TRANSCRIPT

LEGISLATIVE COUNCIL ECONOMY AND INFRASTRUCTURE COMMITTEE

Inquiry into the Multi Purpose Taxi Program (MPTP)

Melbourne—Thursday, 21 October 2021

MEMBERS

Mr Enver Erdogan—Chair
Mr Bernie Finn—Deputy Chair
Mr Rodney Barton
Mr Mark Gepp
Mrs Bev McArthur
Mr Tim Quilty
Mr Lee Tarlamis

PARTICIPATING MEMBERS

Dr Matthew Bach
Ms Melina Bath
Dr Catherine Cumming
Mr David Davis
Mr David Limbrick
Ms Wendy Lovell
Mr Andy Meddick
Mr Edward O'Donohue
Mr Craig Ondarchie
Mr Gordon Rich-Phillips
Ms Harriet Shing
Ms Kaushaliya Vaghela
Ms Sheena Watt

WITNESS *(via videoconference)*

Dr Daniel Davis, Chair, Link Community Transport.

The CHAIR: The Economy and Infrastructure Committee public hearing for the Inquiry into the Multi Purpose Taxi Program continues. Please ensure that mobile phones are switched to silent and any background noise is minimised.

I wish to begin by acknowledging the traditional owners of the land. I pay my respects to their elders past, present and emerging. I wish to welcome any members of the public that are watching via the live broadcast.

My name is Enver Erdogan, and I am Chair of the committee. My Deputy Chair is Mr Bernie Finn. My fellow committee members today are Mr Barton, Mr Lee Tarlamis and Mr Andy Meddick.

To all witnesses giving evidence, the evidence taken at this hearing is protected by parliamentary privilege as provided under the Victorian constitution and further subject to provisions of the Legislative Council standing orders. Therefore any information you provide today is protected; however, anything said outside the hearing may not be protected by law. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing. Ultimately transcripts will be made public and posted on the committee's website.

Could you please leave your opening comments to 5 to 10 minutes to allow plenty of time for discussion and start by stating your name for Hansard. Over to you, Dr Davis.

Dr DAVIS: Dr Daniel Davis. Thank you very much for the inquiry existing and for looking into these important subjects, and we very much appreciate the opportunity to come and speak to you about it and are very grateful that you are taking this seriously and taking an interest in it.

About me: I am the Chair of Link. I am also a visiting fellow at the University of Technology Sydney Institute for Public Policy and Governance and a lead researcher on an upcoming transport disadvantage and the future of community transport research piece that is coming out later in the year. My PhD was on governance of sustained value, particularly looking at both financial and community social outcome measures et cetera, so I am pretty keyed into this whole thing. I also serve as an Australian representative on international standards development for corporate governance, IT governance, AI governance, cybersecurity, innovation management et cetera—so a bit of a grounding in the thing.

The main points of our submission really are that the MPTP, while it is good in what it does, serves only a small segment of Victoria's assisted mobility requirements. We are really interested in getting engagement and focus on that bigger picture. So looking broadly at the end-to-end issue of wellbeing for vulnerable communities and the assisted transport requirements thereof, we actually suggest that the real issue is funding equity. There is a lack of funding across the spectrum, and the main part of that is that Victoria is missing out on over $50 million of funding from a commonwealth program. Vulnerable Victorians—the people you are looking at in the client community—are receiving $1 for every $12 granted in New South Wales and the ACT and only $1 for every $8 granted in Queensland and Tasmania from a commonwealth program. There are other points where this is missing out as well. This is leaving Victoria's most vulnerable exposed, and it risks generational market failure, particularly where there is an expectation of a transport market response to NDIS and home care packages, so some of the big shifts that are going on in aged and disability care. We are already starting to see an impact of that in the numbers that are actually being put into packages for Victoria, where we are already seeing some inequity falling into that, so it is starting to bear out on that front.

We note also, on a slightly different front, that services to vulnerable citizens are fragmented. They do not form part of an integrated system of care. People talk about it, but it is very hard to get access. It is not delivering outcomes that could reduce escalations that impact the quality of people's lives, and it is not reducing avoidable admissions to hospital systems as much as it could, because it is fragmented—little bits and pieces of pocketed funding and different programs. We note also that there is a layered problem with the funding that is available across the sector: there is a lower uptake; it is not being used, as much as the funding is available. Why am I

saying all of this? Uptake and access are issues, and the MPTP is contributing to fragmentation. It is not part of an integrated system of care, and it is not contributing to streamlined access across a range of different services that help people live independently and well in their own homes. It is just a fragmented piece. It is good in what it does if you look at it internally, but if you look at it across the system I think we can do better.

Finally, services to vulnerable citizens have an inherent high level of risk. I do not think I really need to tell you that. The disability royal commission and aged care royal commission have pointed out some enormous failings, and we put forward that the taxi industry generally, and the MPTP, are not really a fit-for-purpose pathway to serve the needs of a vulnerable community. So it serves well in a subset of people who are more able, and looking at it within itself it has its own issues and I am glad you are grappling with them, but looking broadly, I think the issues are much bigger, systemic and important for Victoria.

The MPTP is fine. It does not advance an integrated care-in-the-community approach; it does not advance uptake of available preventative and life-affirming services that you are already funding. It is not a pathway to address the fact that Victoria is missing out on $50 million worth of commonwealth funding—by the way, this is according to the commonwealth numbers that are published, so it is pretty solid stuff. It is not a pathway to address a real service shortfall that exists in Victoria compared to other states. It is not a pathway to address potential market failures that are starting to bear themselves out, and it just remains exposed to royal commission risk in a way that you need a systemic approach to fix. I would suggest that community transport is set up to do this. It is nascent in Victoria because it is underfunded, but it does have training, accreditation and service quality standards around its services. It is fit for purpose but needs some help.

So we recommend the inquiry do a few things: ask government to develop an integrated policy for in-community care for the wellbeing of Victorian citizens that informs mobility requirements. What actually is the need, if that is the outcome, rather than just purely looking at the program in itself? The second one would be to develop a public infrastructure strategy for flexible assisted transport to support this outcome and other aspects of transport disadvantage. Look at it as a joined-up, systemic approach. If we can ask government to do some of these things, I think we will be a lot further forward and be able to have more sophisticated discussions at this kind of level. And to that end we recommend the output of the University of Technology Sydney. A research program that will be coming out later this year is trying to grapple with these issues, and it is doing that with transport departments across four states. This is a common issue, and Victoria is known to be further behind because of some systemic anomalies, so anything we can do to address them will really help address the issue.

The CHAIR: Thank you, Dr Davis. That was a very comprehensive overview of some of the broader issues in the equity space, and I will probably ask a bit about those later. I did have one question. I was waiting for you to come on, and it is a bit different to some of the other witnesses we have had. Some of the witnesses we had on Tuesday and earlier today obviously explained how, and we heard people saying how, in this sector in particular, traditional taxi services have been really good in terms of providing a personal level of service, the continuation and the relationship-building with this vulnerable cohort. What do you say when people say, 'Well, if the new entrants are providing such a bad service and the apps are difficult to use, then is there a need to be concerned? People will just choose not to use such a bad service, and if the traditional service is so good people will just stick with what is working'? I want you to just comment on that, if you could.

Dr DAVIS: You have to look at the whole continuity of need, and as you said, there is a cohort of people who are using MPTP who can get themselves around, who the service works for. They can look after themselves and they can defend themselves. Community transport looks after the complete continuum into the very, very high care. It has been noted in a number of public forums involving seminars from the sector that community transport is seen, and they see themselves, as part of the health system. They notice, for instance, that people are starting to have undiagnosed dementia. It is not a matter that people are unfamiliar with technology; it is that they cannot find themselves through a system and it is because they are getting older and they are starting to have health problems, so it is really seen as the leading edge of community care. They had moved from tertiary care into the PHNs—the primary health networks—but this is actually care in community as the first place of noticing. Look, there are some good taxidrivers out there who build those relationships. We systematise that, we make sure it is there, we give support so that the health escalations and others are reported on. We train people to notice, we report and there is a system to escalate them, and we have started much more taking up that whole, really, community building to make sure that there is actually support for the drivers and the carers who are there because they start to become exposed to trauma. You know, they are involved in people's lives.

The CHAIR: Yes, I understand. We were provided data by CPVV which showed that over 76 per cent of the trips were by people over 50 and over 62 per cent of the trips were by people over 60 years old, so you are right—proportionally it is older people with a lot of those other health issues which are onset. What I might do is move over to Mr Finn and then Mr Barton. Deputy Chair, do you have a question?

Mr FINN: Yes, indeed I do. Thank you, Mr Chairman. Thank you, Dr Davis, for your comprehensive suggestions, I think, more than anything else. Thank you for that. We need more of those every day.

I am particularly interested to hear your suggestion of the development of an integration policy. Now, we know that the multipurpose taxi scheme is working for many, many people. What concerns me is that if you were to refer the development of an integration policy to the bureaucracy, this may well turn into a decade-long lovefest. This is a bureaucrat's dream to be told to develop a policy like this. How would we go about developing such a policy without damaging the service that is already there?

Dr DAVIS: That is a really good question. It is an excellent question. Look, ultimately—

Mr FINN: I am glad somebody is saying something nice about me today.

Dr DAVIS: Look, MPTP, rideshare schemes all have a part in continuing the service, without a doubt. They have a role there and they should always be looking at their own quality and what can be lifted within that. To look across the board is something—as I said, I have got a unique position to be able to see this through the research we are doing that is engaging across multiple states. Everybody is grappling with this as an issue. The feeling that I have, which is to your question of 'How do you stop this from turning into a 10-year internal navel-gazing exercise', I think is to have political buy-in to this. When you specifically look at some of the issues—as I said, Victoria's funding equity issues—of solving a commonwealth funding and equity problem, I doubt it is going to get solved at the bureaucratic level. I think that being able to set some community outcomes—so again I will fit this into the language of social outcome measures, which I know senior parts of government are involved in. I would personally think that that thinking, that logic, should be advanced so that we can set some targets in measurable terms. We can measure against them and we can press for specific strategies that are going to move those targets.

Look, it is a complex issue. All of these things, as with domestic violence and all sorts of other things, are multifactor. They are hard issues to move, but I think that some of the efforts that have been put in there have made some difference. I think some of the focus that has been brought from the political level has helped. And for those bureaucrats who are good at it—and look, individually they do get it if they have an audience who is there to hear and who is focused on telling me how this outcome is going to achieve. It makes their job easier too. It makes their advice possibly less brave and less systemic. I think that is part of the problem. It is hard to get systemic change through the normal governance process. I could address this from a question of systemic innovation and what is observed globally there, but ultimately the answer to that is social outcome measures at the political policy level that say, 'This is what we want to achieve, here is the bureaucratic measure of where we are, this is where we think that government should be trying to make the difference. You know, there are gaps here, here, here and here, and the priority gaps for this government are X, Y, Z, A, B, C—these ones. Come and tell us how they are going to move'.

Mr FINN: So what you are suggesting basically is we watch them like a hawk and make sure that they are actually meeting the goals that we have set?

Dr DAVIS: Yes. And I think getting consistency in social outcome measures in communicating those goals will help, because otherwise you get this language and you get good intention and you get very good speeches on how it is going to happen and it never does—so quantification. I guess I am starting to lean into my PhD area here, which I will refrain from giving you a lecture on.

Mr FINN: That could keep us going for the rest of the week, I fear.

Dr DAVIS: Having said that, there are pockets of this inside areas of government—inside Treasury, inside other areas who are around this. Pulling out the 'What do we want?', using those measures and getting them to then align to funding and internal mechanisms within government is ultimately the answer. This is getting a bit more sophisticated and mature in how we deal with some of these complex systemic issues, and this is one of them.

Mr FINN: Thank you.

The CHAIR: Thank you. Mr Barton.

Mr BARTON: Thank you, Chair. Thank you, Dr Davis. The funding you raised before—how has that come about, and how would you fix that?

Dr DAVIS: The funding inequity issue?

Mr BARTON: Yes.

Dr DAVIS: How has it come about? It is a hangover from previous failings. Going back a way to where a lot of these services were state based, it was very hard to make the case to a state government that things were underfunded, and they were historically in Victoria—for whatever reason. Trying to say why that happened and how that happened and how that was allowed to continue is too hard an exercise for me. When it went to a federal program, we had great hopes that we would now get equity, because how can you get different funding in different states? What the federal program did was purely pick up on what each of the states were doing and say, 'We'll just take that as gospel'. The federal system runs growth rounds where it says, 'In the next year we'll fund this level of service' et cetera. They took guidance from the state governments on where that was required. Victoria had wound down its unit; it was small to start with and not focused on the issue and was rounded down, so in the first—

Mr BARTON: Sorry, Dr Davis. How long ago are we talking there? Are you talking five years ago, 10 years ago, 20 years ago?

Dr DAVIS: Three or four years—so when the whole program moved from state funding to CHSP federal funding, federal aged care. The guidance given by Victoria meant that while all other states except for WA, which was also problematic, requested significant transport funding across all of the different realms, Victoria did not. So Victoria just had not engaged with the problem well, handed over an underfunded system and then did not campaign to fund it, whereas all the other states did. So it just has never really had that prominence of focus in the Victorian government, and that has been allowed to continue through the federal program because the federal program—rather than actually taking responsibility and saying, 'What is the per-head funding across our states and have we got equity in different regions?' et cetera—is still taking guidance from others and not really taking responsibility for that equity. I think it now falls on the Victorian government to address that.

Mr BARTON: One of the issues that has been raised with me is that as we move into the NDIS the federal government is actually going to be removing people from the Multi Purpose Taxi Program and there will be more people worse off more often.

Dr DAVIS: I think so. So the NDIS is well intentioned in many ways, but even if you look at what they predicted was going to be required—so their own market scoping of the size of funding requirement—and you compare that to what is actually getting into programs, so what the assessors will allow to get into an individual's package, there is a huge disparity. So they assess the market at a size. They are actually giving out money into people's packages at a much smaller level, and yet they are relying on a market response that is not getting funded. So in terms of taking an infrastructure view of this, transport has to be infrastructure. It cannot be purely a responsive service—you know, just being highly responsive without having funding—because you have just got a market failure happening there, and we are seeing how that is coming into people's packages. So yes, people are worse off; they are being left worse off, and it is progressively getting worse over time.

Mr BARTON: In your submission you say that you do not believe the taxi industry is capable of meeting the demands of the Multi Purpose Taxi Program, even though we are doing 60 million trips a year. I suggest we might be doing something right when we have got a complaint rate of less than 1 per cent.

Dr DAVIS: No. I am suggesting that if you look at the standards that exist in aged care—aged care quality standards, the disability standards commission et cetera—and you look at the recommendations coming out of the royal commissions for aged care and disability care, which are lifting those standards further, they are systemic quality systems that I do not think the taxi industry is designed currently to be able to address. They really—

The CHAIR: Just one important point, because it is relevant. So you are saying not necessarily deregulation, you saying that actually there should be a higher level of accreditation, training and code of conduct in this subsection of the industry because of the cohort.

Dr DAVIS: Yes. Again, there is a subsection. Given the program is looking at everybody over the age of 60, there are many of those who are well and truly fit and able to look after themselves, and there are people in wheelchairs who have mobility issues who do not have cognitive issues, do not have other health issues, do not have other physical limitations. You know, they can still look after themselves, they just cannot walk. A taxi program is great for that. But where you start to get those other comorbidities, co-risks et cetera, the risk to the individual gets exponentially higher, and I do not see that the taxi industry is structured to put in the quality governance processes that you witness across community transport, residential aged care, disability services et cetera.

I am very familiar with how they are structured and run, and they need a certain kind of organisational structure and backbone to make them happen, and I suspect the taxi industry is ill suited to go there. They are good at what they do, but I think, again, we need to think: where do they fit in the continuum, and have we balanced funding and care across the continuum so they are looking after the appropriate cohort, so that people who should not be looked after by them are not being looked after by them and that people who have highly vulnerable needs do not try to get a taxi where they are going to be at risk, and so that people who should get a taxi and can get a taxi do get a taxi—that is great; I have no problem with that.

Mr BARTON: I have enough trouble getting the Treasurer to buy me a cup of coffee, let alone spend enough money to have a carer for every person with a disability in Victoria.

Dr DAVIS: We are not calling for that. That is a very different argument, for a different inquiry and probably not my beef anyway. We operate in a system where pretty much everybody we are exposed to has had some form of assessment. It already happens. And, look, many people are assessed at low need. What the discussion at the leading edge of the sector is about is: how can we take people on a journey so we are engaging with them while they are low need and continue to engage with them over 10, 15, 20 or 30 years as their needs increase so that they can use the services that are appropriate, particularly the proactive health in-community services, so they do not escalate to primary care and tertiary care—avoidable incidents in hospitals, avoidable escalations that have permanent impact on their lives. So engage with them very light and early while they are still able to look after themselves and carry them through the system over an extended period of time. It is not a huge cost thing given the amount of effort that already goes in; it is just about integrated care.

Mr BARTON: I think the cost would be rather scary, myself. We are going to be running out of time; I just want to change the subject a little bit, about community driving. I know of two places, which I spoke to someone yesterday about, where we have community vehicles running effectively taxi services. In those two communities, because the taxi service is at best lineball, they could not compete against the volunteers. I do not want to say this disrespectfully—volunteers, we cannot survive without them, right?—but we have got an 85-year-old volunteer driving an 85-year-old patient. We do not know which one is the patient, which one is the driver. So the question is: are they fit for purpose? Do they have all the same qualifications as the drivers? Have the vehicles passed the necessary tests? The reason why I say this to you is that a taxi service has closed down altogether and the community has now lost their taxi service because they could not compete against the local hospital giving all their work to the volunteers. The taxi service is gone, so no-one is going to go out on a Friday night, no-one is going out on Christmas Day and there is no chance of having a wheelchair vehicle in that community.

Dr DAVIS: Okay, so the major cost is the cost of aged care, which is in the tens of billions of dollars if not hundreds of billions of dollars over an extended period of time. Volunteering in a community of care is a fundamental part of affordable healthcare costs for the country and the state moving forward, so volunteering is an important part of that. As to whether an 85-year-old driver is fit for purpose, many of the community transport organisations have very strong ongoing training, accreditation, support. So they make sure, whether they are volunteer or paid drivers—and there are hybrids—they are fit for purpose, are capable, are trained and have the support they need. So you are not getting people who themselves need care trying to provide care to others. But it is a community and a continuum, so it is being looked after. Now, whether a volunteer—

Mr BARTON: Sorry, Dr Davis, do they get paid? Do they get reimbursed for fuel and kilometres driven?

Dr DAVIS: A whole lot of different models—there are more models than you can really count. Yes, if they are using their own car, they get reimbursed—if they are using their own vehicles. There are many different models. It is a very complex little sector.

Mr BARTON: I have absolutely no problem with all of that except to say from the transport industry, we say they are commercial passenger vehicle drivers and they should be meeting the same requirements everybody else does.

Dr DAVIS: They have got bus safety standards, and safety standards across the board, and absolutely I agree they should.

The CHAIR: Thank you, Mr Barton. I notice that we have got a tight schedule today. I will just ask any other committee members if they would like to ask questions—Mr Meddick or Mr Tarlamis—or are you happy to keep it on notice?

Mr TARLAMIS: Yes, Chair. Thank you, Dr Davis. I just wanted to clarify: earlier when you were making your contribution and answering other questions, you referred to some of the issues around taxidrivers. I assume you mean that that extends to all commercial passenger vehicles, not just taxidrivers as well, so it is across the board.

Dr DAVIS: Correct.

Mr TARLAMIS: No worries. Thank you for your comprehensive presentation today. It has been really informative.

The CHAIR: I have got a couple of questions. I think you touched on some issues about the NDIS and stuff that we might need to tease out, but obviously because of time today are you happy for us to reach out to you if we have any additional questions about this? Obviously we will have deliberations a few months later in relation to this inquiry, so we will reach out to you if that is okay.

Dr DAVIS: Very much so. We strongly believe the only way through in this is with co-design, involvement, communication and many parties involved, and we are there at any table that is discussing it. Thank you.

The CHAIR: I really appreciate your submission and presentation today. It has been a pleasure to hear from you, and we will give it due consideration at deliberations moving forward. On that note, our next witness is here, I believe. The committee will now take a short break before we get onto the next witness. Thank you, Dr Davis.

Witness withdrew.