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How ongoing action brings results

PURCHASING POWER
End-of-year finance strategies

SMART MOVES
Planning to succeed with your successor

JAPANESE LESSONS
Experiencing excellent service, fine attention to detail and deep relaxation
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My family and I recently returned from our first holiday to Japan (see our travel feature on page 66). One of the things that made a big impression on us was the flawless customer service everywhere we went, from the most obscure little noodle shops to five-star hotels, simply walk through the door and you are instantly greeted with a smile, a bow and a welcome.

Staff are attentive and will approach if you look remotely as though you need attention. Uniforms are clean and neat, shirts are tucked in and the deep respect everyone has for themselves, their employer, their job and, most importantly, for the customer, is prevalent.

This is not service delivered for personal profit – the Japanese do not seek or accept tips. This is service delivered with the kind of warmth, enthusiasm and salesmanship typically found in the long-gone era of Jimmy Stewart and Doris Day films, yet it is ironically delivered against a backdrop that can at times feel like a futuristic sci-fi movie.

Japan offers a great lesson in the fact that no matter how fast technology changes, there are certain things that don’t – feeling appreciated, having a sensory experience and being on the receiving end of kindness and enthusiasm are all things people want from a shopping experience. When they don’t get them, they simply default to the lowest price and the least hassle.

This explains the rise of corporations in healthcare, which are beginning to flourish in the absence of personalised customer service. A patient is a customer, and to deny this is doing the patient a disservice. The healthcare customer expects clinical excellence and a medical solution to their problem, but also expects to be treated with dignity, to be clearly communicated to and educated, to be reassured and, above all, to feel ‘part of the family’.

A customer also wants to be thanked for their custom – a foreign concept I’m sure for the healthcare professional, who may typically expect they should be thanked. In any language – but especially the language of business – “thank you” is the phrase that generates loyalty, repeat business, word-of-mouth publicity and goodwill.

Make no mistake – a healthcare practice is a business, and it’s about time practice principals, managers and staff learnt the language of business and customer relations.

In the absence of customer service and true ‘relationships’ with our healthcare providers, we will gravitate to the easiest, cheapest option. At the very least we are not encouraged to recommend our practitioner or their practice.

Surely it should be the aim of every practice principal to have patients that are raving advocates of your skill, your service, your care and your attentiveness. This breeds loyalty, helps expand your referral base and helps attract high-quality staff and associates, all of which are integral factors to helping establish a practice as an independent entity with longevity beyond the principals work life. It also ultimately results in real, saleable value, and the satisfaction that what you have created will live on to positively serving the community.

I take this opportunity to say a heartfelt Arigato gozaimasu (thank you) to all of our readers for your ongoing support – it is greatly appreciated. Our contributors and I hope you enjoy this edition of The Private Practice, and we wish you a safe, relaxing and fun festive season.

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

Thoracic Society of Australia & New Zealand Private Practice
‘Comprehensive’ – 12-13 October, Sydney

Device Technologies Private Practice Independent Optometrists Symposium – 16 October, Sydney
EVENTS
Device Technologies Private Practice Independent Optometrists Symposium – 30 October, Melbourne

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First there was Wotif.com, Seek.com, Realestate.com.au, Carsales.com.au who have forever changed the way we book accommodation, find jobs, look for property and buy cars.

Now 1stAvailable.com.au will change forever the way Australians book their health care appointments.

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EVENTS

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ECONOMICS & MARKETS

AGEING GRACEFULLY

Our ageing population is sure to have a major impact on the workforce and productivity in years to come. But, as Chris Caton points out, Australia isn’t the only country facing this dilemma.

The Australian share market fell by 1.9% in November, its first fall in five months. For the financial year to date, the market has still risen by 10.8%. For the calendar year to date it is up by 14.4%. The US share market has still risen by 10.8%. For the calendar year to date, the market rose by 2.8% in the month, bringing its year-to-date change to 26.6%. Taking into account the fall in the Australian dollar ($A) its year-to-date change to 26.6%. Taking into account the fall in the Australian dollar ($A) – buying foreign exchange and selling the Australian dollar); indeed it may already have done so.

In the United States, the focus has shifted from fiscal policy back to monetary policy, and the prospect of the beginning of tapering of quantitative easing. During the month it became more likely that Janet Yellen will be appointed chair of the Fed, to replace Ben Bernanke. This increases the likelihood that US monetary policy will continue to be accommodative for as long as necessary, which can’t be bad for markets.

DOMESTIC NEWS

Once again, the RBA opted not to cut the cash rate further from its current record low of 2.5%. The labour-market news for October continued to be mixed, with employment almost static and the unemployment rate rising to 5.7%, thus continuing its upward trend.

The exchange rate had a weak month, falling from 94.7 cents to 91.1 cents. The Reserve Bank Governor continued to do its best to talk the $A down, rightly convinced that the Australian economy would fare better with a lower currency.

Trying to get the $A down by jawboning alone puts the Reserve Bank in the position well summarised by Lady Macbeth in reference to her husband, whom she described as behaving “like the poor cat in the adage”. The adage was, apparently, “the cat would eat fish but would not get its feet wet”. You want something but you are not prepared to act to make it happen.

There have, of course, been rumours that the RBA is prepared to get its feet wet (that is, to intervene – buying foreign exchange and selling the Australian dollar); indeed it may already have done so.

We never find out about these things until after they have happened. In any case, it’s probably best to assume that the currency will fall further.

- The capital spending data provided little new information, merely confirming that we are at or near the peak of the mining capex boom.
- Another rate cut remains unlikely unless the exchange rate and/or the unemployment rate head significantly higher.

WE’RE ALL GETTING OLDER

It is well known that not only is each one of us getting older, but the Australian population is also ageing. The Productivity Commission recently released an excellent study that deals with this issue, entitled An Ageing Australia: Preparing for the Future, November 2013.

Perhaps the most important finding is that, on an ‘unchanged policy’ basis, government spending on healthcare, aged care and the aged pension will increase by about 7% of GDP, to 17%, between now and 2060.

At the same time, GDP growth will be slowing, primarily because the ageing of the population will reduce the rate of growth of the workforce. So, demographically sensitive spending increases as a share of a pie that’s not growing as fast as it used to do. Clearly the effects will be major.

In the past, of course, demographics have worked in our favour. For most of the post-war period, part of the increase in real incomes per capita has been a result of sending an increasing share of the population out to work (mainly through increased female participation). From now on, the share of the population going to work will be on a declining trend.

In recent years also, real incomes in Australia have been boosted by the ‘kindness of strangers’. The commodity price boom has meant that Australia’s export prices have outpaced our import prices. This has been a major factor driving income growth, as outlined in the recent (excellent) speech by Philip Lowe, a deputy governor of the Reserve Bank. The boom is, of course, over. Our terms of trade are in decline.

The third way to raise real incomes is by plain old-fashioned increased productivity. With the first two means of providing income growth moving into reverse, there will be far greater emphasis on productivity growth in the years ahead.

But what about the ageing? Is it really that big a deal?

First, let it be noted that we are not the only country ageing, indeed it’s difficult to find one that isn’t. It’s also worthwhile pointing out that the median age of the Australian population in 2050 will still be significantly less than the current median age in, for example, Japan and Italy.
To me, these two sets of charts put Australia’s ageing problem into perspective. Most other countries have the problem much more than we do. But there is another important issue. Who finishes up dealing with the problem? In many societies, the brunt of it falls on the families. In Australia, and the United States among others, the problem has been socialised; dealing with the issue has been transferred to the government.

But maybe it’s not how old a country is; maybe it’s the extent to which it’s getting older. The next chart therefore shows the likely increase in the aged dependency ratio between now (actually 2010) and 2050.

Australia is still the eighth youngest, although only four of the seven in front of us (Luxembourg, Israel, USA and India) are common to both sets of charts. And the country aging most rapidly is South Korea, which goes from seventh youngest to second oldest in the 40 years to 2050. The countries toward the top end of the scale are, of course, those with low birth rates and/or little or no immigration.

Promises – sometimes costly ones – have been made to the elderly. This doesn’t increase the ageing problem, of course, except insofar as behavior is changed (people retire earlier than otherwise and/or overuse their underpriced healthcare, for example). I personally have no objection to the socialisation of the issue, but it probably increases its visibility.

PUTTING AGE IN PERSPECTIVE

Suppose that we examine ageing by looking at the ratio between the population 65 and over (which no longer seems particularly old to me), and the population of working age, defined as those aged 15 to 64. The next chart shows 40 countries ranked by the likely value of this ratio in 2050. Of these 40 countries, Australia will be the eighth youngest in 2050, with Japan the oldest.

Indeed, by this measure, 22 of the 40 countries are already older than Australia will be in 2050.
MARKETING

ACTION PLAN

New and emerging healthcare trends, policy updates, the growth of social marketing and a renewed focus on customer engagement make right now the time start planning for the exciting year ahead, says Jason Borody.

With big changes to the healthcare market coming up, practices will need to focus on the most effective and economical ways to connect with patients. The industry is changing fast, so don’t get stuck by being complacent.

Word of mouth and referrals from colleagues are valuable commodities to any medical practice. However, in today’s competitive environment, referrals alone are not enough to maintain profitability. It’s time to get strategic with a solid marketing plan, and what better time of year to do it than now.

The facts about online communities

Studies show that 77% of patients searched online prior to booking an appointment. The most commonly researched topics are specific diseases or conditions, treatments or procedures and doctors or other health professionals.

More than ever, you need to understand your patients’ online habits, which are continuously changing with technology trends. Rapid increases in the use of Internet search engines like Google now mean that health providers need to be more savvy in the way they approach their clients.

It’s no longer enough to say you specialise in an area – there must be adequate online evidence to support your claims. Such online evidence can take many forms, including directories, wikis, blogs, forums and comments on Facebook or Twitter. There are numerous places where you, and others, can publish information or personal reviews about anybody or anything.

Engaging with your target audience and providing useful information whenever it is requested builds trust in your practice as well as awareness of your capabilities. Build your online presence in a logical way that both informs and guides your patients without pushing services too hard. Build your reputation and ultimately people begin talking positively about your practice.

In other words, readers will come to know and trust you before they walk in your door.

ON TREND

Keep the following in mind when devising your marketing plans for 2014:

• Content is king: Consistently creating valuable content through a variety of channels, such as social-media platforms plus your website, eNewsletters and videos, will help establish trust with patients. This trend proves that mass-media strategies are becoming less effective and that people want to be made to feel like you’re only talking to them.

• Mobile health: Customers have become accustomed to instant access. If you follow the three “Rs” rule – Relevance, Reliability and Relationship – you can’t go wrong. Provide your customers with compelling content, user-friendly navigation and tools that facilitate a conversation, which will lead to conversion-related actions such as booking an appointment.

• Socialnomics: We can now build audiences across more channels than ever. There is a plethora of new social-media platforms to choose from, which allows you to produce engaging content in a variety of media forms. Diversification is key, building brand equity by making it easier for patients to recognise your brand. Don’t forget to measure your practice’s social engagement by monitoring real-time information about its social reach and degree of interaction.

• Customer centricity: Give your patients a superior experience and you will have a customer for life. Take a look at your practice from a patient’s view and try to get a better understanding of your internal cross-functional touchpoints – this could drastically improve customer-lifetime value.

STEPS TO SUCCESS

Successful medical practices need to be proactive in 2014 by managing change with actionable solutions. The keys to growing your business through online marketing are planning, implementing, measuring and tweaking.

In our experience, most healthcare clients are looking for advice on marketing strategies and our aim is to provide customised medical-marketing plans. We understand the laws and codes that regulate medical marketing in Australia, and develop marketing strategies that are compliant, professional and effective. In short, it is our business to make your business stand out for all the right reasons.

Vividus specialises in healthcare marketing for hospitals, medical centres, GP and specialist practices, and healthcare businesses. The Vividus team work to increase community awareness of your practice and help you build your patient list via local-area marketing, a professional website, online marketing, satisfaction surveys and referral-based marketing.

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SHORT & SHARP

Many of us apply long-term plans to our businesses, but as Adam Basheer writes, the 90-day plan is gaining momentum for all the right reasons.

IN FOCUS

People who hear me speak will know I often talk about the need for small business to focus – focus your time, money and resources only on the activities that will achieve the greatest result and get you to your goals the fastest.

Well, I think that is exactly where the 90-day plan fits. If five years is so far away we can’t see it, three years is within our sights and 12 months is something we can plan out in some detail, then 90 days becomes the absolute focus for the business.

Ask yourself what are your key initiatives, what are your measures and what are your targets in the short-term? The answers should be the absolute focus for you every day. The 90-day plan gives you a greater focus and encourages you to arrange your time and resources around the absolute priority activities. This sounds good to me.

Of course, once you have completed one 90-day plan you must complete the next plan. This encourages planning to be an ongoing activity and is likely to be further stimulus to keep you on track.

The more you plan, the better you get at planning, and the more able you are to match your required outcomes with the available resources. Thus your plans get more accurate. The more accurate your planning is, the more useful and motivating it becomes, and therefore the more it becomes part of your daily practice.

So, it’s a snowball effect to make your business more effective. The more I look at the 90-day plan, the more I like it. Anything that is going to focus your business to this extent has to be a good thing! ☺
TRIED & TESTED

By commissioning a genuine case study, 1stAvailable.com.au put its online appointment-booking product to the test to see if the technology contributed to growing a medical practice and improving patient satisfaction.

When it comes to successful medical practices, Medicross Australia is ahead of the game and serves as a shining example of excellence in innovation. From humble beginnings, Medicross has grown to 12 practices across Queensland – if ever a company was earmarked for growth, this is it.

Since May, the group has experienced exponential growth in patient-booking numbers. For Managing Director Charles Jewaskiewitz, this growth can be attributed to one thing – the incorporation of online appointment-booking service 1stAvailable.com.au. Patient numbers in the period between May and now have exploded. Since its introduction there have been nearly 5000 bookings through the 1stavailable.com.au platform.

"We’re very good at identifying – from an innovation point of view – market trends in technology, embracing it quickly and delivering it to our patients," says Charles. "The healthcare industry has traditionally been very slow in its uptake of technological innovation. People often ask how I have grown Medicross so quickly and my response is always the same – I am focused on understanding customers and bolstering innovation to foster growth."

CASE STUDY

Conducted by Elissa Dargusch at ELC Solutions, this case study focuses on Medicross Coomera, in Queensland. It reviews the integration of online appointment-booking platform 1stAvailable.com.au and evaluates whether the practice has had efficiency gains, as well as the perceptions of staff and patients relating to the service.

PROFILE: Medicross Coomera

Medicross’s strategic goal is to provide patients with a ‘one-stop’ service experience, delivering quality healthcare. A key focus at Medicross Coomera is the patient wait time. Medicross Coomera is Medicross Australia’s largest general practice medical centre. The practice is located in the Gold Coast Medicare catchment area, which has a population of 539,890 people.

THE PROBLEM: Time-consuming telephone bookings

Prior to implementing an online-booking platform, Medicross Coomera was attracting more than 250 patients per week and growing at an unprecedented rate. While the growth was seen as a positive development, the burden on administration staff to deliver quality service without compromising the patient experience was increasing.

One of the key problems was the fact that patients were restricted to telephone-appointment bookings during office hours. According to Medicross staff, patients were becoming increasingly frustrated. Staff were overworked, and were dedicating the majority of their time to taking and arranging bookings. As a result, other important practice tasks were being left unattended.

Technology has changed the way we live, with over 80% of Australians using online solutions for everyday services such as banking and shopping. Unfortunately, accessing healthcare services today remains unnecessarily difficult. Charles admits to being a keen advocate of incorporating technology into medical practices.

"In my view, healthcare needs to catch up with the IT revolution and utilise the power of the Internet. While the telephone has always been important, it does tend to also burden your front-desk resources, especially early in the morning around surgery opening time, when there are a lot of incoming calls," he explains.

"It is not a nice experience, as a patient to come to the front surgery desk in the morning and everybody is on the phones, and you have to wait until they get off the phone to be attended to."

Amanda Ludson, Practice Manager at Medicross Coomera, has worked in healthcare for 10 years and confirms that there is increasing pressure on front desk staff.

"When I first started in the medical industry we had time to talk to patients face to face," she says. "These days it is just so busy that we don’t have that much time, as hard as we try."

ANALYSIS: Establishing which technology solution is best

Medicross established that it needed to find a solution for the length of time spent taking telephone bookings. Internal research highlighted that the process of taking a single telephone booking was lasting up to 10 minutes. Statistics also show that front-desk staff used to spend at least 80% of their time managing bookings over the phone.

Charles knew this was unsustainable. "We had an issue of supply and demand. The time spent on the telephone would continue to increase. Staff would become more stretched. Patient numbers would grow, but this growth would be unsustainable in the future," he says. "Ultimately, some patients would tire of waiting on the phone, while other patients would resent that lack of customer service while in the waiting room.

"Ultimately, some patients would tire of waiting on the phone, while other patients would resent that lack of customer service while in the waiting room."

"Ultimately, some patients would tire of waiting on the phone, while other patients would resent that lack of customer service while in the waiting room."

3
This would lead to a decline in patient numbers and we would ultimately have to close some of our practices.”

Realising he had a serious issue on his hands, Charles started researching the range of technological solutions available on the market. Medicross had used other online appointment systems in the past, but without success.

Medicross had previously used Clinic Connect. The majority of staff found that the platform was extremely difficult technology to use. As a result of this experience, Medicross needed to find a solution that would involve patients, enabling them to make their own decisions and manage their own bookings. This would, in turn, reduce the burden on front-desk staff.

“We needed a solution that would free up time. It needed to be straightforward. The last thing that I wanted to do was implement a technology that was difficult to use and time-consuming,” Charles adds.

**SOLUTION: Implementing the technology**

The only online appointment-booking solution that ticked all of Medicross’s requirements was 1stAvailable.com.au. Ease of integration, flexibility and ease of use make the product vastly different to any other solution on the market.

“We chose 1stAvailable.com.au because it’s the difference – the personal touch, the ability to communicate with the client standing in front of them, instead of being distracted by the phone. This means that the patient experience is 10 times better,” he says. “We have had fantastic feedback. The service is accessed with one password via each patient’s personal computer, at work, at home or via smartphones. According to Medicross, patient uptake was immediate due to the convenience and flexibility of choice. Amanda says the ‘out-of-hours booking functionality’ has proved particularly popular.

“There was an instance where a parent had been up all night with their child, who was suffering from a severe earache. This particular customer was able to make the healthcare appointment immediately, without needing to wait until 7.30am to call the practice,” she explains. “For situations like this, the benefits of out-of-hours booking are immeasurable.”

The availability of 1stAvailable.com.au was actively promoted to existing patients, as well as within the local community, with 1stAvailable coordinating a number of marketing and public-relations initiatives to ensure that uptake of the online-booking platform was immediate.

“Any solution that you choose must have a robust marketing mix associated with it. The difference is 1stAvailable.com.au understands that they need to support us to market it, and that a collaborative approach is a key component,” Charles elaborates. “Their service offering was unmatched, and that’s the difference – the personal touch, the involvement and the eagerness from both parties to make it work.”

**RESULT:** Reduced telephone time, less no-shows and more new patients

The 1stAvailable.com.au online-appointment booking solution went live at Medicross Coomera in May 2013, and in just nine short weeks a total of 2660 new and existing patients had booked using the service.

Charles says 1stAvailable.com.au has transformed Medicross Australia’s business and highlights the fact that front-desk staff are spending significantly less time on the phone, along with the noticeable reduction in ‘no shows’ and the increase in the number of new patients.

“Using 1stAvailable.com.au frees up our front-desk staff, giving them the ability to communicate with the client standing in front of them, instead of being distracted by the phone. This means that the patient experience is 10 times better,” he says. “We have had fantastic feedback. The uptake for our online-booking service is strong. It works well for everybody and we are very pleased with that.”

**IN CONCLUSION**

The 1stAvailable.com.au booking technology was rolled out to all Medicross practices, including general practices and dental practices. Charles Jewaskiewitz attributes part of the medical group’s growth to the online-booking offering.

“For us it’s a brilliant solution,” he says. “For patients it means no more ringing around and no more being placed on hold. You don’t have to remember lots of website addresses, you can make your bookings out of hours and you can quickly find an appointment in an emergency.”

Medicross Coomera’s front-desk staff are equally as happy with the results. “It just works great, and because the staff has supported the implementation, we have achieved such high booking volumes,” says Amanda, who estimates that 45 to 50 less phone calls a day are having to be answered because patients are going online to book.

“The world is online and patients across the healthcare services industry are choosing no more ringing around, no more being placed on hold and no more remembering lots of website addresses or logins,” Amanda adds. “They want the convenience of making healthcare bookings out of hours and being able to quickly find an answer when the situation is urgent.”

---

**ADDITIONAL BENEFITS**

- Return on investment for monthly fees within 24 hours.
- Patient experience rated ‘10 times better’, according to patient surveys.
- Averaging 200 online appointments per week.
- New patients booked in/out of hours.
- Average daily phone usage.

**Before implementing 1stAvailable.com.au**

- New vs Existing patient: 55%
- Booked In/Out of Hours: 90%
- Average Daily Phone Usage: 5%

**After implementing 1stAvailable.com.au**

- New vs Existing patient: 60%
- Booked In/Out of Hours: 95%
- Average Daily Phone Usage: 40%
A matter of privacy

Are you across the forthcoming legislative changes to privacy laws? Natasha Leedman and Enore Panetta provide some insight.

The changes under the Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth) will come into effect on 12 March 2014. That legislation has created complex and considerable changes to the Privacy Act 1988 (Cth), being the first wave in the more recent proposals for privacy reform, and will affect Australian businesses and government agencies across all sectors.

Most importantly, the legislation will strongly impact on the health sector, and practitioners are well advised to be finalising their medical practice’s due diligence and practitioners are well advised to be finalising their medical practice’s due diligence and complaints processes in their APP privacy policies, and also the location of any likely overseas recipients of an individual’s information.

**APP 6 – Use and disclosure of personal information**

APP 6 outlines the circumstances in which an organisation may use or disclose the personal information it holds about an individual.

This principle also introduces some new exceptions to the general requirement that an organisation may only use or disclose personal information for the purpose for which the information was collected.

Those exceptions include where the use or disclosure is reasonably necessary to assist in locating a missing person; to lessen or prevent a serious threat to the life, health or safety of an individual or to public health or safety; to establish, exercise or defend a legal or equitable claim; or for the purpose of a confidential alternative dispute resolution process.

**APP 7 – Direct marketing**

Organisations generally may only use or disclose personal information for a direct-marketing purpose where the individual has either consented to their personal information being used for that purpose, or has a reasonable expectation that their personal information will be used for that purpose.

**APP 8 – Cross-border disclosures**

APP 8, and associated provisions, creates new accountability for organisations with respect to any cross-border disclosure of personal information, and provides the framework for the most contentious of the reforms.

AN OVERVIEW

Central to the changes is the new set of harmonised privacy principles designed to regulate the handling of personal information. Known as the Australian Privacy Principles (APPs), these new principles will replace both the existing National Privacy Principles (NPPs), which apply to Australian businesses, and Information Privacy Principles (IPPs), which apply to Australian government agencies.

The key differences between the APPs and the current principles they will replace are summarised here:

- **APP 1 – Open and transparent management of personal information**

  APP 1 introduces more prescriptive requirements for privacy policies and procedures, with a view to ensuring personal information is handled in an open and transparent manner.

  A health organisation or medical practice must soon have an APP privacy policy and/or procedure that contains the following information:

  - How the organisation or practice collects and holds personal information.
  - The purposes for which the organisation or practice collects, holds, uses and discloses that information.
  - How an individual may access their personal information as held by the organisation or practice, and seek the correction of that information if necessary.
  - How an individual may complain about any breach, and how the organisation or practice will deal with such a complaint.
  - Whether the organisation or practice is likely to disclose personal information to overseas recipients and, if so, if it is practicable to specify the countries in which those recipients are likely to be located.
  - It is now mandatory under APP 1 to implement practices, procedures and systems that will ensure compliance with the APPs.

  **APP 2 – Anonymity and pseudonymity**

  Under APP 2, an organisation must now provide individuals with the option of using a pseudonym. This obligation is in addition to the existing requirement that individuals may deal with an organisation anonymously.

  **APP 3 – Collection of solicited personal information**

  Under APP 3, an organisation must not collect personal information (other than sensitive information), unless the information is reasonably necessary for one or more of the organisation’s functions or activities.

  APP 3 clarifies that sensitive information must only be collected with an individual’s consent, and if the collection is reasonably necessary for one or more of the organisation’s functions or activities.

  An organisation must only collect personal information directly from the individual, unless it is unreasonable or impracticable to do so.

  **APP 4 – Dealing with unsolicited personal information**

  Under APP 4 there are now obligations with respect to the receipt of personal information not solicited. Where an organisation receives unsolicited personal information, it must determine whether it would have been permitted to collect the information under APP 3. If so, APPs 5 to 13 will apply to that information.

  If the information could not have been collected under APP 3, and the information is not contained in a Commonwealth record, the organisation must destroy or de-identify that information as soon as practicable, if it is lawful and reasonable to do so.

  **APP 5 – Notification of the collection of personal information**

  APP 5 specifies certain matters about which an organisation must generally make an individual aware, with respect to the collection of his or her personal information.

  APP 5 imposes an additional obligation on organisations to notify individuals about the access, correction and complaints processes in their APP privacy policies, and also the location of any likely overseas recipients of an individual’s information.
The principle gives organisations long-term responsibility for personal information sent overseas. It stipulates that, prior to disclosing personal information to an overseas recipient, the organisation must take reasonable steps to ensure the recipient does not breach APPs 2 to 13 in respect of that information.

The exceptions to this principle include where the organisation reasonably believes the recipient is subject to a law or binding scheme that has the effect of protecting the information in a substantially similar way to that of the APPs; and where the individual provides his or her consent for the disclosure, after the organisation expressly states the principle will not apply if that consent is given.

These reforms are of particular concern to health organisations and practices which use offshore data storage or processing entities, or otherwise disclose personal information to overseas recipients as, under the new regime, unless an offshore entity is bound by Australian privacy laws, the Australian organisation will be liable for any breaches by the offshore entity.

The liability is a strict one, and applies even after any relevant contract or agreement between the Australian organisation and offshore entity is terminated, however that termination is caused.

• APP 9 – Adoption, use or disclosure of government-related identifiers
  APP 9 prohibits an organisation from adopting, using or disclosing a government-related identifier of an individual, unless an exception applies.

• APP 10 – Quality of personal information
  Under APP 10, an organisation must take reasonable steps to ensure the personal information it collects is accurate, current and complete.

In relation to use and disclosure, the requirements differ from the current principles. For uses and disclosures, the personal information must be relevant, as well as accurate, current and complete, having regard to the purpose of the use or disclosure.

• APP 11 – Security of personal information
  APP 11 requires an organisation to take reasonable steps to protect the personal information which it holds from interference, as well as from misuse, loss, unauthorised access, modification and disclosure as required by the current principles.

  Like NPP 4.2, APP 11 requires an organisation to take reasonable steps to destroy or de-identify personal information if the organisation no longer needs it for any authorised purpose.

  There are two exceptions to this requirement: where the personal information is contained in a Commonwealth record, or where the organisation is required to retain the information by or under an Australian law or order by an Australian court or tribunal.

• APP 12 – Access to personal information
  APP 12 requires an organisation to give an individual access to personal information the organisation holds about that individual, unless an exception applies. The exceptions are substantially similar to the exceptions in NPP 6.

  Organisations are required to respond to requests for access within a reasonable period, and must also give access in the manner as requested by the individual if it is reasonable to do so. If an organisation decides not to give to an individual access to the information, generally it must provide to the individual written reasons for the refusal and the available avenues open for any complaint about the refusal.

  If an organisation provides a financial charge for providing to the individual access to the individual’s personal information, the charge must not be excessive or apply to the making of the request.

• APP 13 – correction of personal information
  APP 13 introduces new obligations with respect to the correction of personal information. This principle now requires an organisation to take reasonable steps to correct personal information to ensure that, having regard to the purpose for which it is held, it is accurate, current, complete, relevant and not misleading.

  An organisation must also respond to a correction request within a reasonable period after the request is made, and must not charge the individual for making the request. When refusing an individual’s correction request, an organisation must generally provide to the individual written reasons for the refusal and notify them of available complaint mechanisms.

POWER SHIFT
The Australian Information Commissioner has been provided with significantly increased powers, which will generally be exercised by the Privacy Commissioner, to encourage and enforce compliance of the new regime.

The Information Commissioner will soon be able to assess the privacy performance of businesses and agencies, which includes being able to conduct investigations and audits. The Information Commissioner will also be able to make determinations, accept enforceable undertakings, commence legal proceedings and, in cases of serious or repeated breaches, seek civil penalties of up to $340,000 against individuals and $1.7 million against bodies corporate.

Note: The content of this article is intended to provide a general overview and guide to the subject matter. Specialist advice should be sought about specific circumstances.

For more information contact Natasha Leedman, Senior Associate or Enore Panetta, Director, Panetta McGrath Lawyers, Perth on 08 9321 0522 or visit www.pmlawyers.com.au


NUMBER CRUNCH

Medicare provider numbers can prove to be a minefield for anyone practising in more than one location. By deciphering fact from fiction, Margaret Faux provides some clarity.

Studying Medicare sometimes feels a bit like conducting a study of the Flat Earth Society. There’s a lot of myth and not a lot of substance, and we betide anyone who dares to travel beyond the horizon.

Much of the confusion derives from the very nature of the Medicare Benefits Schedule (MBS) itself, which is a departmental publication, very much a hybrid work, containing law, fact and plenty of fiction. As Paul Keating might say, it is the ‘fiction that we have to have’. The legal literature and reported cases refer to the MBS very simply as ‘a book’.

In this article I will outline why the issues surrounding provider numbers are so confusing by considering them in the context of some of the many queries I have received from doctors. I will then provide some answers and some rules of thumb.

Why is Medicare so confusing?
The enabling legislation for the Medicare scheme is the Health Insurance Act 1973 (the Act), and its associated regulations and tables. Some components of this complex legal scheme are directly copied and pasted into the MBS, such as the items described in the General Medical Services Table. But the explanatory notes in the MBS reveal something entirely different and are probably best described as an interpretation by the Department of Human Services as to how the scheme should be administered.

It’s obviously an interpretation that clinicians would do well to adopt, though it is important to note that some of the explanatory notes throughout the MBS bear no relationship at all to anything that can be found anywhere in the law.

It makes for interesting work, but problems occur when MBS matters end up in court. Australian courts apply and interpret law, not books. So, while medical practitioners are advised to read and apply the MBS book, if they get it wrong and end up in a court of law, the court will ultimately apply and interpret the law rather than the book.

ON A SERIOUS NOTE

In Suman Sood v Regina (2006) NSWCCA 114 (12 April 2006), Adams J, sitting on the court of criminal appeal, remarked that Dr Sood was in a position where she was being required to interpret a point of law and apply it to the facts which, as a medical practitioner, she had neither the training nor the skills to do.

He went on to make this comment regarding the confusing language contained in the Act:

“This, however, is merely a function of the lack of clarity of the language of the Act. No entirely satisfactory interpretation of the Act is as it seems to me, available.”

And in dissenting from the Chief Justice, he went on to say:

“I do not accept that the legislature intended to place doctors in the position where a not unreasonable interpretation of the Act leads them to make a claim which ex post facto a judge (or, for that matter, a jury) will find to be wrong and render them liable to criminal prosecution.”

Dr Sood was found guilty by a jury of 96 counts of Medicare fraud in circumstances where she bulk billed and also charged an additional fee. She maintained from the outset that she did not know that what she was doing was wrong, and ample evidence was provided in support of this view. Applying the reasoning of Adams J, Dr Sood had made a ‘not unreasonable’ interpretation of the MBS, yet it landed her in a criminal court facing a jail term.

Clearly, medical claiming can be very serious stuff. Medicare is a taxpayer funded scheme, the integrity of which is the responsibility of the Federal Government. So it’s not something any clinician wants to get wrong. But how do you get it right?

In the absence of a national curriculum on the subject, where can anyone go for reliable information and support?

AROUND IN CIRCLES

Perhaps not surprisingly, Medicare has always maintained that ample information and support is available to providers. However there is evidence to suggest that some clinicians disagree. Consider this submission to the 2011 Senate Committee enquiry, which investigated the operations of the Medicare Professional Standards Review committee:

“I was concerned to get the Medicare numbers right for this clinic. They are not straightforward. So I sent quite a lot of information to Medicare asking for help. I said: ‘Are these odd numbers right? Is what I am going to charge right?’ It took months to get a reply. I got a reply saying: ‘We cannot give you an answer, Dr Masters. We suggest you contact the AMA and the college of GPs.’ I contacted the AMA and the college of GPs... and they said: ‘We are not here to interpret the Medicare schedule. That should be done by Medicare.’ Medicare will not do it. The PSR will not do it. The AMA will not do it. The college of GPs will not do it. And we get fined.’

The collective buck-passing eloquently expressed by Dr Masters leaves providers with little option other than to try and work it out themselves or ask their peers, who themselves are in no greater position to know the answers. It serves only to perpetuate MBS myths, misunderstandings and, ultimately, claiming errors.

QUESTIONS & THE ISSUES THEY RAISED

Let’s have a look at provider numbers, where it really shouldn’t be too hard to work out which one to use when. After all, provider numbers are a cornerstone of the Medicare scheme and a pre-requisite for enabling patients to be reimbursed for medical expenses they have incurred.

If the practitioner doesn’t have a Medicare provider number, patients can’t claim Medicare benefits – simple. Yet I am asked questions such as the following almost daily.

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THE QUESTIONS

I saw a patient today at a location where I do not have a currently open provider number. Can I claim using one of my other provider numbers?

I have a contract with a private hospital which stipulates that my private billings for certain procedures I undertake at that location must be done by the hospital. However, I am permitted to do my own billing for other services I provide at that location, such as seeing patients on the ward. But I can only have one provider number at that location (as there is only one street address), so how can I share that provider number between the two different billing arrangements and systems?

I’m an anaesthetist, so I don’t have rooms and I don’t have set lists at the moment. I’m covering for colleagues at various locations and I don’t know from day to day which location I may be at tomorrow. Do I need a provider number at each location, or should I just have one linked to my home? That’s what my colleagues have told me to do. And what do I do if I am at a completely new hospital tomorrow where I had never thought to obtain a provider number because I didn’t know?

I currently have a few provider numbers, one of which is at my rooms. From time to time I may see private patients at the public hospital, where I don’t currently have a provider number. Can I just use my rooms provider number, or do I need to get one at the public hospital? And if I want to do that billing for me, how will that affect my rooms billing?

I use a room in the hospital twice a week to see my outpatients and it does my claiming for the patients I see on the day. If you do my inpatient claiming at that location, what do I do about my provider number? I have another one at the other local private hospital – can I use that?

Under the terms of my contract at the public hospital, the hospital has linked my public-hospital provider number to its system and uses it to claim on my behalf for certain clinics. But what do I do about the private patients I see at that location, where I am entitled to retain the income? I will have to use one of my other provider numbers, won’t I? Otherwise the claimed benefits will be deposited into the hospital’s bank account rather than mine.

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Moving locations daily while I do locums – can I use a home provider number?

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THE ISSUES RAISED

No provider number for a new location. Can I use a different one?

Can I get two provider numbers for the same location?

PROCEED WITH CARE

The problems are twofold. Firstly, Medicare provider numbers are linked to street addresses and currently it is only possible to have one provider number per doctor and per street address, and each Medicare provider number can only be linked to one electronic-claiming system.

As a result, the answer to many of the above dilemmas is that it is simply not possible to ‘share’ one provider number on two different software systems to lodge claims for services provided at one street address. It just can’t be done – end of story.

And it can all go terribly wrong if care is not taken when managing provider numbers. I once witnessed $40,000 of claims for one provider get ‘stuck’ in the crossfire when the day after they had been transmitted, but before they had been paid, the practice was taken offline due to a careless administrative error.

On another occasion, a provider inadvertently linked his public-hospital provider number to a new billing system, whereby the public hospital’s revenue stream for his private patients suddenly dried up as it was now being diverted to the provider’s own bank account, much to the chagrin of the hospital!

You’ll be pleased to know that these types of errors can always be rectified, but not without administrative pain and sometimes significant delays in cash flow. So it’s prudent to always pause before signing any Medicare form for any hospital or practice. Ask yourself if the provider number to which the form relates is currently in use and by whom, and is it linked to claiming software? Sometimes alternative solutions are the only option.

In a conversation with Medicare earlier this year, where I was explaining some of these recurrent issues faced by providers, I was advised that it was now possible to have two provider numbers for the same doctor linked to the same address. All I needed to do was prepare a letter, signed by the provider, setting out the reasons for requiring the second provider number at the same address, and attach it to an application for an additional provider number.

Wonderful, I thought – a watershed. Yet when I tried to assist a client to organise this, by drafting a carefully worded letter and submitting it as instructed, I was advised that it was not possible. Back to square one.

RULES & REGULATIONS

So, are provider numbers location specific, and what exactly does the legislation say?

Before we look at the Act and Regulations, I just want to quickly clarify a point of terminology that can sometimes add to the confusion. LSPN is an acronym for ‘location specific practice number’, not ‘provider number’. LSPNs attach to the premises, not the provider, and relate to diagnostic-imaging services. Any machine used to provide diagnostic imaging services must be registered under an LSPN to enable the payment of Medicare benefits at designated rates. LSPNs exist on a national register, which is accessible online.

The Medicare scheme does not describe ‘location specific provider numbers’ as such, though it is true that provider numbers are attached to locations.

The relevant law pertaining to provider numbers (all underlining added) is found in Section 19 of the Act and Regulation 13, the relevant sections of which are copied below:

HEALTH INSURANCE ACT 1973 – SECT 19

Medicare benefit not payable in respect of certain professional services

(6) A Medicare benefit is not payable in respect of a professional service unless the service is rendered, or on behalf of whom the professional service was rendered, or an employee of that person, has recorded on the account, or on the receipt, for fees in respect of the service or, if an assignment has been made, or an agreement has been entered into, in accordance with section 20A, in relation to the Medicare benefit to respect of the service, of the form of the assignment or agreement, as the case may be, such particulars as are prescribed in relation to professional services generally or in relation to a class of professional services in which that professional service is included.

The prescribed particulars referred to in Section 19 are found in Regulation 13 as follows:

HEALTH INSURANCE REGULATIONS 1975 – REG 13

(1) For the purposes of subsection (6) of the Act, the following particulars are prescribed in relation to professional services generally:

(a) the name of the patient to whom the service was given;
(b) the date on which the service was given;
(c) the amount charged in respect of the service;
(d) the total amount paid in respect of the service;

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HEALTH INSURANCE REGULATIONS 1975 – definitions

"Provider number" means the number that:

(a) is allocated by the Chief Executive Medicare to a practitioner, approved pathology practitioner, optometrist, participating midwife or participating nurse practitioner; and

(b) identifies the person and the place where the person practises his or her profession.

"Practice location", for the provision of a medical service, means the place of practice in relation to which the medical practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Chief Executive Medicare.

There are no cases or reports to assist in interpreting these sections of the scheme, which itself may indicate that it is not something that has been of significant concern to Medicare. However, like so much of the scheme, the drafting is broad (and quite inconsistent if you look closely) but the interpretation is narrow. Have a look at the following extracts taken from the Medicare Act, the particulars prescribed in relation to professional services rendered by a medical practitioner under subsection 3J(1) of the Act:

(a) the name and the address of the medical practitioner;

(b) the provider number of the medical practitioner.

And the relevant definitions of 'provider number' and 'practice location' are also contained in the regulations:

LOCATION, LOCATION

It is apparent that much of Medicare's broad interpretation of the legislation on this topic is not contained, or at least not with any clarity, in the legislation.

Specifically, neither the Act nor the regulations contain Medicare's statement, being that: "A provider number uniquely identifies the medical practitioner and the location from which a service is rendered."

The legislation says a provider number identifies the person and the places where that person practices. The scheme clearly refers to the person (being the medical practitioner) not the place where the service was rendered, and nowhere is there a clause indicating that a medical practitioner is prohibited from using a different provider number than that attached to the service location.

Of course, much of this is a non-issue for many practitioners and specifically for many GPs, who will usually practice in one location. For them it is simple enough, as they will obtain a provider number for that location and it will often be the only provider number they will ever need.

But I've even had GPs ask similar questions to those above when they have started providing inpatient services as CMOs, or are moving around for other reasons. And with Telehealth services now being on the increase, more and more provider numbers will be attached to home addresses or even corporate offices, where the clinician physically sits to undertake the Telehealth consultation.

Many specialists are simply choosing to use one of their existing provider numbers for Telehealth consultations, just as GPs do when they conduct home visits. Still, some practitioners, mostly those providing inpatient services, are not sure which provider number to use when.

SITE SPECIFIC

General practice is almost exclusively made up of outpatient services and, as I have mentioned, it's usually fairly straightforward in that environment. The practitioner should have a provider number linked to that location. Nowhere in the scheme is there any indication that you...
could not use a provider number attached to a different location while you were, for example, waiting for a new one to be issued.

Sometimes the issuing of provider numbers can take much longer than the stated timeframes on Medicare’s website. Earlier this year there was a significant backlog, causing even the simplest applications to take over a month.

So, if you look at the contents of a standard GP invoice, you will find that only one provider number will usually be included, being that of the servicing GP. In contrast, with the exception of anaesthetists (who don’t need referrals to claim most of their services), specialist invoices will always include a minimum of two provider numbers, and three if an inpatient service has been provided.

In the outpatient context, a specialist invoice will include the servicing doctor’s provider number and the referring doctor’s provider number. Inpatient specialist invoices will include a third provider number, being that of the hospital or registered healthcare facility.

As to whether this last invoice containing three provider numbers complies with the legislation or not, it would be difficult to suggest that it doesn’t – even if the provider number used by the specialist was not the provider number linked to the service location.

The two clear requirements of the scheme are met by providing the servicing provider’s name and address. However, it is also standard practice and most software requires that, in addition, the provider number of the location at which the service was provided is included on the claim.

After all of that, all you need is your name and address. But, according to Medicare, ‘the fiction that we have to have’ includes a provider number linked to the service location.

If you think about it from the department’s point of view, Medicare does need to keep its legislative drafting style broad to allow doctors to exercise their clinical discretion. To do otherwise would result in lawyers and bureaucrats determining how doctors should practice medicine, something clearly not in the best interests of the health of the nation. But this is cold comfort for doctors who want and deserve certainty and freedom from fear of a Medicare audit.

ROLL WITH IT

In stark contrast to Medicare’s interpretation of the Act, Adams J in Sood’s case adopted a narrow view and basically said it (the Act) means what it says, and to suggest otherwise would create “…considerable uncertainty in a context where precision of scope is of considerable importance…

Although the Regulations comprise a distinct statutory instrument, it forms part of a detailed, comprehensive scheme. In my respectful opinion, the acceptance of the Crown submission would, in effect, surround each item with a penumbra of indeterminate meaning inconsistent with the structure of the legislative scheme and unfair to the medical practitioners attempting to work within its boundaries.”

Medicare will need to adapt to modern medical practice, where providers have changing needs as they become more mobile and the traditional model of medical practice becomes a thing of the past. Virtual medical practices are here to stay, and this will impact the way provider numbers are used.

But because no-one wants to end up facing criminal prosecution, the best advice is to obtain a provider number at each place where you intend to practice and always use the provider number attached to the location where the service is provided, if you can. But if you simply can’t, use another provider number and include additional information on your invoices to inform Medicare of the location at which the service was provided.

Always ensure you can tick off the legislative requirements, of which there are only two, and if you have specific limitations or restrictions on your provider number, speak with Medicare and follow its instructions on exactly what you can and can’t do.

It’s one of those situations where it’s better to just roll with the Flat Earth Society – don’t fall off the horizon and accept that this is a fiction we just have to have. ©
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To get the most out of your purchase, discuss your needs with an experienced specialist in the industry who understands your profession and your financial circumstances. With the right financing, many of the things on your practice ‘wish list’ that feel out of reach could easily be yours.

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Do you want to still be working full-time in your practice in 2020? If not, when will your successor start? Don’t tell me you haven’t found one yet!

Realistically, if you’re planning to step back or completely away from your practice within the next five to eight years, then the time to start planning is now. It’s a sad fact that, on the retirement of one partner, many GP practices simply follow a semi or unplanned process that often ends up with the practice bought out or appointing a successor. The practice offers a mix of GP and complementary healthcare services, and is very busy. Gillian and Jeremy both have full patient loads and oversee the management and administration, as well as making all key business decisions. The business supports three younger practitioners: Janine (38), Ben (46) and Kelly (43).

Jeremy wants to retire on his 65th birthday – less than three years away. He and Gillian discuss their plans, and Gillian says she wants to retire in six years. Based on casual conversations in the past, both are confident that the younger practitioners will be keen to take over the practice, and they decide to call a meeting to formalise these arrangements.

But Gillian and Jeremy get a shock. At the meeting, Janine announces she wants to spend two years as a volunteer, and is planning to leave for Africa the following year. Ben’s father has been diagnosed with Alzheimer’s, and he was about to ask if he could go part-time so he can spend more time caring for him. Only Kelly is ready and able to step up into ownership of the practice.

CONSIDERING YOUR OPTIONS

Before we return to Gillian and Jeremy, let’s have a look at the pros and cons of three options.

1. Wind down and close the doors
   ✓ Shorter timeframe.
   ✓ Continuity of patient care can be difficult to achieve.
   x Declining revenue but constant or increasing overheads during wind down.
   x Employees may decide to leave during wind down.
   x Income declines with no goodwill value to compensate.

2. Maintain status quo and try to find a buyer or successor
   ✓ Potential to realise greater financial return.
   x Increased likelihood of continued patient care.
   x Increased likelihood of continuing employees.
   x Timing uncertain.
   x Retiree may have less control over the speed of transition from full patient load to few or no patients – and it can be sudden.
   x May end up having to close the doors after all if a buyer or successor can’t be found, or the arrangement does not work out.

3. Grow and transition the practice to one or more successor
   ✓ Greater financial return.
   ✓ Smoother transition in patient care.
   x Employees continue in the practice.

SMART MOVES

Fruitful succession requires strategic planning well in advance of your proposed retirement date. Linda Sirol offers some practical advice.

Did that last one surprise you? It might seem like the kind of growth strategy usually associated with the launch of a practice, but why shouldn’t one end serve as another beginning?

A CASE IN POINT

Don’t assume you already have successors. Let’s look at a case study whereby Gillian, 56, is a GP and co-owner in a group medical practice with physiotherapist Jeremy, who is 62. The practice offers a mix of GP and complementary healthcare services, and is very busy. Gillian and Jeremy both have full patient loads and oversee the management and administration, as well as making all key business decisions. The business supports three younger practitioners: Janine (38), Ben (46) and Kelly (43).

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But Gillian and Jeremy get a shock. At the meeting, Janine announces she wants to spend two years as a volunteer, and is planning to leave for Africa the following year. Ben’s father has been diagnosed with Alzheimer’s, and he was about to ask if he could go part-time so he can spend more time caring for him. Only Kelly is ready and able to step up into ownership of the practice.
• Make a careful assessment of the current situation of your practice and the intentions of others in it.
• Decide when and how transitions will occur in ownership, control, management and clinical work.

2. Make a wishlist about your ideal successor
• Would there be more than one?
• Is there one or more in the practice already?
• What characteristics should they have – clinically, administratively, personally and in terms of their career goals?

3. Search for your successor
• Are they already in the practice, or could they be given some training?
• Who do you know in your professional network?
• If you draw a blank here, you may advertise the opportunity.

4. Agree on a contract
When you find a potential successor, it’s vital to have a written legal agreement that covers all the bases, including:
• Transactional: Are they buying in?
• Transitional: Are they earning in?
• Terms: What if it goes pear-shaped?
• Timing: When do they take over your various roles?

5. Manage and communicate the transition
• Make sure everyone in your practice is kept informed and given options and choices throughout the transition.
• Tell your patients about the transition and aim to maintain their loyalty.
• Show your successor the ropes in a structured and formal way, even if they are from within the practice.
• Agree formally (in writing) on timing and benchmarks in terms of their uptake of your various responsibilities.
• Have early and concrete indicators of success – how many patients should they have taken on in what timeframe, how will successful handover in each area be measured, and what action will be taken if targets are not met?

6. Review the process
In my experience, having no review process in place is one of the major causes of succession failure. I am often approached by doctors who tell me they selected a successor, but now – two to three years or more down the track – it isn’t working, and they’re not sure what to do about it.

The answer here is to be proactive – have in place formal mechanisms for reviewing the arrangement regularly. If it’s not working, fix or terminate it rather than letting the problem fester.

THE RESULTS
I’m happy to say that, after their initial shock, Gillian and Jeremy sought some advice and assistance with their succession planning. The advisor helped them devise a strategy and set up a transitional ownership structure that enabled Kelly to take first refusal on Jeremy’s share of the practice. Kelly entered an agreement to buy Jeremy’s share of the practice over the next three years while she gradually stepped up into his management role.

Together, Kelly, Gillian and Jeremy sought new practitioners to bring into the business to share and eventually take over Jeremy’s caseload, to cover for Janine while she volunteered and to allow Ben to go part-time. In the selection process, they also looked at the potential of the applicants as successors who could buy Gillian’s share of the practice and allow her to retire as planned.

As a result, the practice continues to thrive and grow, with new practitioners building on Gillian and Jeremy’s success, and Janine and Ben both having the option to return to it in the future.

SO, HOW ABOUT YOU?
If you’re planning to retire or exit at all – and particularly in the next five to eight years – sit down now and plan a fulfilling exit that:
• Gives you a great financial return and/or ongoing income.
• Allows you to control the timing and terms of your exit from practice.
• Provides peace of mind that your patients are being cared for by doctors you have helped train and are aligned with your values and culture.
• Is transitional and a less ‘jarring’ change in lifestyle.

Clearly Option 3 is the one I’m advocating here! It’s up to you to decide what is most important to you in terms of your legacy and your future income, and to assess the three options against your timeframe and resources. Once you have done this, decide firmly on your option and implement it. With some forward thinking and solid planning, retirement can be a whole new beginning.
PROTECTING YOUR REVENUE

Want to protect your golden goose? Then Chris Mariani suggests doing some research into business expenses insurance.

A doctor who recently attended a Private Practice course on risk management commented: “I’ve got business expenses insurance, so I think I’m fully covered, aren’t I?” As explained below, the answer to the question is, “You’re partly covered!”

The terminology ‘business expenses insurance’ can mean different things to different people. Commonly, ‘business expenses insurance’ is a policy attached to an income-protection contract. This insurance covers your fixed business expenses should a claim be triggered by an accident or illness that prevents you from working.

Another type of ‘business expenses insurance’ is commonly found within a property or business-package policy. Under this policy type, the insurer covers the business’s loss of revenue when it is unable to trade due to an ‘insured peril’, such as a fire or storm damage.

There are some risks that you can’t transfer to insurance, or that would be cost prohibitive, such as lost revenue suffered due to cancellation or suspension of your medical registration. Hence, good risk management should always be practised, and insurance viewed as a final layer of protection.

Insuring your revenue in a property or business package policy

Most medical practices – whether a GP clinic, specialist rooms or day surgery – are reliant on their practice premises in order to function. In the case of a single-site GP clinic or a day surgery, the business would likely grind to a complete halt in the event of a major fire or storm damage, and the practice would likely face the choice of:

- Closing down the practice and waiting for repair/rebuild.
- Finding new (or temporary) premises asap, with the aim being to get back trading asap.

‘Business interruption’ (BI) insurance is designed to put the business back in the same financial position it would have enjoyed but for the loss of the aforementioned fire or storm. There are numerous ‘moving parts’ to consider when reviewing the need for BI cover, and due to the complexity of both individual circumstances and the policy cover, the following is only a brief summary of some of the things to consider:

FACTORS TO CONSIDER

What is my strategy in the event of a disaster?

You should have a clear idea of what you would intend to do in the event of, say, the premises burning down, and then match the BI cover to suit your strategy, referred to in risk management as a Business Continuity Plan (BCP). The practice that intends to find new rental premises quickly will require a different BI structure to the practice that intends to close down for a lengthy rebuild.

What lost revenue should I cover?

To understand this, you need to look at both your BCP strategy and what expenses you will continue to incur versus those that are truly variable. For example, a GP clinic that engages contracted doctors will generally be under no obligation to pay the contracted doctors (as the contractor is only paid a percentage of billings they generate), while the business is closed. However, the business would risk those doctors leaving to find an alternative practice to engage with, meaning that on re-opening, the business has lost its key people.

Most clients I advise will opt to insure 100% of their gross revenue (including wages and contractor payments), as it provides flexibility should a disaster strike.

What ‘Additional Increased Costs of Working’ should I cover?

BI not only covers lost revenue but can also be extended to cover the additional costs you incur that assist you getting back to your pre-loss situation. This could include costs such as overtime, IT consultants, additional short-term rent and advertising to advise current patients of your new location. Many policies only provide a small amount of automatic cover (some as low as $10,000), and our experience has revealed that even for small practices this should be at least $100,000.

How long should I insure for?

This is generally a function of:

- How long it will take to repair/rebuild/reoccupy the premises, or how long it will find to commence trading at new premises (with sufficient time to allow for things such as council approval, demolition, etcetera).
- How long the business will take for the business to return to its pre-loss position (i.e. when it is back to 100% revenue and no further additional costs are being incurred).
- Are you tenant, landlord or both?

Again, your BCP strategy dictates what you would do in the event of a disaster and will therefore also dictate the period you need to insure for. This is referred to as the ‘indemnity period’ in the BI policy.

What events can ‘trigger’ a claim under the BI section?

The most common types of events that trigger the BI cover are claims covered under the ‘fire and perils’ sections of the policy – i.e. fire, storm, earthquake and theft, especially where malicious damage occurs. The better policies also provide cover in the event of:

- Closure by public authority (e.g. Legionnaires disease, murder or suicide).
- Interruption of public utilities (e.g. electricity, gas, etcetera), which means you are unable to conduct your business.
- Customers or supplier’s premises (where loss at their premises impacts your business).

Again, your individual circumstances need to be considered – for example, consulting rooms within a hospital will have different exposures and needs to a rural GP clinic.

I’m not reliant on a particular premises, so do I really need cover? Possibly not. The only client I have seen in recent times who truly had no or little exposure to ‘their rooms’ was a specialist who essentially rented room space on a casual basis at a number of different locations, and would spend a day or two at each location per week. The specialist’s BCP strategy would simply be to move any patients to any
one of the other locations he rented, so he was confident he did not need BI cover. He may have still benefited from holding ‘Additional Increased Cost of Working’ cover, as, for example, it could be used to pay the costs of hiring transport for patients that had to travel further to see him.

What other types of insurance can cover lost revenue from different risks?
There is also cover available for other types of lost revenue caused by different triggers, including:
• Cyber risks: A hacker manages to break into your server and delete, tamper with or demand a ransom. This may result in lost revenue (as it can be difficult to trade without patient records) and additional IT costs.
• Electronic or machinery breakdown: The air-conditioning breaks down in the middle of summer and patients avoid the premises due to the heatwave, resulting in a loss of revenue.

WHERE TO START
Firstly, don’t try to do this yourself! You wouldn’t do your own taxes and would instead use an experienced accountant. Insurance is the same, so engage an insurance broker who has experience in the medical sector and have them complete a review of your particular circumstances.

The broker should be able to recommend a suitable policy structure and will be able to source the most appropriate cover for you. The broker works for you, so their duty is to you, not to the insurers, who will simply sell you the product they have on the shelf.

If you have any questions or need advice on your insurances, please contact Chris Mariani on 02 9905 7005, 0419 017 011 or chris@mgrs.com.au for an obligation-free discussion and review.

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Defining Trauma

In the final instalment of a three-part series, Katherine Ashby examines the different levels of coverage between trauma policies.

When purchasing insurance, nothing is more important than reading the fine print. This holds true not just for home or car insurance but also when insuring your most important assets – yourself and your family. Where total and permanent disability (TPD) and income protection insurance insure your ability to work, trauma insurance is payable entirely upon meeting the definition of one of the listed illnesses or injuries. This makes the list of conditions and the definitions behind them of the utmost importance.

To re-cap, trauma insurance is known by many names, including Crisis, Critical Illness, Recovery, Living and Trauma. The names all refer to what the cover is designed to do, provide a lump sum of money to support you and your recovery if you suffer from a traumatic illness or injury. The amount of cover you take out is then payable to you if you suffer one of these events. For example, if you insure yourself for $500,000 and then have a heart attack, meeting the policy definition as this is an insured event, the $500,000 would be payable.

Levels of cover

Most insurers have a standard and a premier policy. Unlike other types of insurance, over 95% of policies purchased are the premier type. Standard policies will generally have between 10 and 40 conditions, whereas premier policies will have the maximum, usually more than 40.

Premier policies will also provide partial payments (between 10 and 25%) of the sum insured for early stage or more minor conditions. For example, this could be carcinoma in situ of the breast, early stage leukaemia or loss of hearing in one ear. One of the main areas policies can differ is where the insurer puts the line between a full payment and a partial payment, particular for common cancers.

Specific conditions for medical professionals

Most trauma policies have a condition for occupationally acquired HIV. This means you would be covered if you acquired HIV in your workplace, which may be due to a needlestick injury, blood splatters or even inhalation of bone dust. You can also add an additional amount of cover, usually referred to as a Needlestick benefit. Despite its name, Needlestick cover is not limited to needlestick injuries alone – it will pay a lump sum in the event you are diagnosed with occupationally acquired HIV, Hepatitis B or Hepatitis C.

Needlestick cover will provide a lump sum of up to $1 million, dependent on your sum insured. The amount you choose does not need to be the same as the trauma sum you are insured for, and the cover is significantly cheaper. For this reason it is common for medical professionals to have much higher cover amounts for needlestick than trauma.

Cover for children

Trauma cover isn’t just for adults. Insurers also provide Child cover, which covers children aged two and above in the event of death or suffering a significant illness or injury. The most common claims for children are for cancer and injuries caused by accidents, such as severe burns or major head trauma.

Even if you have your own insurance, it won’t cover you to take time off work to be with you child should they become sick or injured. Child cover provides a lump sum in this instance, meaning you can take time off work and put funds towards medical treatment.

Children can be covered for up to $200,000 and the full amount is payable in the event of a claim. Some policies will have a small amount of inbuilt free cover as part of an adult policy. For example, BT automatically provides $10,000 of cover with adult policies.

Cover for adult children

We often think of trauma insurance as something you need if you have debts and/or dependents. But more and more parents are looking to take out trauma policies for their adult children, particularly when they first begin going out to nightclubs or driving on their own. In fact, some advisers refer to this as P-plater insurance.

Trauma provides a strong level of coverage for serious injuries resulting from accidents, including paralysis, major head trauma or severe burns. A claim is also payable if an accident results in someone being in hospital for a certain length of time – for instance, if your son had an accident that resulted in him being in a coma for more than 72 hours or in intensive care for more than 11 days. The claim payment would then allow you and/or him to take time off work and, more importantly, to fund the best medical care available.

PEACE OF MIND

In this series we’ve covered off many issues, starting with how much cover you may need, followed by how the cover should be structured and finishing up in this edition with the definitions and benefits to look for. Trauma cover is complicated, and advisers spend a great deal of time working with you to assess your needs before researching and contrasting the policies available. Expert advice is essential.

Trauma cover is a fantastic product as it provides flexibility and financial peace of mind when your family is faced with a serious illness or injury. It is less well known than the other lump-sum policies, life insurance and total and permanent disability, yet the chances of claim are far higher. If you’re not sure whether you have trauma cover or you need to review your policies, speak with your financial adviser.

In 2012, Australian insurers paid over $555 million in trauma claims to 5193 claimants (Source: The Risk Store Industry Stats 2012). The leading cause of claim was cancer, followed by heart disease and neurological conditions.

At BT, our experience mirrored this, with cancer making up 60% of claims for men and 84% of claims for women.
You may believe you are free to do what you want with your superannuation and your will, but as Donal Griffin highlights, this is not necessarily the case.

Self-managed super funds (SMSFs) have continued to grow in number despite, or perhaps because of, the global financial crisis. The people establishing these funds clearly want to take control of their finances and would like that control to extend to whoever receives any balance remaining after they die.

The ability to nominate beneficiaries for your superannuation is restricted by the Superannuation Industry (Supervision) Act 1993 and related legislation and regulations. Many people are unaware that they cannot validly nominate a friend, a charity or any person who is not a ‘dependant’ or their estate to receive their superannuation. In our experience, superannuation is increasingly becoming an asset that attracts the attention of disappointed people who expected to be beneficiaries of a substantial member balance.

People may be dismayed to discover that they may not have been treated the same as their siblings by a parent or, more annoyingly, by a third-party professional super-fund trustee.

Often one of the deceased’s children, as the executor, steps into the role of SMSF trustee. If there is no valid binding nomination in place, the bad news for the other siblings is that unless a will directs that adjustments be made for superannuation payments, the executor can pay the super to themselves with impunity.

Some of you may be outraged by this, however the law is fairly settled in this area. For more than a century, freedom of testation in Australia has been restricted by legislation that allows a broad range of people to challenge one’s will. Ignoring the reality of potential claims can put the person managing an estate under terrible stress and financial pressure, as they are the person disappointed parties will sue.

The only way to have certainty with superannuation is to ensure that binding nominations are in place and up to date (they usually lapse every three years). Regulation 6.17A sets out in detail which requirements must be included in the nomination for non-SMSFs, including the fact that it must be in writing and signed and dated by the member in the presence of two independent adult witnesses.

At de Groot Lawyers we are continually amazed by how many unwitnessed or undated nominations we see. People assume their wishes are clear but often they are invalid.

But, if you have an SMSF, you have more flexibility and certainty, as well as more responsibilities in terms of compliance with complex superannuation rules. The terms ‘self-managed’ and ‘DIY’ are disingenuous and professional support is usually essential.

Despite the three-year period, there are good tax reasons for checking nominations annually. For instance, if a nominated child beneficiary turns 18 and is no longer financially dependent, 16.5% tax will apply to any taxable benefit they receive.

DETERMINING FACTORS

So, who makes the determination? If there is no binding nomination that is valid, the trustees of super funds make the determination, but they need to follow due process. When we see disputes ventilated, it is often the case that allegations are made around the trustees making a determination without following due process, in terms of notices, quorums for meetings, analysis of reasons given (if any) and resolutions.

We see many clients who love the tax environment of their super fund but are less excited by the fact that there are limited number of people to whom they can pay their superannuation on their death. In particular, it is usual for them to pay a pension or a lump sum to a spouse but, just as commonly, they may want to put controls over that spouse’s use of the money, with a view to it being available for their children when their spouse passes away.

Superannuation is an excellent asset-accumulation vehicle but cannot be as easily utilised as an asset-transfer vehicle. Regulation 6.22 of SIS Regulations 1994 states that benefits must be paid to either or both of the following:

• The member’s legal personal representative.
• One or more of the member’s dependants.
• A nominated child beneficiary.

The cases reveal that compliance with the statutory requirements is mandatory and strictly monitored. Decisions can be surprising and disappointing, depending on your position.

In most cases, particularly if there is a dispute about who should apply to be the legal personal representative (i.e. a spouse versus the de facto spouse or a child versus another child of the deceased), it would be prudent to be clear as to who the legal personal representative is. Some cases show that there has been confusion as to whether a death benefit is paid to a person in their capacity as legal personal representative or in their personal capacity.

TIES THAT BIND

What is a binding death benefit nomination?

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CHOOSING AN ADVISER

When it comes to making sound financial decisions, David O’Callaghan says it is essential to engage someone that is fully equipped to point you in the right direction.

Over the years I have presented at many courses and conferences, and regardless of the topic I am presenting on a common question often gets asked: “How do I choose a good financial adviser?”

Considering the importance of having someone on your team who can assist you in making the right financial decisions, this is not a surprise. So, let’s go through some of the key factors you should be looking at when making your decision.

What advice do you want?
You may be looking for an ongoing relationship with an adviser or simply one-off advice to address a specific matter. Whatever the case may be, you need to be clear about this as the estimation of cost will likely reflect the advice required.

What are your goals and objectives?
A common problem people have when they seek advice is they haven’t really thought about what they want to achieve. They come into the adviser’s office and say, “Tell me what I should do.” This is akin to going into a doctor’s surgery and asking the doctor to prescribe a medicine to fix you before they have had a chance to examine you. Think about what you are looking to achieve and this will help the adviser to help you.

Who do your friends use?
This can be somewhat of a double-edged sword. On one hand, knowing a friend or colleague already uses the services of the adviser can provide comfort, but be warned – your friend may not have a good understanding of what a quality advice firm looks like. Over the years there have been a number of groups who have targeted doctors and provided questionable advice at best. And when things go badly and they are asked “Why did you go to them?”, the general response is because someone they knew recommended them.

So don’t be a lemming. It can be fine to obtain a referral from a colleague, but don’t go in blindly. Do your due diligence and ask questions.

STARTING POINT
A good place to start when looking to engage an adviser is to find out if they are a member of a professional association – the main two in Australia are the Financial Planning Association and the Association of Financial Advisers. While membership does not provide certainty regarding an adviser’s skills and ability, there is a code of conduct and ethics members must adhere to. There are disciplinary actions that can be imposed if the code is not followed.

If you are looking for an adviser who is a member of the Financial Planning Association (FPA), I would suggest it is best to deal with a Certified Financial Planner.

Obtain a copy of the FSG
The Financial Services Guide (FSG) is a guide that outlines a range of information relating to the financial advisory business. It covers important matters such as who the licensee is, how the firm charges, dispute resolution, services available, privacy and relationships with other entities. You should receive a copy of the firm’s FSG prior to any advisory services being provided. Ask for one to be sent to you prior to your initial meeting with the adviser.

YOUR STEP-BY-STEP GUIDE
1. Work out what type of advice you require.
2. Ask friends/colleagues/family or someone in finance, such as an accountant or lawyer, for a recommendation.
3. Research the names.
   a. Check the company website.
   b. Obtain (and read) their FSG.
   c. Research their licensee (detailed in the FSG).
4. Meet with two or three advisers, and have your questions ready.
5. Obtain initial advice from the adviser you deem most suitable. A charge will probably be incurred at this point.
Check the adviser is licensed
To be a financial adviser in Australia, an individual must be a holder of an Australian Financial Services license or be a representative of a licensee. If they are neither, I would suggest you immediately move on. Many people who have been duped by investment-scheme promoters have subsequently found out that the people who recommended they invest in the scheme were not licensed.

Part of being licensed is a requirement to hold Professional Indemnity (PI) insurance, which provides a level of protection in the event that your adviser breaches the law. It should be noted that PI insurance does not cover you in the event your investment loses money.

Ask upfront about fees
You should expect to pay for the advice you receive. If you are not paying, you should question why not. Advisory businesses are not charities, so if you are not paying a fee for the advice then how are they financially viable? Often advisers are employed by a product manufacturer such as a bank, super fund or insurance company, and their so-called ‘free’ service is funded by the management fees their employer charges its funds. So, guess whose product you will end up getting? Fees do vary widely, depending on the services provided. Now, I’m not saying go out and find the most expensive firm, but be careful trying to save a few bucks in advisory fees, as this could cost you 10 times that amount in the long term through poor advice or dismal investment returns.

Most advice firms will not charge for an initial introductory meeting but it is at this meeting when you should ask for an estimate of upfront and ongoing advice fees. Remember, if the adviser says there aren’t any costs, question their suitability.

Let’s now take a look at some of the ‘how’.

Determine who owns the business and who is the licensee
As mentioned above, you want to be careful of the adviser being influenced in their product selection due to the business owner, their employer. While many of the large licensees are now owned by banks or insurance companies, you should be asking what products they have available to use – are they restricted to the products of the employer? The licensee will generally have an Approved Products List (APL) or guidelines on what the adviser can offer.

Ask to see the APL
Many licensees require their advisers to operate off an Approved Products List. This list typically includes products the licensee has looked into and is comfortable with the adviser recommending. You should be asking if the products and, importantly, platforms on the list are purely that of the parent company. It is not uncommon for the list to include a range of different companies’ products, yet the platforms are purely that of the parent. I would stay away from these, as platform choice can be an integral aspect of a well-structured investment plan.

It should be noted that even if a product is on an APL, this does not give a guarantee of its security and/or performance. This was seen with some devastating consequence during the global financial crisis, when some of the products on APLs exploded and left investors with little or nothing. In saying that, I would be using products on an APL where possible, as you should expect at least some level of scrutiny for them to make it on the list.

Check education, experience and accreditation
Apart from being licensed, ensure that the adviser you are speaking to has appropriate experience (I would suggest a minimum of five years) and is appropriately qualified. While it has improved in recent years, in my opinion the base level of qualification to provide financial advice is still too low. You should be looking for more than just the minimum.

To provide advice in certain areas, many licensees require the adviser to complete an additional level of qualification. Two examples where some additional level of training and accreditation is often required are listed securities and self-managed super funds. If there is a possibility that you may need advice in these areas, check for the additional accreditation or ask if the adviser is authorised to advise on these matters.

ADDITIONAL CONSIDERATIONS
A financial adviser should be treated as a long-term partner, so be sure to consider the following when choosing the right person for the job.

Go in for the long haul
The relationship you develop with your adviser may last for many years. It may also end up being multigenerational. For this reason, I suggest you choose someone that is not going to retire in the next year or two.

Ask about client types
To get a feel for whether the advisor is going to understand your particular situation, it’s a good idea to ask what types of clients they normally deal with. While there may be a range, almost all advisers have been around for a while will lean toward having most of their clients in a particular segment.

Beware of big promises
Be very careful of advisers that make big promises. A quality advisor does not need to provide the lure of high returns or huge tax savings. Unfortunately I have seen this on many occasions, and people do fall for it. If promises are being made that seem too good to be true, they probably are.

Gauge the level of service
It’s important to determine what level of service you would like to receive. Ask how often will you be reviewing your financial plans and how often you should expect to be contacted by the adviser. Again, this will give you a better perspective as to whether the fees are reasonable and will also establish clear expectations for both parties.

Educate yourself
Being armed with the right questions to ask yet not knowing if the response you receive is the right one can be an issue. One of the best ways to address this is to gain at least a basic understanding of financial matters. This can be done through reading or attending an education program. You don’t have to spend countless hours doing this, but a small investment of your time can pay off in spades, and you will be probably feel more confident knowing you are not proceeding purely on blind faith.

Ask about the range of services offered
Understanding the types of services you’re after can give you a way to shortlist potential advisers. If you are thinking of establishing a self-managed super fund, make sure the person you are talking to is skilled in that area. Do they have clients in a similar position to you? If you require legal or accounting advice, do they have associates in these areas? While many advisers refer this to another business (and that is fine), it is important that they have contacts so all areas of your financial position can be addressed.

Enquire about cancelling your contract
When deciding on which adviser to use, I recommend that you establish the costs or timeframes required if you choose to terminate their services. Most of the old and nasty exit fees have been removed from products, however you should be careful of any issues that could make it potentially difficult to leave.

Fee contracts can usually be cancelled by either party within a set timeframe of, say, 30 days. The onus is on you to determine what the process is to leave if you are unhappy.

It is important to understand that, in many cases, there is a clear distinction between the adviser and the investments. This may allow you to terminate the adviser’s services without affecting your investments. It can be as simple as signing a letter diverting the advisory fees you are paying from the investment to the new advisory firm, or cancelling them altogether.

Happy financial planning!
While talking to one of my patients, I wanted more information about her earlier IVF cycle and said to her: "Did you ask your doctor why he selected that particular dose of HMG injection for your super ovulation?"

She seemed puzzled, and responded by saying: "How can I question my doctor – isn’t that rude? Won’t he get offended if I ask him questions? I don’t want to upset him by challenging his authority. And, in any case, what do I understand about any of these medical terms? Even if he did answer my question, most of it would go over my head so there would be very little point in cross-examining him. And he’s the expert, so I am sure he must know what he’s doing!"

I think this is a hangover from the good old days, when the family doctor knew everything there was to know about the family and could be trusted to make the right decisions for the patient. In that age, all the medical knowledge was locked up in medical books and journals that only doctors had access to. There was little patients could do if they wanted to conduct their own research.

ANSWERING BACK
When doctors were seen as being a trusted friend, philosopher and guide, it made a lot of sense for a patient to blindly accept what their doctor told them. Patients felt no need to ask any questions. Times have changed, however, and this archaic attitude has to stop.

For one, most people no longer have a family physician and often deal with specialists, where the interaction can be episodic, disjointed and therefore lacking in understanding regarding the patient’s personal preferences.

Even more importantly, it is now possible for patients to do their own homework on the Internet, so they can find the information they need in order to be able to have an intelligent discussion with their doctor. This can be good for both patient and doctor – such patients keep us on our toes.

However some patients still believe that questioning their doctor is rude and inappropriate. In fact, there are still many doctors who take offence when patients ask them questions. I have heard stories of doctors responding to questions by saying things such as: “I have spent 10 years of my life studying this problem, so I know everything there is to know about this.”

Some doctors will treat any information gathered from the Internet as being garbage, as they believe online information is unreliable. This can instantly make a patient feel they are stupid, and that the time they spent researching was worthless.

I’ve even heard of a doctor saying: “If you want to ask questions, I suggest you find another doctor. If you don’t trust me, what’s the point of coming to me?”

CHANGING TACK
Doctors who get defensive when questioned are not good doctors, in my opinion. There is no reason for a doctor to feel threatened when a patient asks questions. Everyone knows that when you are sick, you are likely to have lots of questions, and it’s part of the doctor’s job description to answer those questions and allay any doubts and fears. Any doctor who doesn’t do this is not doing a good job.

A good doctor will encourage questions and will also help patients to ask intelligent questions so they can form an effective partnership that keeps both parties happy with the quality of medical care being provided. Indeed, it is the role of any patient to ask questions, and it is the responsibility of all doctors to help find answers to those questions.
The rules of engagement

How important are patient relationships for your practice? Melissa McCormack provides some perspective from medical practitioners in the United States.

The phrase ‘patient engagement’ seems ubiquitous these days. Meaningful use Stage 2 requires it, bloggers tout it and there’s even a growing body of academic research about its benefits. Most of the discourse focuses on how patient engagement impacts patient health or overall costs to the US health system.

But despite all the attention patient engagement gets, little is said about tangible benefits for medical practices. So, I talked to doctors who have mastered the patient relationship to learn more about what it is and how it can benefit doctors. It turns out that getting your patients engaged could make you more money, make your patients happier and boost your job satisfaction to boot.

A strategy for patient partnership
Before understanding why patient engagement benefits your practice, it’s important to understand what it is and how it works. A key thing to note is that ‘engagement’ itself isn’t the end goal. Instead, it can be thought of as a tool for transforming the doctor-patient relationship.

For Judith Hibbard, Dr.P.H. – Professor of Health Policy at the University of Oregon, Clinical Professor in the Department of Public Health and Preventive Medicine at the Oregon Health and Sciences University, and recognised expert on consumerism in healthcare – that transformation takes the form of “patient activation”. She describes activated patients as those who have “the knowledge, skill and confidence to manage their healthcare”. Dr Hibbard developed the Patient Activation Measure (PAM), a 100-point scale used to assess a patient’s level of activation. The score is based on such determinations as whether patients can demonstrate an understanding of why they’re taking a particular medication, or whether patients feel comfortable voicing concerns even when the doctor does not ask about their concerns.

For Dr Hibbard, activation is the ultimate goal and engagement is a tool for reaching it.

Dr Danny Sands is Assistant Clinical Professor of Medicine at Harvard Medical School. He’s also a practicing physician and patient evangelist who, during his tenure at Beth Israel Deaconess, developed one of the nation’s first patient portals. He echoes the idea that patient engagement isn’t the be-all and end-all. For him, the ultimate goal is “participatory medicine”. Not unlike patient activation, participatory medicine has to do with changing the care ecosystem to get patients interested in maintaining their health outside of clinical office visits.

Ultimately, engagement refers to activities undertaken to create a sort of partnership between doctors and patients. The physician brings necessary medical expertise. The patient brings the knowledge of his or her own symptoms and experiences, and the ability to act on a treatment plan.

It gets patients active outside of appointments
The activities you could undertake to create this ‘partnership’ with your patients are virtually limitless, but my conversations unearthed a couple of recurring themes. Broadly, the idea is to get your patients thinking about their health even when they’re not in your office.

Encourage external research
For Dr Sands, the key to getting patients engaged is knowledge. He recommends encouraging patients to seek out information about their conditions themselves, rather than relying solely on you.
He provides a few tips:

• Ask patients whether they go online for health information (he makes this part of his annual history and physical examination).
• For patients who say yes, ask which websites they find valuable.
• Use what you learn from those patients to share helpful websites with others.
• Give homework assignments. Encourage patients to do some reading on their own and bring questions to their next visit. For example, for a patient newly diagnosed with Type 2 diabetes, you could direct them to the Mayo Clinic’s online summary of the condition to read about complications, risk factors and treatments.

As Dr Sands says, this type of dialogue “provides [patients] with a sort of tacit approval that you’re okay with them getting information from other places besides you. And that leads to honest disclosures in the future.”

Acting on their own behalf also makes patients feel empowered. Plus, your implicit acknowledgement that you don’t know everything makes you less intimidating, which makes patients more willing to accept that they can have a partnership with you.

Make communication easier

It will be difficult for your patients to be engaged in their healthcare if they don’t feel they can engage with your practice. Tools such as patient portals allow patients to schedule appointments and view test results online and/or send direct, secure messages to your practice. These features make it easier for your patients to connect with your practice, and by extension feel more in control of addressing their health needs.

Some doctors worry about letting their patients send direct messages. Will you have to dedicate extra time to responding to those messages? Will patients try to use a message in lieu of an office visit? Most often, the answer is no.

Dr Sands’ research in developing Beth Israel’s patient portal found that less than 1% of every 100 patients using a portal, you can expect to receive about 20 total messages per month, and on average those messages take less time to respond to (two minutes) than the average phone call (five minutes). Additionally, studies have indicated that patients who utilise direct messaging tools don’t visit the office less frequently.

It makes your practice more profitable

Understanding what patient engagement is and how it works is important, but the more complicated part of the equation is its impact. How specifically will engaging patients affect your practice?

Cost benefits from improved outcomes

A commonly cited benefit of patient engagement is lowered costs. That usually refers to lower costs in the US health system as a whole, which manifest most obviously in decreased hospital readmission rates and emergency department utilisation.

This is because engaged patients tend to have better outcomes. Dr Leslie Kernisan is a clinical instructor at the University of California, San Francisco, who also practices geriatric medicine. As Dr Kernisan explains, patients are more likely to follow through on treatment plans when they’re engaged, making them more likely to achieve health goals – and less likely to need emergency hospitalisation.

If you’re one of many practices already transitioning toward value-based reimbursement, then you’ll see a direct financial gain as a result of a more engaged patient base with improved outcomes.

“The more that payment models are linked with outcome, the more important engagement is,” says Dr Hibbard.

That’s not to say practices still operating under fee-for-service payment models won’t see financial benefits from improved patient engagement, too. Read on.

Higher billing rates

Another benefit your practice can reap from treating more engaged patients is optimised office time. Dr Sands points out that patients who better understand their conditions and are active in managing their own health usually don’t return over and over again for the same low-intensity problems.

That means you’re not spending countless appointments addressing the same low-intensity issues you’ve addressed with the patient many times before. Instead, you can spend your office time on more complex clinical issues – which means that, on average, you could be billing at a higher level.

More appointments and reduced no-shows

If your patient-engagement initiatives include a patient portal or other online appointment-setting feature, you’ll likely see a scheduling benefit.

Dr Kernisan describes patient engagement as “reducing the friction” for patients at the various touch points they have with you. She says, for instance, that patients often dread the phone call, not wanting to sit on hold to make, re-schedule or cancel appointments. Offering online scheduling is one way to reduce that friction.

When patients can manage appointments easily and at their convenience, they’re more likely to come in for preventive care. This tends to improve outcomes, but it also means you’re scheduling a visit that otherwise might not have happened, which is a plus for practices that are paid by the visit.

Your no-shows should decline as well. Dr Kernisan points out that when patients don’t have to spend valuable time on hold to reschedule or cancel appointments, they’re less likely to simply not show up. That means you don’t have unexpected empty slots in your day. If your practice’s income depends on getting and keeping slots filled, this benefits your bottom line.

Attracting and retaining patients

Patient satisfaction flourishes when patients see themselves as active partners in their care. Dr Kernisan, Dr Hibbard and Dr Sands all echoed this sentiment – engaged patients are happier patients.

When patients can schedule appointments or communicate with you more easily, feel that you value them as partners in their own care, and when their health benefits from their more active role, they’re happier with your practice. This helps you keep existing patients coming back for more. Better patient satisfaction “can be a loyalty selling point,” says Dr Kernisan. It also helps you attract new patients. Existing happy patients may recommend you to friends or colleagues. Moreover, public reports on your practice, such as those provided to Medicare patients through Physician Compare, could also lead to an influx of new patients.

It makes your work more fulfilling

Your bottom line is important, but so is your personal and professional fulfillment, especially when nearly half of all physicians are experiencing symptoms of burnout. That’s another area where patient engagement can be a boon. Patients aren’t the only ones whose satisfaction increases as a result of engagement – chances are you’ll be happier, too.

Dr Sands sets up the following scenario: “Imagine a patient who is not engaged of his or her own volition, and is just sort of a passive spectator to their own health,” he says. “You go through this exercise where you have ridiculous conversations with them. You’re telling them things over and over again, they’re not following your advice... it’s just not satisfying.”

Making your patients feel like partners in their own healthcare can change that. As Dr Kernisan explains, “It’s like any kind of working relationship. You often get better results when both parties feel like they have buy-in and have been heard.”

When your patients are engaged, they’re more responsive and you’re less likely to feel like you’re spinning your wheels.

Dr Hibbard adds that helping your patients achieve desired health outcomes is a point of professional pride. Think about it this way – the overarching goal of medicine is, loosely, to heal. You can’t do that effectively if you’re the only one interested in reaching that goal. Encouraging your patients to communicate with you, ask questions, do their own research and be active participants in their care makes you more likely to achieve the basic goals of medicine. And that’s bound to be professionally satisfying.

Whereas historically the physician has shoudered most of the burden of getting patients “well”, a fully engaged patient shares that responsibility. Think of it as delegating some of your workload to the patient. This not only keeps patients healthier and happier but can mean increased profitability for your practice, and higher satisfaction for you.
Want to create a sustainable practice? Mike Watson says it can be as easy as getting clued up on eco-friendly products and changing a few old habits.

While sustainability has been an important factor in the corporate interior-design field over the last few years, there has been little attention paid within the healthcare market. This is partly because of the belief that there is little room for variation from tried and tested materials, and partly because the industry is fearful of making environmental improvements in case they impact on efficiency.

Here at Innova Design we believe there is enough enthusiasm for sustainability among the general public that any practice willing to use eco-friendliness as a point of difference will reap the benefits. Making the change doesn’t have to be difficult or expensive. Products and usage are the two key areas where implementing changes can have a positive environmental impact.

PRODUCTS

These days there are flooring products available that look and wear like vinyl but are made from 97% natural materials. Crafted from linseed oil, jute and flax, these products have a 30-year life cycle. They will not only enhance the appearance of your surgery but are extremely hard wearing and carry a very small carbon footprint.

Carpet, on the other hand, is about as ungreen as you can get. Producing just one square metre of nylon carpet will use 16 megajoules of energy, 4.5 kilograms of non-renewable materials and 1.7 litres of water.

Most carpets are made from synthetic materials – namely nylon, polyester and acrylic – all of which are petroleum-based and thus not sustainable. The synthetic fibres are backed by materials such as latex, polyvinyl chloride (PVC), 4-phenylcyclohexene and polyurethane, which are also petroleum-based, as are the adhesives used to secure carpeting to floors in some applications and the latex padding used in others.

As part of the manufacturing process, these carpets are treated with dyes and chemicals to repel stains and retard mildew or fire. In addition to being non-sustainable or renewable, carpet, backing, adhesives and chemical treatments tend to release volatile organic chemicals (VOCs), which many people are sensitive to. Exposure can result in a range of symptoms, including runny and itchy eyes, breathing problems, skin reactions and headaches. Even worse, SB latex, which is used in 90% of carpets, is a suspected carcinogen.

While carpet seems to have a pretty short life on the floor, it lasts forever in a landfill and, until recently, not a lot of effort has been expended toward recycling it.

Natural stone

Using natural stone for feature walls or reception floors can make a memorable first impression. After all, what’s more earth-friendly than the earth itself?
Natural stone is non-toxic and lasts a lifetime. No chemicals go into its quarrying or production – it’s pure and therefore void of any foreign substance that might be harmful to the earth or to your health.

Walls
Let’s look at the internal walls themselves. From a manufacturing standpoint, drywall is already pretty eco-friendly. The cores are made from 90-95% recycled material, mostly reclaimed drywall, while the paper exterior is made from 100% recycled content, mostly old newspapers. It’s the wall covering doing the damage. The energy used in traditional wallpaper manufacturer and the chemicals used in its installation would all but rule it out in our ideal eco clinic.

Natural wall coverings such as grasscloth and sisal make excellent alternatives, and fortunately there are now many eco-friendly paints available that are not based on petroleum products and are free of VOC’s which can cause damage to our health long after application.

Joinery
Custom-made joinery is an important part of every eco upgrade. Everything from your reception desk to built-in storage cupboards can make up a good part of your effect on the environment. Particle board itself is quite eco-friendly, as it’s made from the offcuts and waste of other timber products. However its carbon footprint is boosted by the energy used in production and the glues and chemicals in the mix.

There are alternatives well worth investigating that look and perform identically. Solid raw timber that lasts a lifetime is an excellent option and can make a stunning impact in your reception area.

Lighting
The simplest way to do a little for the environment and save money in the process is to use LED lights where possible and to avoid halogen bulbs. Motion sensor switches add a further eco edge.

USAGE
In an existing surgery, the best way to reduce your environmental footprint is to change the habits of a lifetime, as our behavioral patterns probably have more impact than the built environment around us.

At Innova, we have drastically reduced our weekly operating costs by simply doing the following:
• Turning out the lights in any room not being used.
• Backing up and turning computers, copiers and printers off at the socket.
• Turning up the air conditioning by one degree.
• Opening up the windows and turning the air-conditioning off during good weather.
• Keeping recycled paper trays for each size next to the copier. Tip: Never throw away a one-sided sheet of paper – if you are creating more one-sided paper than you can use in the copier, staple the pages together to make notepads.
• Re-using files and folders by turning them inside out.

Much of this is common sense but can be so easy to overlook. The financial benefits will no doubt surprise you as much as they did us, and the environment will be eternally grateful.
I have a long history with Japan even though, until recently, I had never been there. My Father, one of a long line of migrant entrepreneurs, was the first Datsun Dealer in Sydney.

Dolphin Motors started in Coogee in 1968, and until his premature death in 1980, my Dad travelled to ‘head office’ for business many times and brought back little bits of Japan with him each time.

I grew up in the 1970s with Japanese art on our walls, a taste for abalone, soba noodles and tempura, remote-control cars, walkie talkies, Sony colour TVs (at a time when the only programs broadcast in colour were the cricket and Gilligan’s Island), and my Mum and Dad lounging in yukata (house robes) sipping sake. Forty years ago this was all very exotic and a touch eccentric.

The point of this introduction is to set the scene for a much-anticipated personal pilgrimage, this holiday was something my father didn’t manage to do with my sister and I.

Apart from fulfilling a sort of subconscious desire to share this first time experience with my children – something my father didn’t manage to do with my sister and I.

Forty years ago this was all very exotic and a touch eccentric.

An exhilarating blend of ancient and modern, with a dash of humour and Zen.

LOCAL LIVING

Move over New York, Tokyo is my new number-one world capital. It’s sprawling, diverse and as high-rise as it is vast – the CBD stretches for as far as the eye can see.

Fortunately we arranged to spend four days in the Tokyo district of Meguro at the beginning of our trip, and then returned to the centre of Tokyo for another four days at the end.

About a half hour train ride out of the magnificent yet daunting megalopolis, the quiet little suburban town of Gakugei-daigaku, in the Meguro district, is the perfect place to acclimatise and get our bearings.

Japanese natives live, shop and eat here – it is the real deal and we instantly feel immersed in the local way of life.

Our temporary home is Tokyo’s first boutique hotel, Hotel Claska, a quirky and modern, Japanese ‘home away from home’, filled with character, personalised attention, modern design and a superb restaurant – all in all giving off an overwhelming sense of staying at a cool friend’s house. We couldn’t have picked a better location or finer hotel to start our adventure, and I highly recommend it to you.

The Claska epitomises what we later come to understand as the modern Japanese personality – eccentric, extremely hospitable, focused on outstanding attention to detail and surprisingly fun-loving (a good example is the funky dog-grooming parlour adjacent to the lobby, which has porthole windows so you can watch fluffy poodles being washed and clipped).

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The Claska epitomises what we later come to understand as the modern Japanese personality – eccentric, extremely hospitable, focused on outstanding attention to detail and surprisingly fun-loving (a good example is the funky dog-grooming parlour adjacent to the lobby, which has porthole windows so you can watch fluffy poodles being washed and clipped).

These characteristics are prevalent at every turn – from the architecture (both ancient and cutting-edge modern) and the cuisine (this is a food loving nation, up there with the French and Italians when it comes to reverence for ingredients, presentation and the delight of eating) to the sense of personal style – the way everyone in Japan presents themselves starts from a foundation of deep respect and is often imbued with a highly developed sense of humour.

Although we venture in to the big end of town, it is only for a brief shopping trip. We prefer to leave the city until the end of our holiday and focus our first four days on the neighbourhood surrounding the Claska. We discover a kooky collection of furniture stores, soba (noodle) houses, cafés, bars, art galleries, boutique grocers and Pachinko (Japanese poker machine) parlours, all surrounding a meandering river and housed in brightly coloured little lanes fringed between Meguro and Gakugei-daigaku train stations.

SLOW MOTION

Really getting to know a place, one suburb at a time, is my preferred mode of travelling. We deeply immerse ourselves in all our four-block radius has to offer. We get to know the fruit vendor from whom we buy our perfectly formed, blood-red apples; the rockabilly quaffed barman at the Blue Reef Whisky Bar, who recommends a variety of Japanese liquor for our nightcaps; and the sausage dogs and poodles who walk their masters daily at the local children’s playground.
Speaking of kids, ours are having a ball. Although we are out exploring all day and crave our spacious and exceedingly comfortable room at the Claska by mid-afternoon, we are never very far from home and spend big chunks of time luxuriating over breakfast, absorbing the local art and contemporary design at galleries and studios, leisurely devouring manga comics at the second-hand bookstore and slurping our way through steaming bowls of noodles. Our pace is slow and satisfying.

This, of course, is important when travelling with young kids. At the end of the day, coming home to the Claska feels like slipping on your favourite bathrobe and slippers – it’s relaxed, comfortable and familiar.

As stylish as five-star hotels can be, they rarely manage to evoke this feeling.

In terms of getting out and about, Japan has the most efficient and expansive rail system I have experienced, and when we say goodbye to our friends at the Claska and Meguro, it’s hello to the Bullet Train (the Shinkansen) and the impressive 320km/hour journey to Kyoto.

OLD & NEW DELIGHTS

Kyoto offers a slice of old-world Japan. This is where you come for temples and shrines in pristine forests, real geisha and tea ceremonies, kaiseki (highly refined Japanese degustation) cuisine, modernist architecture (which provided obvious inspiration to Frank Lloyd Wright and his contemporaries), as well as kimono seamstresses and samurai movie studios. Strangely, none of these iconic expressions of Japan seem kitsch or remotely touristy.

As steeped in tradition and authenticity as Kyoto is, it is also a modern city. It’s one of the gaming capitals of the world (home to Nintendo and Mario) and is on the cutting edge of global culinary creativity and innovative interior and industrial design. This is where you can see some of the world’s most futuristic constructions, such as the soaring seven-storey steel and glass Japan Rail Kyoto Station, and the lighthouse-like Kyoto Tower.

In perfect sync with this juxtaposition of new and old world, we chose to stay at the Kyoto Hyatt Regency, which, according to travel writer Gary A. Warner of The Orange County Register, “fuses Japanese and Scandinavian influences of wood and soft lighting into a hotel that is modern but not out of place in the old quarters.”

This is five-star luxury at its best, but with character and soul.

Once again, our overwhelming first impression is of effortless hospitality – the staff do not expect or accept tips as their service is not motivated by personal profit but seemingly stems from a deep sense of integrity, respect and pride in their jobs.

There is much to be learnt from the Japanese when it comes to customer service. There’s a genuine warmth to every interaction, and a deep-seated desire to please. And, as experienced at every turn during our stay at the Hyatt, a supremely high level of professionalism to rival the planet’s most superior hotels… All this while retaining Japanese quirkiness, honouring tradition and pushing the boundaries of the modern aesthetic.

The hotel’s design is inspired – it definitely doesn’t play it as safe as you might expect from a member of a global chain. The design team, renowned practice Super Potato, created the mood of a modern Japanese art gallery and installation space. They retained the unmistakable ambience of a Japanese guesthouse yet didn’t lose sight of the need to satisfy international-traveller demands for creature comforts and world-class facilities.

The guestrooms boast washi-paper fittings, a kaleidoscope of kimono-fabric headboards and luxuriously deep bathtubs crafted from white oak.

The restaurants and bars are world-class and defy the notion that hotel fare is simply a watered-down version of real local cuisine – it’s a good sign that most of the diners are Japanese. As well as Japanese dishes, there are French and classic Italian offerings – almost competing with each other in a real-life version of Iron Chef! As for the location, it’s in a quiet part of east Kyoto but within easy striking distance of Kyoto Station, Gion, Shijo-dori and other attractions.

Today, it’s the iconic Buddhist temples or Shinto shrines of Kyoto – they are simply overwhelming!

Any lover of architecture will be blown away by the arresting facades, which encapsulate interiors characterised by the simplification of form and an absence of decoration – modes of design we typically refer to as ‘open plan’ and ‘minimalism’. The Japanese understood hundreds of years before the rest of the world that great
design is defined not by how nice something looks, but by how well it works.

CULTURAL EXPERIENCES

The geisha tradition is still alive and well in Kyoto, and not just for tourist purposes. With their white-painted faces, traditional Japanese hairstyles and fabulous kimonos, they can be found gliding through the perfectly maintained medieval streets of the Gion neighbourhood.

In Kyoto there are 100 maiko (apprentice geisha), and 200 geiko (mature geisha). Aged under 20, a maiko usually starts her career as young as 15, working hard to become a professional in Japanese traditional culture and entertainment, such as the fine art of flower arrangement, performing tea ceremonies and mastering traditional music and dance.

It really is a thrill to see them perform with such poise and grace, and there are various options for a geisha experience, depending on your budget. On the food front, no visit to Kyoto would be complete without experiencing kaiseki, described by Anthony Bourdain in Mind of a Chef as, “a multi-course meal, ultra-refined, obsessively local and seasonal and very traditional”.

According to David Chang – the culinary enfant terrible of the moment – Kikunoi in Kyoto is, “one of the best restaurants in the world, arguably the best Kaiseki restaurant in Japan and an extraordinary experience”. I’m sorry to say that, sans babysitters, dining at Kikunoi was not possible (we overcame this impediment to fine dining at our next port of call). But I thought the best way to describe kaiseki and to explain the different courses of the meal and how the ingredients and dishes were closely tied to each season was to quote Kikunoi owner and chef Yoshihiro Murata’s book.

Describing a meal served at the start of cherry blossom season, Murata writes that it would try to evoke “…feelings of sitting under cherry blossom trees on a regal crimson carpet, while watching the delicate pink petals flutter elegantly to earth.” (Sigh.)

We did manage a kid-friendly kaiseki experience in Gion – not quite the three-hour affair of Kikunoi but certainly a great first taste of this extraordinary and theatrical five sensory dining experience. To whet your appetite further here’s the description of one of the 10 courses: Salt-pickled ‘firefly’ squid (hotaru ika), sushis with kinome, grilled squid, fava beans, poached egg bearing octopus, mountain yam ‘butterfly’, lily bulb (yurine) with ikura, skewer of prawns, avocado and tai (red sea bream) liver pate.

Apart from temple worship, gastronomic gluttony and hotel-lobby lounging, my wife and daughter got fitted for kimonos, the kids graduated from ninja school at the Toei Samurai Movie studio, and we all rode rickshaws through the serenely green Bamboo Forest and visited every one of the 139 speciality shops at Nishiki Markets. All activities are highly recommended.

BACK IN TIME

As splendid as our suburban Tokyo and cultural Kyoto adventures have been, it’s our next stop in the town of Kinosaki that really blows us away and is the real highlight of our trip.

Situated in Northern Hyogo Prefecture, on Japan’s western coast, Kinosaki is just under three hours from Kyoto by train but a million miles from care. Supposedly discovered in the 8th century by a Buddhist saint, this onsen (natural hot spring) town is where the Japanese come to holiday, and it’s clear why. Life in the big city can be frenetic, exhausting and depleting. Onsen provide locals and visitors alike with the chance to unwind and soak up the recuperative benefits of submerging in the almost scaldingly hot, mineral-rich water that emerges from the centre of the earth.

We’ve done our research and know that Kinosaki is renowned as some of the
world's best onsen towns. We know it’s supposed to be quaint, unspoilt, traditional and renowned for delicious local crab, the quality and authenticity of its ryokan (guest houses) and, of course, for its famous communal baths.

It’s not until we arrive and step off the station platform and in to the beautiful willow-lined streets – populated by invitingly authentic eateries, dissected by an age-old trickling river and criss-crossed by ancient stone bridges – that we realise we’ve been transported several centuries back in time to a place on earth dedicated to restoring body, mind and spirit. I feel as though I’m quite literally in heaven.

The shuttle bus takes us to the first of our Kinosaki ryokan, while my family, like kids in a lolly shop, point at the exotic sights and make mental notes on where to return for a meal, a drink, a family photo and deeper investigation. One thing we are all puzzled by is the fact that everyone, and I mean everyone, in the streets is wearing Japanese robes and wooden clogs. There’s not a pair of jeans or shorts, a t-shirt or a pair of runners in sight.

Driving the short distance to the Nishimuraya Shogetsutei Hotel, you soon realise that this is old Japan. It’s not done up to feel like or resemble old Japan but is literally a place that time forgot – or, more accurately, a place painstakingly kept intact throughout the centuries out of a deep respect and reverence for the past.

The years keep rollin’ by

Harry Chapin song, Circle:
All my life’s a circle;
Sunrise and sundown;
The Moon rolls thru the night time;
Till the daybreak comes around.
All my life’s a circle;
But I can’t tell you why;
The Season’s spinning round again;
The years keep rollin’ by

Our ryokan experience begins on the seventh floor. We love the fact that the entrance to our room is a sliding door. Stepping in we feel tatami mats (traditional rice-straw floor covering) under foot and, venturing further in, we are greeted by shoji (translucent-paper room dividers), which slide effortlessly to reveal a large room sparsely appointed with low furniture and a sunken viewing deck looking out to the forest.

This room would not look out of place in one of Akira Kurosawa’s samurai movies – it is perfect. We are so mesmerised we don’t even notice our attendant measuring the children for their yukata – mine and Michelle’s are hanging in the wardrobe.

We all freshen up, don our robes and wooden clogs, and off we go to explore the town and try our hand at communal-bath hopping. There are seven baths in all, aside from the private ones in the ryokan.

Clip-clopping through these ancient streets clad in traditional garb is a slightly surreal experience, yet it feels perfectly comfortable. Our transformation to truly relaxed beings has officially begun.

We have a delicious sashimi and sushi lunch (the only meal you need buy, as breakfast and dinner are included in the room rate at every ryokan), and after leaving sufficient time for digestion, we make our way to our first bathhouse for a decidedly unique experience.

After working through the bathing tips checklist and taking some time to overcome our modesty, my seven-year-old son and I gingerly lower ourselves in to the steaming hot outdoor bath. Following a few minutes spent adjusting to the temperature, the transition to altered states of consciousness begins. As my son so succinctly puts it, “Dad, I have never felt so relaxed!”

Donning our robes, we float out of the bathhouse and back on to the charming streets, sampling post-bath snacks and drinks from the shops...
lining the path to our hotel while swapping comments on this unique experience.

**FUN FOR ALL**

During the remainder of our time at the Shogetsutei we visit the gardens and eat traditional and modern meals both in and out of our hotel – highlights include the local delicacies of Tajima Beef and Snow Crab. We explore the whole town and incrementally deepen our state of relaxation with repeated visits to both communal hot springs and the private spa-like cabana at our hotel. We all become one with Kinosaki.

One wonderful surprise we hadn’t counted on was that a mere 15-minute bus ride away is a state-of-the-art marine park. More than an aquarium, this is the most technologically advanced and futuristic facility of its kind any of us have ever seen – it looks like a villain’s lair from an early James Bond movie.

The contrast with sleepy Kinosaki is quite jarring but the wow factor is way up there, and we all have an absolute ball. There are seal, walrus and dolphin shows, fish feeding, an enormous 12-metre deep aquarium spanning three floors and, the highlight for us, a huge manmade pond where you can hire a rod and tackle, buy some bait and catch your own tiny fish (the adjacent restaurant will clean and cook them for you, tempura style). We catch enough for lunch for four and, washed down with an icy cold Sapporo Beer, it’s an excellent meal.

**A TOUCH OF LUXURY**

As overwhelmingly satisfying as our stay in Kinosaki has been up to know, we are about to take it up a notch. In fact, we are about to have the most luxurious, authentic and dreamlike experience of our holiday, courtesy of the Nishimuraya Honkan – a 150-year-old inn (formerly a magistrates office) and adjacent public bath.

A favourite among Japanese nobility, artists and the business elite since the mid-1800s, the Honkan is considered by many to be the country’s number-one ryokan. We are greeted by the manager and reception staff with the formality and professionalism you would expect from one of the great hotels of the world, yet there is a warm twinkle in their eyes, as if to hint at the gentle and embracing hospitality to come.

The lobby appears unchanged since the doors first opened. From the blend of Chinese, European and Japanese antique furniture to the ancient-oak panelling, dim sepia lighting and faint aroma of cypress – it sets the scene and lures us in.

Our room is tatami-mat, washi-paper sliding divider and black-lacquer perfection. It leads out onto the architecturally designed central garden, around which all four wings of the ryokan are built.

Words could never do this place justice – we are humbled by the history, the love and the respect that has gone in to every detail. The kids quickly get their robes on and scramble into the garden to feed the koi fish and pose for pictures.

Michelle and I relax on the viewing deck, complete with a pebbled floor that provides a subtle foot massage. Drinking our welcome plum liqueur, we catch each other struggling to process this sensory overload and simply laugh. We don’t leave the ryokan – why would you waste one precious moment of this!

Lisa, our kimono-clad room attendant, is so sweet and moves with the grace of a ballerina. She anticipates our needs, delivering drinks, snacks and food for the koi, and she lays out our futons for sleep then rolls and packs them away in the morning.

Then there is our magnificent multi-course kaiseki dinner. Served by Lisa, it’s like watching and actively participating in fine theatre. The captivating service brings me to a zen-like state that keeps me...
thoroughly engaged throughout the meal. Dish after dish is extraordinary – everything is uncomplicated yet remarkable due to the use of the finest seasonal ingredients.

Two standout dishes are the red tanner crab and autumn vegetables seasoned with miso paste and roasted on a magnolia leaf, and the grilled abalone with liver sauce.

There’s only so much euphoria we can take (and afford), and we eventually say our goodbyes to Lisa and the incredible Nishimuraya team, who offer us a parting gift of incense and crab crackers – a traditional gift and an act typical of these beautifully warm-hearted people. Kinosaki, we will be back!

LAST, BUT NOT LEAST

Now it’s back to Tokyo for the last leg of our holiday, this time to the heart of the big city. We have four days to visit the major districts, yet are determined to do it at a leisurely pace.

We head to the pungent yet fascinating Tsukiji Seafood Market at the crack of dawn (eating breakfast ramen at a local ‘hole in the wall’ with fishermen); take in the designer lifestyle of Roppongi Hills; explore the super department stores in Ginza, and experience an archi-tour of Omotesando, one of the foremost ‘architectural showcase’ streets in the world, which features a multitude of fashion flagship stores all competing with each other for the most futuristic design.

We miss our old neighbourhood of Gakugei-daigaku and spend a day back there among the little doughnut shops, noodle houses and design studios – this really is our favourite part of Tokyo.

Our base in Tokyo is the grand Hotel Okura, set in Minato, surrounded by foreign embassies and exuding a 1960s aesthetic. The hotel’s website says it best:

The main lobby gives expression to a uniquely Japanese style of hospitality in an atmosphere of restful serenity that crystallises the traditional and timeless charm of Wa (harmony). . . . a firm dignity impervious to fleeting fashion exquisitely converges with innovative approaches in a hotel replete with genuine originality.

Soon enough our holiday comes to a close. We’ve spent three weeks immersed in the most fascinating culture, accumulating experiences and memories that we will talk about for the rest of our lives. We all bonded deeply with each other and, above all, have recharged our batteries and are ready to face the challenges of work and family life… Until next time.
When purchasing property, John McGrath says it’s important to identify any hidden problems upfront so you avoid unnecessary costs down the track.

The excitement of buying a new home or investment property can be quickly diminished through the discovery of hidden problems that you hadn’t noticed during your inspection. This is why it’s critically important to always get a pest and building report before you buy – even on brand new properties.

A national survey commissioned by St George Bank found 55% of Australian homebuyers discovered problems with their new homes after moving in. Here is a list of the top 10 problems buyers identified, according to the survey:

1. Plumbing problems – 28%
2. Poor TV reception – 23%
3. Bad mobile phone coverage – 20%
4. Noisy neighbours – 19%
5. Cracks in the walls or floors – 18%
6. High-speed Internet not available – 16%
7. Parking on the street is difficult – 10%
8. Rising damp – 8%
9. Future developments in the area – 8%
10. Insufficient parking onsite – 8%

ON THE LOOKOUT

When inspecting a prospective new home or investment, you should always be on the lookout for obvious defects. If you identify any major problems, it might be best to give that property a miss. At the very least you’ll save yourself the cost of a building report and possibly avoid costly and time-consuming rectification work.

Take note of the following during inspection time:

• Check the power board in the electricity box. If it’s relatively new (especially if it has a circuit breaker), that’s good. If the board is in original condition, it could indicate that the home is due for rewiring.
• Sagging floors (check near fireplaces) or moving floorboards can indicate problems with the stumps or bearers.
• Are the walls flat, straight and free of cracks? If not, the foundations might be shifting.
• Dark stains around the skirting boards can indicate rising damp. That’s not necessarily a deal breaker, but you need to get it checked out.
• Turn on a tap in the bathroom and check the water pressure (hot and cold). If it’s weak, there might be problems with the plumbing.
• Is the roofline sagging? The trusses or the entire roof might need replacing.
• Stains on the ceilings or rafters indicate there is a leak in the roof.
• Is the underfloor area well ventilated and free of signs of termites?
Avoiding Labels

No doctor wants to be known as disruptive. Here, Dike Drummond offers advice on how to raise your concerns and avoid name-calling.

‘Disruptive physician’ is one of the most misused terms in healthcare these days. In many organisations, those two words have become the c-suite’s trump card to quash any physician resistance to new administrative programs. These programs often have purely financial motives, or are a brazen attempt to dump additional tasks on physicians, with no regard for their workload or stress levels.

The doctor’s legitimate concerns about quality of care don’t matter. They are lost in the politics of the silos of the administrative and clinical sides of the organisation. Having been quickly identified as not being a ‘team player’, the ‘disruptive physician’ label comes flying out and the doctor is deftly tossed under the bus so the meeting can move on to the next topic.

Often, this is bullying, plain and simple. It can create permanent consequences for the physician, including diversion into any number of ‘treatment programs’ and, not uncommonly, losing their job.

However, sometimes the disruptive name-calling is just a consequence of a fundamental clash of communication styles between physicians and administrators. In this situation, the skills inside the ‘Disruptive Physician’s Toolkit’ will allow you to:

• Air your legitimate concern.
• Be heard by the administration.
• Avoid being labeled as ‘disruptive’ in the process.

SUBCULTURE CLASH

The first thing to understand is why physicians and administrators regularly have communication clashes. Physicians are highly trained experts at finding a unifying diagnosis – i.e. the crux of the problem, the thing likely to go wrong. We see clinical issues that administrators are completely unaware of and we do this at lightning speed, because our diagnoses must often be made quickly.

When we see a problem, we point it out without hesitation and we are not used to having to explain ourselves. And we shoot from the hip – we see it and call it without regard for the social setting or the politically correct thing to say in the given situation. One word for this is ‘blurt’.

This is not how you make your point in the midst of a meeting about a program with a group of administrators. They do not think or communicate in this fashion. It is not what you say, but how you are saying it. Disruptive-physician labeling can often be the result of this clash of communication styles.

THE DISRUPTIVE PHYSICIAN’S TOOLKIT

Use the following tips as a guide to avoid labeling and ensure your survival within the workplace.

Speak up

When you know you are going into a meeting with administrators and have a concern, talk to as many people as possible before the meeting. To raise a concern for the first time in the midst of a meeting is the definition of rude to an administrator. Discovery and building of consensus is best done before the meeting occurs, much like the work in politics is done in conversations before voting takes place. You want your concern to be discussed, shared and understood, and you at least want a partial consensus on what to do about it well in advance of any committee meeting.

Ask questions

Rather than making statements, ask questions of everyone involved in the proposal, and everyone who will be part of the decision on whether or not it goes forward. Always start your questions with the words ‘what’ or ‘how’. This guarantees an open-ended question that will draw the maximum information from the person you are speaking to.

Here are some simple yet powerful examples:

• "What are your thoughts on program X?"
• "How do you see program X affecting the quality of care?"
• "I have some concerns about X. How do you see we might be able to address them?"

Channel Columbo

Do your best to imitate the character of Columbo in the old TV series. With hand to the forehead, be self-deprecating by saying something along the lines of: “Maybe this is a silly question, but I was wondering…”

Columbo’s style goes against our supposed channeling of the old TV series. Do not communicate like a doctor and here’s why…

• "Do not raise your concern the way you would normally do on automatic pilot – as a declarative statement of fact. For example: “I think this is a bad idea, and here’s why…” Always ask an open-ended question and remember to channel Columbo by appearing to be either curious or confused.

• "I am confused here. This patient flows…"

WHAT NOT TO DO

When it comes to being heard and agreed with, there are things you must avoid doing.

Don’t communicate like a doctor

Do not raise your concern the way you would normally do on automatic pilot – as a declarative statement of fact. For example: “I think this is a bad idea, and here’s why…” Always ask an open-ended question and remember to channel Columbo by appearing to be either curious or confused.

• "I am confused here. This patient flows…"

• "I agree that none of us wants the quality of care to suffer as a result of this initiative…”

Used early and often, this phrase can help to keep everyone focused on the big picture, and not your objection. It states something no-one can disagree with and keeps people from immediately disagreeing with you.
to see 35 patients a day, but a number of us here are concerned it will only increase the EMR documentation backlog and that will affect the quality of care. I am curious what your thoughts are about our concerns here, Mr CEO?"

Do not show any emotion
In particular, do not do any of the following:
• Stand up.
• Raise your voice.
• Furrow your brow.
• Slam your fist on the table, point fingers, slam doors, swear or throw things.
• Send any body language signals of anger, frustration or hostility.

Instead, focus on your breathing and asking questions.
If you do feel any of the above emotions, name them out loud. Let people know what you are feeling with a civil tongue – just make sure you have done the work before the meeting so everyone is aware of your concerns and feelings.

Try saying something along the lines of: “I must admit when I hear your answer, what comes up for me is frustration. I am curious about what we can come up with for a proposal here that could address both of our concerns.”

Do not leave paper or voicemail trails
It is completely appropriate to be seriously paranoid about documentation of any of your concerns in a format that could be shared. Do not send emails, text messages or messages through your EMR, or leave voicemails, especially if you are upset and venting to someone you feel is a trusted colleague. If you must vent in an email, write it and then delete it. If you do leave recorded or written evidence of your concerns, you are running an almost 100% risk of those documents or voicemails falling into the hands of someone who will label you as the next ‘disruptive physician’ on staff. This is because it will be impossible for that person not to take your concerns and tone out of context.

Make sure you raise your concerns only in conversations, where the other person can understand your energy, tone, body language and caring for everyone involved – especially patients. There is no way any of that can be understood through a text, email or voice message, especially by an administrator who does not agree with or understand your position.

THE CHOICE IS YOURS
Ultimately, if you work in an organisation with a pattern of hostility towards physicians and clinical staff, and a habit of bullying with the ‘disruptive’ label, you will have to decide whether this is something you will tolerate or not. You always have the option to vote with your feet.

If you do decide to leave, it is my intention for the ‘Disruptive Physician Toolkit’ to ensure that:
• Your concerns have been heard.
• You gave it your best shot at ensuring the program made clinical sense.
• You don’t have the ‘disruptive physician’ label hanging around your neck and getting in the way of you finding a more suitable position.

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