THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON FRIDAY 1 APRIL 2022.

Mr ARNOLD STROOBACK WAS CALLED, MADE THE STATUTORY DECLARATION AND APPEARED VIA WEBEX.

CHAIR (Ms Forrest) - Welcome to the committee. What you say is part of our public record and everything you say before the committee is covered by parliamentary privilege. If there is anything of a confidential nature you wish to discuss you can make that request to the committee and the committee will then consider it, otherwise it's all public. It is streaming as well.

Mr STROOBACK - I came to Australia in 2005 from the Netherlands. You probably picked up my accent already.

It was before Buurtzorg even started. I was the Honorary Consul to Western Australia between 2008 and 2018, and that is when I came in contact with Buurtzorg. When my 10 year tenure ended, I basically started Buurtzorg Australia together with my business partner.

When Buurtzorg started as an organisation, they picked an existing model called the BSO model. BSO was an organisation in the Netherlands in the 1970s-mid 1990s, in software services. It was the first company I ever worked for, after my university years.

For me, it is a home-coming. I've got a medical background, so for me in this stage of life, it's something medical again - back to a BSO model. In Australia something Dutch cannot be better. It is a perfect world for me at the moment.

When Buurtzorg started, they took BSO model and brought it to the next level, and that really became sensational. But for me, it is a home-coming thing because the principles are very similar.

About me - one comment to make is that I am in a training room, and the air-conditioner stopped working this morning. I was able to darken the whole floor and if I switch it on, everything has light and electricity but I think if I get to 35 degrees I will start sweating. Otherwise I will go back to Melbourne where it is nice and cool, but there are too many people, and it is too noisy, so I will battle through.

How do I share my screen?

CHAIR - That is good, thank you.

Mr STROOBACK - It is about 20 minutes, so I will tell you a little bit about what it is, and what it does - more as a context. Then we can talk about what effect it has and also compare it between the Netherlands and here.

It is 'Humanity Above Bureaucracy', and I think that is a strong statement. It is back with human services, and with health and care, and that should be the starting point.

It was about eight years before they started, so the 1990s, or early 2000s, and a lot of changes, like we have now in Australia, happened: new insurance schemes; different ways of dealing with funding; and trying to cope with the increase of demand. Demand went up, but the cost went up more steeply. Every politician hates to see graphs go like that - so, how do you get a parallel again?

The response was, what I call, professionalising the sector: economies of scale; big organisations; more management layers; more process driven; more transactional. It was mostly to be expected because when the quality went down it became an unattractive sector, could not get people in - it was like a downwards spiral. The wrong incentives. We can see a couple of things, it is about transactions, so a lot of relatively low level care and support was provided without really dramatic changes in outcomes.

Everyone was unhappy. Clients were unhappy, the sector was unhappy, government was unhappy. It was just quite a disaster, in almost seven or eight years it went from a good running system almost into the ground. In that time, Jos de Blok was a registered nurse himself, he was an executive of one of those big organisations and he said I do not know where to change anymore. He just had to start from scratch, and together with four others they resigned from their positions and sat around the kitchen table and decided the starting point is that we need care and support and someone who can provide it. They were talking about home care.

That is where they started, and they started reasoning from there. It sounds very simple but it was quite a dramatic change in how they approached things. How it looks is that just like the DSL model in autonomous units, they brought it back to teams of a maximum of twelve care and support workers in a relatively small area,

'Buurt' is the Dutch word for neighbourhood, and also community, so it is not the literal translation, and 'zorg'; is the Dutch word for care - care in your local community. Buurt is a very important part of the Dutch social fabric, so everyone lives in a buurt, that is your neighbours, your neighbours across, your local IGA, your local butcher.

And what is expected from you, is that you give and take. If you do not do that, and basically turn your back to the buurt, it is not seen as very social. Of course, you have people like that, but it is not the default in what is expected. When Buurtzorg started - care in your buurt - everyone understood immediately what they stood for.

It is always a two-way street - the person who needs care and support and the one who can provide it. Basically, it gives almost full control to the team's distributed system, and the back office relatively small role is to do the bureaucracy side of thing, making sure that people are getting paid, and it is invoiced and compliance and those things. But the clients of the back offices are the teams, the focus is where the action is. This is why we call it the back office and not head office, to emphasise that a bit.

Happy people - we can see in a typical Dutch picture. I have to say in general when I go back to the Netherlands, I visit a couple of teams. I haven’t been doing that of course in the last two years, being a West Australian, and an Australian in general. But whenever I visit the teams there, they are what I call annoyingly happy, they are so happy to be there, to do the work, to be together in a team, and that is one of the most important appeals of the organisation. It makes very good, strong teams, and teams that are not a collection of individuals, but a real team with give and take and highs and lows.

And things will go wrong of course, especially when you have more aged care, people tend to die all in the same week, or it feels a bit like that. It has an impact on the team. How do you cope with that, how do you get yourself through as a team? A couple of key elements: on top is trust instead of control. Again, it looks very simple, but there is hardly any control in that regard. The teams work from a framework, and how they do it and what they do, that's to the team. It is not centralised. What clients they take on, who are going to be their colleagues in the team, how do they do it within the framework - that is to the team. The boundaries are of course the compliances, but further than that, how it works and how it's done is by the teams. The outcomes are the responsibility of the directors, and that doesn't change.

Self-management we call it, entrepreneurial spirit, and basically running around shops, and matching 12 humane values as a core driver. We say get out of the transactions but look holistically to it and bring your own version into the mix, what we call, the wholeness. Obviously, only a sliver of job description, but everything, your life experience, how you look at the world, and, the person that we care for, same, same. So, there's the holistic approach. They are not a collection of body parts where you have to do something. It's the whole person.

So, humane values are a core driver and careworkers and clients are equally important and I will address this later on. But the question is, who is more important, the client or the careworker? Of course, the client is more important, but then again if the careworker is not happy, then it is not in the interest of the client. So, we have an adjustable, an interesting discussion, so make it an equally number one position, and the whole model is based on keeping staff happy and engaged, to drive them, and the client happy.

Team health, what we call it, is always on the agenda, if the team is overstretched, overworked, especially with COVID-19, getting very complex, that is not good so you have to address it together as a team and try to find solutions.

It is an important element of the model. We do not have managers besides the two directors, in Holland there is a director on the front end and a director on the back end, here in Australia I am on the front side, I am the CEO and Brett Parker is on the back end of the organisation. We are the only two directors and managers and that is it.

We work with coaches, and coaches are safe, they do not have a hierarchical position with the teams. They make sure that the teams will function, and if there are conflicts there is a more external person to help to resolve the team conflicts. Again, a smaller serving back office, that's important, so we do not tell the teams what to do; we always ask questions, and also, it is thinking about the clients of the back office are the teams that gives a different dynamic to the things so it is very important.

Solution driven, that is very important. Do not dwell on the problem, that is often what you see happening. An incident happens and everyone goes into damage control mode, and you have judicial process and checks and balances, and the one who was involved is temporarily out of the mix, and so nobody knows what really happened. The client is far away, and so often they think, hello, what about me?

It is solution driven, it is very much, okay this happened, we have to learn from our mistakes and analyse it a bit, but for now we have to find solutions to resolve the matter. That gives a very positive drive to the organisation, looking forward, looking that way.

Focus on relationships, warm and meaningful relationships, that's just important. One of the slogans is, 'First coffee then care', besides that we drink lots of coffee in Northern Europe, it symbolises that sometimes you sit on your bum and just have a chat. How are you, what is important to you, how do you feel today? You cannot roster a relationship, and say, now we have six minutes to build up a relationship, how are you going? It does not work like that.

We say also to everyone, take the moment and don't waste a crisis. In politics that's an important slogan and in our situation if something goes wrong, use that to get through together. It's always a two-way street. Again, a non-transactional holistic approach, is very important. The moment you feel as a client that people are doing a transactional deal with you, it does not feel good and also you miss a lot of stuff. Health does not work like that. One of our other slogans is, 'Health is a profession not a process'. These things always come back. If I go a little bit fast, I have 20 minutes so I will go through it a little bit, so if I am going too fast, just let me know. All good?

Committee members - Yes.

Mr STROOBACH - A small picture of the back office which is where it all happens, or not. So, it is a small building. It is more like a big house - 37 FTE, 51 people. Most of them work part-time. Well, it is a spider in a web for 50 000 employees in the Netherlands and also internationals there from 25 countries. Basically, healthcare is charged, staff are paid and compliancy and that is it.

We have a lot of international visitors and when they enter the building and they always ask, is this a regional office, or where is the rest? There is no rest. This is it. Two dogs are roaming around. It is very serene, very pleasant, very unassuming. But being there, it really sinks in, all of this to work in a distributed organisation, and solve many things. You do not need much really to make it work, as clockwork, because that is happening.

Also, a low output is not a driver. The good thing is it is 80 per cent or 92 cents of every dollar meant for the client ends up over there. Now you can do more things.

And the results are great, that it is over the 15 years. It is always nine-and-a-half or higher, client satisfaction, employee satisfaction, and - to the surprise of many - five times best employer of the year.

The first time it happened, people were a bit (indistinct), and said how is that possible? It must have cost a lot of money to get to the best employer of the year status, because normally Shell wins, or Philips, or Rabobank. One of those organisations. Out of nowhere, a care provider came out of the blue.

A funny thing is next year we won again and the third year, again. So three years in a row. That had never happened before. So, something works. Here we go, first we cope and then care.

I will put it in a quick picture just to make sure a bit of an understanding. We have four clusters. The frontline, the biggest one of 50 000 plus. We have 22 coaches at the moment in the Netherlands, a back office of 37 FTE and two directors and managers. The only hierarchical relationship is between the managing directors and the rest, but further than that

there is no hierarchical relationship. It increases, really, the collaboration because within the cluster, alongside management, everyone is equal in the decision-making process in the hierarchy and also within the teams. Of course, there are more experienced and highly-qualified people, and some are new to the game, but it does not mean there is a hierarchical position. It is very important in the whole model.

We are talking about home care in the Netherlands which is very big. Being in a hospital or an aged care facility, that is the last resort. Hospitals try to kick you out as soon as possible, because that is firstly a very expensive place, but also a dangerous place. People die over there.

It is a very complex place. You try to get people to go home as soon as possible, but they still need a lot of care sometimes. That is very well organised nowadays in the Netherlands because it just had better outcomes and it keeps the cost at bay. Especially in aged care, you want to stay in your own ecosystem as long as possible in general, and how do you do that?

In Holland, the aged care facilities have almost disappeared. It's the last stages or the complicated things, or the specialised areas like dementia villages. Those kind of things. But in general, everyone stays where they are. Effect on happiness in general and how people feel about their life, their quality of life, those kind of things.

If you go back to a home care situation, what does the client want? If I am the client at home and I open the front door, what do I want at the other side of the door? I would like to have a competent person, someone who knows me, someone who is happy to work in the sector. Someone who is happy to work with the organisation they work for. Someone who is happy to work with me, and feels trusted, and likes me as a client, and knows me as a client. I know it is going to be a good experience; that is basically what you want.

But the other side of the scale is that someone I've never seen before, they've never seen me before, basically he does not care, or she does not care, they are there for the pay check. He hates the organisation that he works for but needs the money, and becomes very cynical. But on the other side of the scale, I am here to do a job, I go in and out and probably never see you again because I was rostered here and whatever happens, happens.

That is not what you want. How do we get number one? The whole model is based on making sure we get the number one situation. Where I started, the wholeness and engagement are so important. Books are written about it, and there are so many articles - how do you get an engaged workforce? It's top priority, especially in the human services, because that's where we are, as well as a client being treated as a whole person, and the focus on quality of life, that's in general what it's all about. Elements like choice and control, would also have a place, includes sense of care in Australia - we embrace that model here too, like many western countries. It's so important. And of course, feeling safe. The Royal Commission picked up a lot of things that were not safe, and that's so important.

It's a bit of repetition, what is important in home care, what are we doing in health. Your health is the most precious thing, quality of life, independence, dignity and compassion, whether it's aged care, disability care or post operation care, is so important as a human being. But also, in a complex world of health, the seamless and collaborative approach of other providers between hospital and the home care providers, between therapies and all the things - how do we do that, so the client does not have to navigate through the whole system and figure out how things work, and everyone starts the whole story again. You don't want

that. That is important in health. So is cost-effectiveness on a national level, it's scaleable and sustainable and no more, no less.

Prevention in health is very important, and also early intervention. The better the relationships are between the client and the one who provides the care, the better educated the person is, the better they know the person - that is all in prevention and early intervention.

All of the insurance companies are involved in what they call the billable percentages. In Holland, I don't know the exact percentages because it changes every year. Say, 61 per cent of everyone in care had to be billable. That means that is not the case for 39 per cent, and that is related to having a coffee with someone; it's related to doing a presentation at the police station, and talking about Alzheimer's in the neighbourhood and not arresting someone but bringing them home. Those kind of things.

And what insurance companies find out is the percentage is going too high; the focus is more on the care side of things. You get tenfold back, because prevention is going down and people are going early and more to hospitals. It's an important mechanism to be aware of.

This is equilibrium, with the client and team being equally important. There is also sustainability, and that is the dollar and compliancy side. If you're not compliant you lose your registration so you can't operate, you don't have clients, and you don't have staff. It is an equilibrium. Sometimes the team has to give, sometimes the clients have to give, and sometimes the dollar has to give. That is the thing we as an organisation try to do, and the teams do that too. Most of the balancing act is done by the team. I will quickly go through it, there are a lot of technicalities.

About Buurtzorg Australia - we started in April 2018; officially before that, in 2015 NDIS and also government agencies went to the Netherlands and to other parts of the world and had a look at different models. We can throw a lot of money at it, but if you want to change the outcome, you have to do more than that. That is how the relationship started. Jos de Blok went a couple of times to Australia and gave keynote talks, we did workshops and things. There was so much interest, he decided to set up shop in Australia, and that happened in 2018. But basically, we call it advisory services - talking about the model helping more organisations, if they want to know or want to work in the Buurtzorg way. Working, giving presentations, things like this. The royal commissions went to the Netherlands, with those kinds of elements more on the model.

In late 2020, we started as a care provider. We do that under the banner 'Neighbourhood Care'. If you're a client and you see Buurtzorg, you think, I'm not sure what it is, that is a strange word, and so we decided to change that into an English word. That is when we started, in the midst of the COVID-19 pandemic; what were we thinking! There were complications of course with that, but so far so good. We have experience in remote Queensland, with a client who was interested in the Buurtzorg way of working, really remote. We have - I'm not allowed to say 'remote' about the northern teams we have, it's about 100km east of Perth, and they call it a country area, is that right? I call it country, so it's not remote, apparently. As a Dutch guy, we don't have an understanding about remoteness - what we call remote in the Netherlands is a suburb in Holland. It is a different scale of things.

We started 2020 with a strategic partner in Adelaide, and that's also a Buurtzorg organisation, mainly in NDIS. That's how it started, because NDIS had the most interest in the

model and you start somewhere. In Holland it started in aged care and went to disability care and other care. Here, we started in the disability and aged care, and we do a few fee for service in aged care because we're not registered for the aged care packages. Unfortunately, fee for service and people paying it themselves is an increasing situation because the waiting list of 18 months is a problem for many people.

Our experience in the more country or rural areas is that the good thing about the model is that you don't need much; you just need the people who can do the actual work. The back office can be anywhere. The main back offices for services for this remote Queensland organisation, we combined with the back office for our own organisation. That is the beauty of the model. You need a good local team, , and that's the only thing you need. It is relatively simple. Also, we found out that as the Buurt is very important in the Dutch social fabric, there is the same thing in country areas. The community spirit is amazing, the give and take, and we're in it together. That works really favourably for the model, it's just a nice fit. You don't have to tell someone in a remote area that community is important; that is in the fabric, they know. Some regions have never been served before, especially in disability care. If you talk about rewarding work, you've got one there; although sometimes NDIS doesn't make it easy and they change classifications again, and those kinds of things, but that's operational.

Despite a neighbourhood approach, distance can still be a challenge, because - again - 'remote' can be very remote in Australia. And of course, the only thing you need is a good team, but sometimes it's not easy to find suitable staff. Health, in general, is a highly regulated market, not only in Australia but in general western countries.

If you are not used to a more corporate environment, where you have to be compliant to things and you have to do some admin, you have to put information in the system, and those kind of things, if you are not used to that we found out that we took it for granted that people knew. But if, for example, you had been a farm boy for 10 years, the first time you work in a more corporate environment - although it is not very corporate - but administration and education, more formalities, and compliance situation, that is a shock. So you have to take time to do that. It takes a little bit longer to build up a team that really functions. You can see it is all about how people like to work. People like to work like that.

Sometimes you have to do an adaptation. For example, we call it the Buurtzorg light. We did it also in Northam to start with, like, we call it a coordinator, who just - it is not management but to make sure that the rostering is done, because the rostering is done centrally, and get the things going. It is like a phasing, if you start with that, and then you phase more into the Buurtzorg way of working to the next stage, and that works fine.

All right, I think that is about it, for the moment. And now how do I get back again?

More troubleshooting, tech issues.

All right. I'm back.

CHAIR - Thanks, Arnold. It is really interesting, the model itself. It seems from what you've said, certainly in Australia, it is more focused around providing disability care and aged care. Is it being used to provide other teams who provide primary health care in communities like nursing care, perhaps podiatry, physio, occupational therapy, those sorts of things, or is it really just focusing on disability and aged care at the moment?

Mr STROOBACK - We have therapists. We have physios, occupational therapy and speech. At the moment the funding goes via the NDIS -

CHAIR - The NDIS, yes.

Mr STROOBACK - health side of things. At the moment we talk with the Primary Health Network. We have three PHNs in Australia, and they are also a funder and they are in mental health, but also they do more and more in aged care. That is what we are discussing at the moment with them.

At the moment there is, I think, if you talk about percentages it is 80 per cent NDIS and 50 per cent aged care, and then 5 per cent like PHN, something and there is something else, so the main is NDIS.

CHAIR - With the Primary Health Network, how has it funded the model to be delivered in a community? Can you talk me through how that has worked?

Mr STROOBACK - We are talking about it to do a test in one of the areas here in Perth, funded by the PHN. That is where we are discussing the situation.

CHAIR - What is the scope of that service? I know it is only in discussion but I am interested in what is being proposed in terms of what the PHN are looking at, perhaps funding, and what services and to what part of the community, if you like?

Mr STROOBACK - There are two elements we are discussing at the moment. There is the mental health side of things and the aged care side of things. Then really in a community setting, in the Buurtzorg way, working, to see how that works in the primary context. So, it is less process driven and basically the whole team approach as we just discussed, putting it into context.

One of the things PHN is interested in, and hopefully they are going to trial that bit too, is that in Holland the registered people, health is a registered profession. If you look at Buurtzorg, 70 per cent are registered, registered nurses, therapists, and they have a semi-registered situation, for non-bachelor people. That is not as stringent as a register like you have here.

CHAIR - Sorry, I might need you repeat that. We lost you a minute.

Mr STROOBACK - The registered people can make decisions on what was going to happen, so, basically, they can decide the amount of funding that is required. Whatever they do is funded, if I am a GP and you go to me, and I say, it's alright this is my diagnosis, this is what I think is happening, and this is what I'm going to do. That is where a GP is not challenged about that, that is not going to happen if it is funded.

The same is also true in home care. If a registered nurse goes to a home, a new client and sees this is happening, and says, this is what is going to happen, that is no ACAT assessment, there are none of those kinds of things. It is more on the statistic side where that changes. Why is that happening like that? There is something else happening there. Then they look into those things, but the decision-making is lower in health care in that regard, so

not doctors but also lower-level. That made the whole system 40 per cent cheaper in the Netherlands.

CHAIR - Do you employ doctors, at all?

Mr STROOBACK - Not in Buurtzorg. In Holland, no, nurses and therapists that is it.

CHAIR - Yes, okay.

Mr STROOBACK - One thing to add to it, and that is why PHN was interested, in Holland we also have Buurtzorg teams in mental health, because mental health has a different funding mechanism. The Buurtzorg teams have doctors. They have psychiatrists, they have clinical psychologists and support workers, so they have teams with doctors in them.

CHAIR - So the model can be adapted to provide a community-based mental health team to care for the mental health and wellbeing of our community?

Mr STROOBACK - Yes.

CHAIR - So you could adapt it to provide just general allied health care. If a GP - and they are limited in number - who is in our small community and they know that this person has two or three chronic diseases, they need to see a respiratory nurse, they need to see a dietician, they need to see a podiatrist, they can refer this person to the team, who would then work out how they're going to provide that? Is that how it works?

Mr STROOBACK - Yes, that is exactly how it works.

CHAIR - How do you go attracting staff?

Mr STROOBACK - That's a challenge of course. Also in the Netherlands if you look at registered nurses who work in community care, of course as a nurse you can work in a hospital, you used to be a nurse yourself, you know that hospitals are different beats. They are complex, a very technical environment. Community care is a different setting and also a different way of working as a nurse or a therapist. In the Netherlands, I think about 60 per cent or 70 per cent of all the registered nurses working in home care, community care, work already for Buurtzorg, so you can see it plateauing now. How do you grow further?

It is the biggest care provider in Holland, it is a massive organisation. When they started, there were only five people, but there was so much frustration in the sector because people were leaving the sector. They just want to be a nurse or a therapist again. I know what to do, do not tell me what to do or tell me something to do and I see something different. It was a very unhappy situation.

Suddenly they could work again, how they had been taught to work while they were doing uni, and so we were having the satisfaction, and that attracted - the first year was a bit silent but then the floodgates opened up and it was just happening so quickly. I think it only took seven years to go to 8000 people or something. It was just unbelievable how quickly it went.

CHAIR - We have heard evidence about the importance of engaging the community to understand what your community needs are, particularly in our rural areas, where there are limited services, particularly available close to where people live. From what I am hearing is that it is a model that enables the staff employed in the team to work together with the community and with the client who they end up caring for to determine what care they need when they need it.

Mr STROOBACK - Exactly. I think having a small team in a small area, it is a very simple effect that the team knows the area and the area knows a team. The moment they start knowing each other, then half of the thing is already done. If you talk about person-centred care, and there is only person-centred care when relationships develop. Being in a community setting, a small team in a small area, it is so much easier to build up relationships and also prevention. You know things are going on and if you are a nurse you are trained to see things and interpret things and communicate with the GPs.

In Holland when Buurtzorg started, the GPs loved Buurtzorg, because the GPs sees the patient only once a month, or once every three months, but the community care nurses saw them perhaps daily. So that is very important information. They are still doing that all the time. Right, I will see Mrs Smith tomorrow morning, shall I do something about her medication? They call the team, what do you think? As a registered nurse they can talk about the medical side of things. They can say, yes, I think it is a good idea because this is what I am seeing. He makes a decision based on that. It is a three-minute call but the outcome is so much better because we start all working together.

CHAIR - It is timely.

Mr STROOBACK - Yes, that is it.

CHAIR - The role of the coaches, can you describe the role of the coaches a bit for me?

Mr STROOBACK - Of course because we do not have management, you still need people out of the team, a bit of seniority in that regard. So if your team conflicts how do you resolve it as a team? Or if you have an unbalanced team, so you hired someone that you thought was a good idea and it is not working, how do you do that? A team coach can help as an outsider.

Also, the coaches help with recruiting in the sense that the team side who is going to be hired, is going to be part of the team, but you have to be careful. You tend to hire people a bit like yourself, so you get a monoculture. So the coach can say, 'I wouldn't do that, otherwise you get all blue people or red people, or whatever types you use, so think about this, think about, to make sure you have a balanced approach'.

Also a coach can do one-to-one coaching. Also some extra training, for example, if there are compliancy changes, how do you disseminate that? A coach can help with the implementation of things, how does it work? Am I interpreting this? Can I do it or cannot I do it, things like COVID-19, how do you deal with that? Coaches are an important element. To give you an idea, coaches have about 40 teams they service, so many teams, if they want to manage, they cannot.

CHAIR - True, that is very sensible.

Mr DUIGAN - I am interested in rolling it out. We are looking at rural and remote communities. You mentioned before that building a team in those rural and remote areas is challenging. Can you outline those challenges? Is there a particular size of population you need that can have a team, or how does it actually work?

Mr STROOBACK - We don't have the real statistics yet, how it works here, because it's relatively small. We have two teams in remote areas, so it's too little to have significant data about that. In the Netherlands you need a population of about 10 000 people to have a team, but that's in the Netherlands. If you look at South Korea it's a completely different ballgame again, and Japan too. So it will be different again in Australia.

I think the challenge is to find people, especially registered people, to work in a rural setting. We also found out that qualified people are often transient, for example because their partner is working in - especially in Western Australia in the mines. They are there for two years and then they move on to the next mine again, and then suddenly, they disappear. So it's a more transient situation. That is the experience we had, and again, what I said, also if you have a look at the support workers level of work, people with a Cert III and not a bachelor degree, that side of things, they often don't have a more formal work experience, because it's a highly regulated market. Why can't I do the things that I want to do? Yes and no, you can do stuff, but still, for NDIS rules and regulations, and yes with COVID-19, extra things. You have to make sure that the signature, and there's health agreement in place - (words indistinct) - he worked in a flower shop -

CHAIR - Sorry, what was that?

Mr STROOBACK - No, I was saying if you don't have any experience like that - it is a learning curve, and we found out that we have to slow down the pace to make sure that people are feeling comfortable when more training is required. I am very pleased with the outcomes, in Northam, for example, and it's just that we can't keep up with the demands and - because now - for the people, because sometimes they fight - they don't want to move to Perth, live in country area for -

CHAIR - Our internet seems to be a bit patchy at the minute.

Mr STROOBACK - Yes, okay. Can you still hear me?

CHAIR - It has been coming in and out a bit. Just with the community that you mentioned to me that you were travelling out east of Perth to, how big is the population of that area? Do you have a team out there and what are they doing?

Mr STROOBACK - We have a team of about nine at the moment, and they mainly do disability care, but also a lot of coordination, so we have a support coordinator. She lives in York, close to Northam, also a country area. We try to coordinate all the silos available in Australian health setting, the local hospitals, the hospitals in Perth, therapists, and god knows what, and GPs, so that is a bit of an extra that we do, and also help people navigate through the system.

CHAIR - What is the population that's served by that team?

Mr STROOBACK - I don't know, because Northam itself, that's a bit of the original town, but we have a lot of small towns around it which we service. Meckering -I think only a couple of hundred people live there.

We would take the whole area over there. That is the difference with the city, the metropolitan area, and country is that the buurt is too big. Also, for staff, we have different rules; for example, commuting is up to x kilometres, and then we start paying you for above that. Otherwise, especially with the petrol price nowadays, it is just not possible. It is normal if you live in country to drive 60 kilometres to the next client. We changed our model to accommodate that, and also, still make sure that it is funded enough.

Mr DUIGAN - Are you pursuing being registered to provide home care packages. Presumably that helps the funding and sustainability of your model?

Mr STROOBACK - We will look at it in the next financial year, I have to say.

The threshold is very high at the moment, and also there are a lot of changes. If you look at aged care packages, and NDIS, they are getting more and more together. Lots of moving parts, things change all the time, so we got advice to hold on Hopefully, in the new financial year it will have tapered out a little bit and we can wait for the new budget coming through. We took that advice that we hold on and we look into it next financial year.

To give you an example, it is like when we started NDIS. Western Australia was not part of the NDIS, and then suddenly, before it started 1 July, they postponed it to the 1 December. Then we had to re-register again for the state, and then for 1 December, we had to re-register for the national NDIS. Then, after 6 months, we got our first audit, so we could apply for the other services it could provide because we only got a core side of things. That was May, and it finished in July. I am still waiting for the results - almost a year down the track. if you need to change something in Australia, it is these kind of things, because it hinders the service for us as a provider.

AGP is the same thing. It is a small organisation at the moment. Only 40 people. Can we afford to go through a process like that? Initial fee of $10 000 and then the audit another $50 000, and wait. I sound cynical, but as an organisation, you have to be careful what you do in that sense.

CHAIR - Are staff employed on a contract? What is their employment arrangement?

Mr STROOBACK - Permanent part-time, in general. We have a little clout of casual workers because of COVID-19. Sometimes you start with a casual arrangement. It depends on the flexibility.

If people say I can only work in the mornings, Tuesdays, Thursdays and Fridays - we don't know sometimes whether that works for the team. I'll start with a casual, and see how we go, if it works. We always try to convert the casuals into permanent part-time, because the teams are really core to the model, and you can only get a good team, if it is a two-way street. If we cannot commit as an organisation, why would people commit?

CHAIR - You don't have full time staff in the teams?

Mr STROOBACK - We have a few, but most people do not want to work full time. .

As long as it works for the team. I am getting involved in some interviews because they ask me, because I have a lot of experience with doing interviews. But the team decides whether it fits and suits the team.

CHAIR - Are they paid according to the federal award wages? How are their salaries set, or their rates of pay?

Mr STROOBACK - We pay award levels. Within awards you can play around the levels you give. In some organisations they would say 2.1, and with us they were going to be 2.3 for example, so we try to be a little more generous on that side. we would also like later on, because in Holland too we are a for benefit organisation. It is not legally known in Australia - you are a not for profit or a for profit organisation. In Europe, you also have the for benefit organisation, which means that it runs like a business, but the way the dividend is treated is different.

CHAIR - Are you classified as a not for profit or a for profit organisation?

Mr STROOBACK - For profit organisation.

CHAIR - Right, but you are really for purpose rather than profit?

Mr STROOBACK - Yes; we call it benefit.

Mr DUIGAN - How well do the teams work in different cultural settings across different countries? Do you find that the teams in the Netherlands work very well, but you have to work harder to establish a team that works in Australia, for example; or is it universal?

Mr STROOBACK - From every country we hear that it might work in Netherlands but it will not work here. That is not the case. Sometimes it takes longer. I never realised it in the time I lived out here, but the default here is a hierarchical organisation - everything is with layers of management, and instruction down and reporting up.

In Northern Europe, you do not have those organisations. Government organisations have layers of managements, but further then that the default is now a flat organisation. We found that the employees we hired, have never been exposed to working for a flat organisation. It takes time and trust. There is a strange feeling - won't I need to ask permission? Nope, what do you think should happen?

Go for it. And that’s new. We found out it takes a couple of months, and then it won't go back. You see it everywhere. In China as well, you would not expect that but sometimes have a different outcome, the first time I saw a photo with the team in a row together and they're all standing in meticulous uniforms, and one in front of them with a little pet. That does not look like Buurtzorg, but the thing is that role is rotated, so this month you’re the front man, the next month I'm the front man. It's basically resolved.

CHAIR - Adapted culturally.

Mr STROOBACK - Yes, it is. In Australia, it is not having the experience to work for a flat organisation. It takes two or three months and its fine.

CHAIR - Do you seek accreditation, or do you need to be accredited?

Mr STROOBACK - In NDS you do not need to be accredited along as you work with the plan manager and self-managed clients. If you want what they call NDS managed clients you have to be accredited. We have done that, so we are accredited or licenced for NDIS. We are not accredited for aged care packages, and that is something were looking to in the next financial year.

CHAIR - What if you are providing a primary health care model; would you need any accreditation to provide that care?

Mr STROOBACK - If you want to be able to collect Medicare, then we need to be registered for Medicare.

CHAIR - Sure, and do you do that?

Mr STROOBACK - We are looking into that, and that is also the discussion with PHN. That is like a project for us, what does it mean, and what do we need to do. It's quite confusing, I have to say. If you talk someone in aged care, they do not have a clue what is happening in my NDIS, or with Medicare. They know their own little silo, but there aren't many people who have a bit of an overview.

CHAIR - I think it is been constructed that way. Okay, well thanks, we've had an hour of your time, we really appreciate that, Arnold, for taking the time to explain it, it is really interesting, and I think it's good to look beyond our own experience at times to see what might be possible.

Mr STROOBACK - Yes, that's great, and if you have further questions later on, I'm happy to answer.

CHAIR - Thank you, and if you could just email through that presentation to Jenny, that would be great.

Mr STROOBACK - Yes, I'll do that right away.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.