New Zealand Nurses Organisation Submission to the Electricity Commission On the

Proposed changes to the Guideline on arrangements to assist low income and vulnerable consumers

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INTRODUCTION

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Electricity Commission's proposed changes to the Guideline on arrangements to assist low income and vulnerable consumers.

2. The New Zealand Nurses Organisation (NZNO) is the leading professional body of nurses and nursing union in Aotearoa New Zealand, representing over 42 000 nurses and health workers. Our members include nurses, midwives, students, kaimahi hauora, health care workers and allied health professionals, who work in a variety of hospital and community settings where the Guideline is relevant.

3. NZNO has consulted its staff and members in the preparation of this submission in particular Professional Nursing and Regional Advisors, Policy Analysts, Te Runanga o Aotearoa (the arm through which our Te Tiriti o Waitangi partnership is articulated), Industrial Advisors, the Primary Health Care (PHC), Aged Care and District Health Board (DHB) Sectors and specialist Colleges and Sections.

4. We note that NZNO members testified at the inquiry following Mrs Muliaga's address and their comments and subsequent changed procedures at Counties-Manukau DHB inform this submission.

5. NZNO applauds the Electricity Commission for being proactive in auditing the effectiveness of Guideline issued subsequent to the death of Mrs Muliaga in 2007, and in proposing changes to increase the Guideline's effectiveness.

6. NZNO generally supports the underlying principles of the document and efforts to make all processes simple, transparent and consistent. However, while we agree that:

    - consumers must be responsible for notifying their electricity retailer;

- medical dependency should be defined by health rather than equipment need; and that

- retailers have a right to be paid,

we do not believe that the factors contributing to vulnerability have been fully recognised. The issues surrounding responsibility for medically dependent vulnerable consumers (MDVC) are complex and reference fundamental individual and societal obligations such as individual accountability, social justice and humanity. Often many people and many agencies are involved - families, hospitals, Primary Health Care Organisations, Accident Compensation Corporation, health professionals and social workers - so that *as well as* the clearly defined responsibilities mentioned, various 'safety nets' need to be in place to ensure an extra layer of protection for the most vulnerable members of our society, including children and the elderly who may not be primarily responsible for their own care. We don't believe that adequate consideration has been given to the above and consider that the Guideline falls short of addressing the risk for some highly vulnerable consumers. In our opinion while the proposed changes clarify that DHBs and retailers responsibilities, they fall short of mitigating risk for MDVC.

7. We are also concerned that the discussion is largely restricted to DHBs consumers and retailers, whereas we think the issues with MDVC should be considered in a much broader context.

8. We note that there has been a large increase in the numbers of MDVC. This is to be expected with any new regulation – one would hope that strategies designed to protect the vulnerable would work. We also suggest that this trend will continue as we have an aging population and disproportionate numbers of older people are medically dependent. However, even with the large increase, NZNO observes that MDVC still comprise less than 1% of consumers, which is consistent with expectations, and assumes that only a

small number would not be meeting their financial obligations to the retailer. NZNO supports moves to assist low income and vulnerable consumers and believes there should be robust protection from disconnection of electricity supply for MDVC. Robust protection assumes that there will be multiple processes to mitigate risks for the most vulnerable people.

Principles: Questions 1 and 2

9. NZNO believes a statement of principles clarifying the rights and obligations of consumers and retailers is appropriate and useful in this context. However in view of the circumstances and public outrage which prompted the 2007 changes to the Guideline, we recommend including a position statement of principle that acknowledges the consensus view that in a civilized, socially just and humane society, life should be not be put at risk because of an unpaid electricity account.

10. We support the principles in general but believe that Section 4 which narrowly defines “acting in good faith” as “engagement” with only one agency, Work and Income New Zealand (WINZ), does not afford adequate protection to vulnerable consumers. Engagement is subject to wide interpretation, would be difficult to effect satisfactorily and it is not clear that WINZ would be the appropriate or only agency to consult (what assurance could there be that WINZ would have access to the relevant health information?). The intention of the statement is also compromised by the phrase “to the extent possible” which again would be subject to wide interpretation.

11. NZNO strongly recommends that for this group an independent safety mechanism referenced to health rather than financial circumstances is necessary. We suggest that other measures such as a standardized information leaflet in several different languages could be developed for general distribution and compulsory reference to a national register of medically dependent vulnerable consumers (MDVCs) prior to disconnection would provide useful cost-effective safeguards.

Policy Objectives: Questions 3 and 4

12. The statement of policy objectives is admirably clear and concise and it is appropriate to include it in the Guideline.

Standards Questions: 5 and 6

13. NZNO believes it is appropriate to include the standards in the Guideline but believes they need modification.

14. Section 3.4.1 (c) does not offer sufficient assurance of protection to MDVC or guidance to the DHB, and may be impractical. Both research and nurses' experience indicates that there are many circumstances in which instructions following discharge are not followed even when a high risk patient is involved. Language, resources, income, ancillary support, comprehension and stress are all factors that could impact on timely communication with a retailer and are the factors that define a vulnerable consumer.

15. Although the DHB is responsible for hospital discharge, it is equally responsible for subsequent healthcare. In practice, hospital stays are very short and hospital discharge(s) is/are only one process in many interactions over an extended period of time necessary to manage the complexities of secondary healthcare for medically dependent consumers. The Guideline does not reflect this balance adequately. In addition, a number of agencies are likely to be involved in secondary care depending on the circumstances and this will materially affect the degree of consumer support. If an injury is involved there will be an ACC case manager, for instance; if it is a chronic condition it will probably be managed by a GP, who may or may not employ community nurses to coordinate care; and/or care may be managed through district nursing or home-based treatment services or even Non-Government Agencies such as the Asthma Foundation, DeBRA or CanTEEN. Other government social agencies such as WINZ and Children Young Persons and Families (CYPF) may also be involved if there are dependents or the consumer is a child; technical equipment and support also needs to be

considered. NZNO members advise that where a number of agencies and vulnerable consumers are involved, it is essential to have a social worker to coordinate delivery of healthcare and equipment, and provide relevant social support. Community advocates also provide a valuable resource in these situations and could be provided with standard information and guidelines to empower MDVC.

16. NZNO recommends that the Counties Manukau DHB checklist and guideline for MVDC be used as a basis for the development of consistent standardised information and guidelines to *all* individuals and organisations including consumers, families, community advocates, retailers, DHBs, PHOs, social and community agencies. (Please note that CMDHB has indicated to NZNO that it would be happy to share this information.) The Guideline should not be restricted to DHBs, retailers, consumers and referenced only to WINZ.

17. NZNO is at a loss to understand why in 2009, with the advantage of digital information and communications technologies which the electricity industry and health agencies use to considerable advantage, the Electricity Commission would assert that “any register of MDVCs is likely to be less than complete”. It is not only the consumer who should be accountable; retailers and health professionals and other social agency workers are also responsible for safe, proper practice including maintaining accurate records and following standard procedures. The public is entitled to expect professional and commercial competence, especially where life is at risk. Though such systems are always open to human error, they provide another layer of protection for MDVC.

18. NZNO also questions why there should be “risks associated with incomplete information” and suggests that this is a resolvable issue, especially if standardised guidelines were developed which included information sheets in multiple languages. A register would offer another line of protection and has the advantage of being independent, low cost and accessible through multiple

entry points so GPs, who largely take over responsibility for chronic care consumers after discharge can have input as well as retailers.

Background Section: Question 7

19. NZNO agrees that electricity is an essential service and warrants differentiation from other services by a policy of assistance to vulnerable consumers.

MDVC: Questions 8, 9, 10 and 11

20. NZNO supports option (a) the definition of MVDC being linked to the medical condition and believes the proposed definition MVDC and CEME are clear and practical with the following exception.

21. We **do not support** the definition of vulnerable consumer as it leaves out a major reason for vulnerability which is inability to access services because of language or culture. We strongly recommend that the definition of vulnerable consumers should include reference to cultural and language competency along with age etc. We also suggest the definition for vulnerable consumer should include low income as well as financial insecurity since the latter could be interpreted as excluding any employed person regardless of income and financial obligations and responsibilities.

22. We recommend that consideration be given to including "severely compromising the consumer's health" for assessing the degree of dependence. We also raise the question as to whether children need special protection.

23. The process of identifying a MDVC should be (b) a process of assessment by a medical professional and all MVDC should be assigned a social/lead/case worker to coordinate health and social care.

Consistent policy between the Commission and DHBs

Questions 12 and 13

24. Vulnerable consumers often move address, and may move to a different DHB which makes it very difficult for any one agency, DHB or PHO to be responsible for them. In Mrs Muliaga's case, the DHB did all that this 2007 Guideline subsequently required: the family was advised several times about the need to contact the electricity retailer (and indeed Mr Muliaga did attempt to pay the bill but was thwarted by a bureaucratic error regarding the account name) and letters were written to inform the retailer. Yet Mrs Muliaga died. Clearly that process did not protect her. The DHB has since streamlined processes and introduced a checklist and a key person in the clinical team to minimise risk and manage transitions such as discharge to General Practitioner or District Nursing care. However these safety measures are not followed in all DHBs or in all PHOs.

25. NZNO takes issue with the faulty logic behind the Ministry of Health's statement (Page 11) that being well enough to be discharged from hospital indicates adequate ability to communicate with an electricity retailer and questions whether a support person would necessarily be able to "assist them with the notification". (It is not clear what "assist" means in that context either.) Most medically dependent consumers spend comparatively little time in hospital, and recovery and chronic care is usually managed through PHOs. MDVC, by definition, are at risk of not having the usual resources to deal competently with a retailer. Several factors, apart from health and income, contribute to risk. Whilst most consumers have the resources and support to meet their financial obligations, or negotiate reduced payments or help from the Ministry of Social Development, vulnerable consumers may lack the language, knowledge or confidence to do so. Their circumstances may be exacerbated by other difficulties such as unemployment, inadequate housing, and isolation, lack of transport or family problems. It is these consumers, in unnatural and straitened circumstances, who need extra protection or help. It cannot be assumed that patients discharged from hospital have the support they need, particularly since "support person" in a healthcare context may

more narrowly denote support in terms of ability to manage medical dependency rather than support in the broader social context.

26. Vulnerability cannot be assessed solely in terms of health and economic status and NZNO is concerned that the proposed Guideline does not take into account a consumer's ability to access resources and support.

27. NZNO suggests that although it is clearly the responsibility of consumers to inform retailers of medical dependency, in the case of MDVC there needs to be a 'safety net'. We recommend that all MVDCs should be assigned a social worker to help guide the consumer through the process of informing the retailer and this should be stipulated in contractual arrangements between PHOs and DHBs. As Counties Manukau DHB has found, identifying a lead person and providing them with a checklist which includes reference to informing electricity retailers, provides a degree of extra support for the vulnerable.

28. With reference to the "similar policies" in the United Kingdom and Australia we note that there are significant differences in both electricity supply contracts and access to health care from Aotearoa New Zealand. The UK has the National Health Service, with no charge to the consumer for secondary care or medicine, which is not the case here. In Australia there is no ACC and a complex mix of Federal, State and private health insurance prevails which bears no resemblance to New Zealand's government funded public health care. There is a clear division between health and social agencies in the UK, which do not work closely together as ours do. Needless to say the history, culture and demography of all three countries are dissimilar. Further, in both Australia and the UK, there is similar concern and significant support at grassroots and policy level for measures (as expressed in the UK Fuel-Poverty Strategy, for example) to disallow disconnection in households where there are aged, disabled or young children and put in place strategies to help vulnerable consumers, incur less energy debt and manage payments better.

Whilst we are aware that the latter is not the focus of the guideline, we believe it is germane to indicate that the issue is not straightforward.

29. We agree that it should be the consumers' responsibility to notify retailers when dependency ceases but suggest that if there are problems getting MDVC to inform the retailer when the information is critical, it is unlikely that they would inform retailers when it wasn't. Experience suggests that vulnerable consumers frequently change address without informing health agencies, even in circumstances where health care is critical. Again the issue is not whether consumers *should* inform retailers, but, in the case of MDVC, whether they do and what can be done to mitigate the risk to those consumers, who may be dependents, if they don't.

30. NZNO agrees that the retailer should have the right to verify MDVC status every 12 months but also recommends that they should be obliged to check a MDVC register before disconnection. The balance between privacy and the retailers' right to relevant information, which in this case is simply whether the consumer is medically dependent on an electricity supply, needs to be maintained. NZNO suggests that an independent source of that specific information should be available to retailers.

31. We believe that, in a caring community, responsibility for protecting the vulnerable should be shared, so that, in addition to consumer obligations, all government, community and commercial agencies should have defined processes which will offer extra protection to vulnerable consumers.

Other proposed updates Questions 14, 15 and 16

32. We agree that low income is often a measure of vulnerability but as stated earlier, **would not support** its omission unless it was specified in the definition of vulnerable consumer.

33. We have no objection to incorporating the main elements of the Electricity Consumer Code of Practice into the Guideline.

34. We strongly support having a restriction on retailers' disconnection of a consumer for non-payment of services other than electricity.

RECOMMENDATIONS

35. In conclusion NZNO again thanks you for this opportunity to comment on the proposed changes to the Guideline for MDVC, and recommends that you:

- **Note** that we agree that electricity is an essential service;
- **Note** our general support for the Guideline but **agree** that it falls short of adequately protecting MDVC;
- **Note** our support for the Guideline principles;
- **Note** we have a concern with the Ministry of Health's assertion that a patient is only discharged if they are well enough to communicate with their retailer or if they have a support person to do so;
- **Amend** the definition of vulnerable consumer to reflect that low income and cultural and language difficulties which affect access to services are factors contributing to vulnerability;
- **Add** **'**severely compromising consumer health' to assessment of degree of dependency;
- **Agree** that MDVC constitute a small number of consumers who need special assistance and protection;
- **Agree** to add a position statement to the effect that life should not be at risk because of an unpaid electricity account;
- **Agree** that many other agencies as well as WINZ and DHBs need to be involved in mitigating the risk for MDVC and should be consulted;
- **Agree** that while the main accountability lies with consumers or their caregivers, retailers and health and social agencies also need to be accountable, especially where MDVC are concerned;

- **Agree** that 'acting in good faith' is poorly defined and requires more comprehensive explanation and instruction for retailers;

  Agree that developing standardized information sheets and guidelines in multiple languages should be a priority;

- **Agree** that the Counties Manukau DHB checklist and guideline would be a useful starting point to develop standardized information and note that it is available for this purpose;

- **Agree** that a national register of MDVC and assigning a lead person (social worker) to coordinate support would provide extra support for MDVC; and

- **Note** our support for restricting retailers' disconnection of a consumer for non-payment of services other than electricity**.**

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