemented, the software auto-updates, meaning nothing more is required of the provider/user.

II II An SLC outlines what services will be provided.

Telehealth

If you work rurally, have a large proportion of high-needs patients or just want to utilise the latest innovations, consider implementing telehealth services. A useful website that explains telehealth and networks and has other useful resources relating to ICT is the **NZ Telehealth Resource Centre**. This Centre also offers free site visits to those considering setting up a telehealth service to help with system selection and implementation as well as workshops.

Patient management systems and record transfer

You may already have a preferred PMS, or the practice you are buying into may already be set up with one. However, technology in this area is developing rapidly, and Patients First may be a useful organisation to keep tabs on.

Patients First facilitates the development and implementation of information technology solutions and frameworks to support the delivery of health services to the public. In 2011, Patients First completed a comprehensive evaluation of primary care IT systems produced in New Zealand and repeated the process in 2015.

Patients First provides **a range of services**, such as hMael™ (a secure messaging platform) and GP2GP (a medical record transfer system), and occasionally reviews systems such as patient portals available in New Zealand.

Electronic patient portals

The goal of patient portals is to broaden the engagement between patients and their general practice to create better patient outcomes. Evidence to date finds that most patients are enthusiastic about having the opportunity to access their health records online and use services such as booking appointments, requesting repeat prescriptions or seeing (clinician-annotated) test results. Currently, e-portals available in New Zealand are module-based, and the practice can choose which features will be made available to patients.

Some health professionals have expressed concern that patients may be confused by medical jargon or that practices might be bombarded by patients commenting or seeking additional information. Feedback from GPs suggests portals do not change the level of contact patients have with their practice and that making health information and services available online can reduce the number of phone calls and text messages between patients and practices.

We recommend the Colleges resource **Patient portals – practical guidelines for implementation (2015).**

ePrescription service

General practices will be seeing the roll-out of the New Zealand ePrescription Service (NZePS), which allows for the secure electronic exchange of prescription information between prescriber and dispenser.[16] Implementing NZePS is part of an evolving process for the way medicines are prescribed in New Zealand. More information about ePrescribing is available in the **RNZCGP Policy Brief – Issue 8: ePrescriptions in general practice.**

FURTHER INFORMATION

Medical Council of New Zealand; 2016. **Statement on telehealth**.

Connected Health; 2014. Case study: **Telehealth enhances rural healthcare**.

Website

The modern day standard for businesses is a website that houses information catering to common enquiries about opening hours, contact numbers, what services are offered and so forth. As well as this basic information, websites can be a marketing tool and a means of promoting unique aspects of your business.

A website can be as interactive or as basic as your practice can handle maintaining. Some practices may have the resources to regularly update news pages and newsletters, while for others, it may just be an online flyer that outlines the key facts.

Key questions to ask when considering your practice's website:

- What resource does your practice have in terms of time and ability to maintain a website?
- What (financial) resource does your practice have to develop a website?
- How will your patients use it – purely to find basic information, for booking appointments or for contacting you?
- Who is your audience? Remember that a wide demographic is now using the internet, with many connected via their mobile phones.

It is also important to keep in mind the future direction of technology and patient expectations when considering your practice's website. More than ever, patients expect websites to be mobile friendly, and the structure of websites has changed accordingly (fpr example, **single-page scroll websites**).

Top tip: Choose a domain name that is easy to remember and spell.

While the idea of developing a website may sound complicated and expensive, this doesn't have to be the case. There are many **free website development tools** that offer simple but effective templates and user-friendly content management systems. For example, most free **WordPress** templates are mobile friendly and responsive, meaning that they work with computers, tablets and smartphones.

Health and safety

Under the Health and Safety at Work Act 2015, your practice is responsible for the workplace health and safety of all staff and others affected by the work it carries out, ie patients and visitors. You also have this responsibility as a governing officer of the practice and as a worker. Ensuring the health and safety of practice staff through identifying, assessing and managing risks is a legal requirement and is in your best interest. Risks might include:

- electrical
- tripping and slipping
- lifting (ie storage solutions)
- poor ergonomics (screen, chair, desk height)
- obstruction of doorways, hallways and exits
- hazardous substances and clinical sharps
- poor lighting, heating/cooling
- noise levels
- security
- earthquake-prone building.

FURTHER INFORMATION

The Privacy Commissioner provides **technology guidance** on its website as well as **specific guidance about secure email** for health information.

"The bare minimum done well is better than best intentions not maintained."

– Dr Matt Wildbore, New Zealand Doctor, 2007

Infection control is a particular hazard in medical practices but can be managed through good systems, waste management and staff education and training.

Aiming for Excellence and the Foundation Standard cover all aspects of health and safety.

Disaster preparedness and risk management

There are two levels of disaster preparedness that your practice should consider:

1. **Public health disaster** (at a regional or national level), such as a major earthquake, flooding or pandemic. It is important that your practice has a risk-based, comprehensive emergency management plan that generically covers all hazards, as well as specific contingency plans for well selected priority hazards. The Ministry of Health **National Health Emergency Plan: A Framework** for the health and disability sector supports and provides guidance for health providers in emergency planning and management. It also provides a business continuity plan template as well as specific guidance for pandemics.
2. **Practice-level disaster management**, ie evacuation procedure in the event of a fire. This would normally be the responsibility of the practice manager and is expected as part of the quality standards.

Closing and selling your practice

At some point, for whatever reason (such as retirement, illness or relocation), the time may come when you need to sell your practice. If possible, it is advisable to start planning and preparing for your departure from the practice as early as possible. As a GP and practice owner, you have a legal and ethical duty to provide continuity of care to your patients. Some legal, regulatory and insurance issues you (or your legal representative/estate) will need to consider are:

- medical indemnity
- patient health information (such as storage of medical records)
- transferring medical records to another health provider
- business issues
- staff issues
- disposal of prescription pads and medications.

If you are closing your practice, informing patients of the pending practice closure is the first step to maintaining continuity of care as it allows for timely clinical handover to another practice of the patient's choice.

Succession planning is made easier if your practice has:

- robust legal and financial advice
- strong management leadership and support
- sound business systems and processes
- an appropriate structure of legal entity (ie the entity rather than the individual is responsible for replacement of a shareholder when a shareholder exits)
- nurtured nursing and medical students to future-proof recruitment
- a strong team culture and ethos that can sustain change
- support from the PHO.

FURTHER INFORMATION

A recommended read on the substantial changes to the Health and Safety at Work Act is an article in *On MAS* magazine: Moore S. **Health and safety: a new decade**. On MAS. 2016. p13.

WorkSafe New Zealand website.

A supplementary guide to the Foundation Standard and *Aiming for Excellence* entitled **Health and safety things to think about** was developed in April 2016 to explain health and safety requirements under the Health and Safety Work Act 2015.

Ministry of Health. **Pandemic influenza guidance for the health sector** webpage.

Ministry of Health. **Emergence management, disaster planning and business continuity in primary care** webpage.

Selling

As noted in the College's resource **Midlife to retirement**, Professor Campbell Murdoch (Chair of the College's Rural Faculty) suggests that GPs should not regard owning a practice as owning an investment that will increase in value over time but should instead assess the value in accordance with the salary and benefits that accrue over the span of ownership.

> "Getting a good return when selling a practice can be assisted by allowing a long lead-in time and by effective marketing. Becoming a teaching practice, for example, is a good way to develop links with younger doctors who may later be interested in buying a practice. It also allows them to develop an affinity for your practice and the community. Selling the practice in stages over time is another good way to bring in a successor who might not otherwise be able to afford to buy a practice outright. Other alternatives include selling to a corporate body, amalgamating with other local practices, closing the practice, or transitioning ownership to a community-owned trust. The Medical Assurance Society can provide excellent guidance and advice about your options."[17]

APPENDIX 1:

Getting a job in GPEP2

The Registrars' Chapter of the College does not take any responsibility for decisions made by individual registrars regarding their employment in GPEP2. We recommend seeking professional advice when considering any contract or employment offer.

How do I go about looking for a job?

Cast your net wide – the more people who know you're looking for a job, the better your chances of hearing about vacancies. Talk to:

- your GPEP1 teachers and medical educators
- other GPEP1 registrars in your area
- other GPs in your area – CME and GP Faculty events are a good opportunity to canvass opportunities
- practices in the area in which you're interested in working.

See these resources:

- **ePulse**, found on the College website
- the medical vacancies section of the **NZMA website**
- the professional classified section of the ***New Zealand Doctor* website**, as well as the fortnightly magazine
- **www.kiwihealthjobs.com**
- local newspaper advertisements
- **TradeMe**, **SEEK** and other job vacancy websites.

What should I consider when looking at GPEP2 jobs?

- Is the practice CORNERSTONE® accredited? If not, you will need to make a formal request to the College to have the practice accepted as an approved training location.
- Do you have any extra skills, qualifications, or interests that contribute to or complement the practice, eg paediatrics diploma, O&G diploma, minor surgery, sports medicine, travel medicine?
- What clinical support is available?
- Are there regular meetings to discuss issues? Does the practice have a monthly peer review group?
- How many hours or tenths will you be expected to work? (In GPEP2, the College considers eight-tenths full-time, although some registrars choose to work more than this.)

- How are the sessions/tenths structured (for example, how many patients are you expected to see per session, how many breaks do you get, how long are appointment times etc?)
- Do you get paid for paperwork/non-clinical time?
- What is the remuneration? How are you paid, for example, as a locum, contractor or employee?
- Do you get along with the other GPs and staff at the practice? Does it seem a nice environment to work in?
- How close is it to home? Consider commuting time and whether you want to work in a practice within your own community or not.
- Do you like dealing with their particular population demographic? Is the population high or low needs? Are there many casual patients, or is it mostly registered patients?
- Does the practice open on weekends? Are you expected to work on the weekends or after-hours?
- How many other GPs are there in the practice? Are you expected to cover other GPs when they go on leave? Do you have to arrange your own locum cover for leave?
- Does the practice have a social calendar? Is it involved in any community initiatives or events?

What should I consider when looking at my contract?

- Remuneration: **the MAS remuneration survey** shows median rates paid to GPs around New Zealand. Note that some practices will not pay a GPEP2 the same as an experienced Fellow, even though you may be seeing the same number of patients.
- Is the practice looking to employ staff? If the practice really needs a new doctor, you may be able to negotiate terms in your favour.
- How many days of annual leave and sick leave do they provide?
- KiwiSaver or other retirement savings scheme.
- Do they cover costs such as APC, medical indemnity insurance, GPEP2 fees etc?
- Do they cover the costs of any CME/conferences?
- What will be your after-hours commitment? Are you paid additionally for after-hours or is it included in your salary?
- How do you want to be employed? The two main options for employment, contractor and employee, are explained **here**.

APPENDIX 2:

HealthyPractice® (MAS) fact sheet: General medical practice valuation methods

General medical practice valuation methods

Valuation methods for general medical practices include:

- assessing the value of tangible assets and goodwill separately, using, for example, **rule of thumb**, plus assets, or
- 'earnings related' methods that consider the economic value of the owner's interest in the practice, for example, **future maintainable earnings**.

Tangible assets may include the fixtures and fittings, equipment and contents owned by the existing practice, as well as stocks of medical supplies and consumables.

Also included in assets of the practice could be 'debtors' that are to be transferred to any purchaser. If this is the case, you would usually take into account the age and status of the debtors and apply a discount factor based on this.

Rule of thumb

Goodwill is often calculated on industry 'rule of thumb' methods. For general medical practice this has historically been assessed as a percentage of gross income, ie of total fees, excluding GST.

Practice value = % gross income (goodwill) + assets

A percentage of gross income, however, does not take into account the variation of expenses that may apply across practices, and hence, the resulting expected profit and return on investment to the owner. This is especially relevant when the practice is part of a group practice with high expenses where the buyer has little control over their share of group practice expenses.

We have seen less use of this 'rule of thumb' method to calculate practice values in recent years, but when used, goodwill values for profitable and well-managed practices that are part of a larger group in attractive locations generally sit in a range of 25 to 35 percent of gross income (net of GST).

With capitation-based funding the goodwill component tends to be attached to the enrolled patient base given the income streams derived from them, especially where capitation funding is a larger portion of the total revenue. As a result more recently we have seen practice goodwill valued on the basis of a dollar sum per enrolled patient – anywhere from $10 to in excess of $150. Our

January 2016 HealthyPractice® analysis of 507 subscriber practices had a median enrolled patient base of 1,682 per FTE general practitioner.

The goodwill component can vary from a base percentage of gross income for a number of reasons. Factors that affect goodwill may include:

- profitability of the practice
- practice location
- enrolled patient base, patient demographics and funding streams
- after-hours arrangements
- state, type of premises, eg modern, purpose built
- lease terms
- management structures
- practice systems
- contractual service arrangements
- plant and equipment and state of repair, and
- availability, skill and cost of staff and GP workforce.

In recent years we have seen goodwill values increase but mainly for large, well-managed and profitable urban practices in attractive locations. For solo or small practices without good management structures and systems, there have often been reductions in goodwill values – to the extent that in some areas, practices have attracted little or no goodwill value, especially in hard-to-staff rural locations. In many of these areas DHBs, PHOs and community trusts have become the 'owners of last resort' when GP practice owners have retired and there are no younger GPs prepared to take on the workforce and other risks associated with ownership.

Future maintainable earnings (FME)

With changes to primary care including practice amalgamations and corporatisation, a more traditional business basis of valuation is now commonly used. Earnings related methods, such as FME, look at the value of the practice to an investor rather than to a working practitioner. With this approach an estimate of maintainable earnings is made and a multiple is applied to these earnings to establish a value. What that multiple is will depend on the risks and growth prospects for the business and the primary care sector in general. In general practice the FME is often assessed as being the 'normalised' historical earnings before interest, taxation and depreciation (EBITD) after the deduction of a market income for the GP owner. Market remuneration for a full-time GP is currently around $180,000 to $220,000 per annum and can vary based on individual GP factors like experience, expertise, qualifications, patient numbers seen or revenues generated as well as things like hours to be worked and practice location. Our most recent **GP locum and associate remuneration survey report** provides more detailed information.

Using historical earnings does require an analysis of how the EBITD is made up to determine whether or not this is a good indicator of future earnings. The historical EBITD also needs to be adjusted to take into account any income not available to the buyer or expenses that will not be incurred.

Once the normalised EBITD has been determined then the multiplier is applied to calculate the value of the practice as a going concern, including the fixed assets needed to produce the future earnings.

Practice value (goodwill and fixed assets) = Future EBITD x multiplier

The multiplier currently applied in general practice can be anywhere between 2 and 3.5 depending on the location and other factors. If part of a large well-managed group practice in a major city we would expect the multiplier to be around 3 or more, whereas a hard-to-staff rural location may be closer to 2.

For example:

Practice value calculation	
Gross fees	$480,000
less expenses	$200,000
Net profit (before GP remuneration)	$280,000
less estimated market GP remuneration	$220,000
EBITD (estimated FME)	$60,000
Estimated practice value	
EBITD x 3	$180,000

General

Whilst practice values have increased in recent years, there has been a significant variation in sale prices. We have seen practices with around 1,600 to 2,000 enrolled patients (solo or part of a group practice) unable to be sold for any value or fetch a sale price in excess of $350,000, generally when part of larger group practice with group practice revenue streams.

Practices that are part of a large well-managed urban group practice in popular cities obtain highest values, whereas small, rural practices in less popular areas often attract little or no value. Even in major cities we have seen that solo practices have a more limited potential market for a number of reasons. In particular, younger GPs often do not want the responsibility of being the owner, manager and clinician and see other advantages of buying into a larger group practice, including better work/life balance, collegial support, and management expertise.

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