



**Submission on the
Victorian Aids & Equipment Program Redevelopment
Service Delivery Model Discussion Paper**

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Introduction

We commend the Victorian Government and the Department of Human Services for recognising and initiating action to reform the Victorian Aids & Equipment Program. As the Discussion Paper notes, redeveloping the service delivery model is a critical aspect of this reform for ensuring that people with disabilities can access aids and equipment that are essential to their lives.

Our response to the Discussion Paper is grounded in the everyday comments and experiences of the many people with MS who rely on A&EP, and in the extensive experience of our occupational therapists and physiotherapists who frequently work with clients on their aids and equipment needs, and with the existing A&EP. In particular, Dawn Prasad, Diedre Evans, and Robyn Soulsby all made significant contributions to this response.

MS Australia provides a range of health promotion and disability services including respite, case management, allied health, community nursing and information. People with MS rely extensively on the Victorian A&EP, and they value the contribution it often makes to their lives. However, they also regularly confront the Program's inadequacies, and are looking forward to many of the much-needed changes that have been foreshadowed in the Discussion Paper.

MS is a chronic and incurable disease that randomly attacks the central nervous system (brain and spinal cord). Symptoms of MS are unpredictable and vary greatly from person to person and over time in the same person. Symptoms may include: extreme fatigue, tingling, numbness, impaired vision, loss of balance and muscle coordination, slurred speech, tremors, stiffness, bladder and bowel problems, difficulty walking, problems with memory and concentration, mood swings and in severe cases, partial or complete paralysis.

People with MS and aids and equipment

Aids and equipment are an essential part of managing the disabling effects of MS, and the VA&EP is often the entry point to the disability service system for Victorians with MS. In Australia, the Australian MS Longitudinal Study has estimated the cost of such modifications and aids for people with MS as \$1646 per person per annum, based on expenditure over the five years to August 2003 (Access Economics 2005). Updating this figure to 2008 prices (\$1912.26 per person per annum) and multiplying it by the number of people with MS in Victoria (approximately 6000 people) provides a cost estimate of \$11.5m for 2008.

In many cases, people with MS self-fund equipment and home/vehicle modifications with their savings (often with their superannuation or family assistance) because they cannot wait for state equipment schemes to respond, or because the modifications are either not funded or are short-funded.

There are clear dangers with this situation of people going outside the system – mainly around cost and self-prescription. A common example is where people have purchased an electric scooter privately, only to find out that it does not offer the right trunk support or controls, and it becomes redundant and is sold off cheaply or sits at home in a shed – and the mobility needs of the person remain unmet. If they had sought a prescription, a customised electric wheelchair may have been selected that was more suitable for their needs.

The need for adequate purchasing power, cost efficiency and effectiveness of the Victorian A&EP gains new significance when the overall scale of need for assistance is acknowledged. Redeveloping the system will hopefully generate some much-needed gains, but it must be acknowledged that additional funding will still be required above and beyond gains made through redevelopment.

The balance of our response directly addresses the questions posed in the Discussion Paper.

1. Do you support the proposed aims, objectives and principles?

The proposed aims, objectives and principles are a good start, but they require significant strengthening in relation to several vital issues:

- Timeliness of assistance provided
- Responsiveness to clients' changing needs, and prevention of avoidable deterioration
- Direct involvement of people with disabilities and their families in the ongoing development and evaluation of the effectiveness and efficiency of the program
- Accountability and complaints handling
- Addressing the intersection of other sources of funding (State and Commonwealth) for aids and equipment
- Location of residence

These issues are discussed in more detail below.

Proposed aim

Given the significance of the need for timely provision of aids and equipment, this must be incorporated into the aim of the program. For example,

‘The Victorian A&EP provides people with a permanent or long-term disability with subsidised aids, equipment and home and vehicle modifications in a ***timely manner*** to enhance independence in their home, facilitate community participation and support families and carers in their role.’ (page 11 of the Discussion Paper, the words in bold italics are the suggested change)

Timeliness is often critical in responding to changes in someone's disability or their circumstances, and in minimising further deterioration and strain on carers, as well as maximising opportunities and quality of life. Additionally it is not uncommon for delays to result in equipment being provided that is no longer appropriate or useable – these

problems arise most often with children, but also happen at other life stages, particularly in relation to progressive neurological diseases such as MS.

Proposed principles

To ensure that the A&EP is effective into the future, four additional principles are required regarding: (a) consumer and carer engagement; (b) complaints handling and accountability; (c) commitment to being responsive to changes in client needs; and (d) the intersection of other A&E funding sources/programs. These are described in more detail below, and it is also essential that these are followed through in relation to program objectives.

Suggestions for strengthening the three principles already proposed in the Discussion Paper are also described below.

Consumer and carer engagement

The participation of people with disabilities and their families in the ongoing development and evaluation of A&EP over the coming years is essential to its success. Such involvement is also in line with the Department and the Victorian Government's commitment to inclusion and participation. It is not enough to involve consumers only at times of review or as respondents to satisfaction surveys. If A&EP is to be successful, effective and relevant in the lives of people with disabilities and their families, they must have a more direct link to involvement at a strategic level in an ongoing way.

Involvement at this level would also assist in the delivery of commitments regarding transparency and accountability, and provide an avenue for assisting the Department to determine some of the more complex issues such as 'what is timeliness'; 'what do we mean by equitable access'; and 'how do we combine issues of equity and prevention in relation to equitable access'. A principle in relation to consumer and carer involvement must be developed and incorporated, such as:

'People with disabilities and their families will participate directly in the ongoing service development, service delivery and service evaluation processes.'

The need for such involvement has already been acknowledged in part by DHS through the establishment recently of the Governance Advisory Group, which is intended to include consumers and carers. It is unlikely however that the meeting of this group 3 times a year will be sufficient to ensure consumer and carer engagement with the program at a strategic level. The establishment and resourcing of a group of consumers and carers that meets more regularly, and that can then present issues to the Governance Advisory Group and others as needed is likely to be more effective and deliver better results.

Complaints

The A&EP needs to have its own complaints handling process for all users of the program. Currently the complaints process is highly decentralised and ad-hoc. Given the historical propensity for complaints in this program, a simple and transparent process is required.

In relation to complaints handling and an additional avenue of accountability, A&EP should come under the jurisdiction of the Disability Services Commissioner. This move would facilitate the external and independent review of complaints. The A&EP currently does not fall within the Disability Act, Aged Care, health or other specific legislation, and, consequently, serious accountability risks exist for the program. A relevant principle could read as follows:

‘The accountability of A&EP will be assisted by having complaints fall under the jurisdiction of the Disability Services Commissioner.’

Responsiveness to changing needs and preventing avoidable deterioration

Without a stronger commitment to responding to changing needs, consumers with progressive conditions, children and those in changing circumstances will continue to not have their needs adequately met. The temptation to limit access to one-time-only or once-every-five years to high-cost equipment is inevitable given the chronic under-funding of A&EP. Such arbitrary barriers conflict with the aim of A&EP, and prevent much-needed assistance from being provided.

Concomitantly, it is also vital to ensure that preventing avoidable deterioration is a key principle that permeates all aspects of A&EP. This principle is an essential component for ensuring that the program is effective in minimising the financial and human costs over time to government, consumers, their families and the community. A relevant principle could read as follows:

‘Timely responses to changing consumer needs, and the prevention of avoidable deterioration.’

While this principle may seem daunting and difficult to deliver on, it will ensure that these issues are acknowledged and that A&EP strives to meet them. Anything less will simply ensure that A&EP continues to not meet the needs of those who need its assistance the most. The example outlined in the box illustrates the false economy of delays and under-servicing of needs for assistance.

Pressure care

Pressure ulcers have major impacts on the lives of people with MS and spinal cord injury, resulting in extended time out of circulation (work, social and family activities). They can become socially isolated as a result of having to spend long periods in hospital or bed. Surgery or

expensive vacuum treatment sometimes is required and long-term complications are an ever-present risk.

In 2001 it was estimated that \$350 million was spent on caring for patients with pressure ulcers. The inpatient recovery time for a serious pressure ulcer is measured in months or even years. In 2001 the cost of each pressure ulcer was \$61,000 (Australian Wound Management Association 2001). Using the CPI (which is less than the medical CPI), this cost has increased by 18% since 2001, and in 2007 would have come to over \$412m.

While not all pressure ulcers can be prevented, many are caused by inadequate equipment, notably seating and mattresses. Providing the correct pressure relieving equipment is not optional for the individual; however, the waiting times and limits on types of products make it so.

If they are unable to get the right equipment, people with MS with pressure ulcers commonly spend up to 6 months in hospital recovering. Such a stay costs in the vicinity of \$80,000–100,000, and can result in increased community care costs and carer burden upon discharge.

The purchase of an \$8000 mattress and good seating in addition to self-management support can prevent such episodes. Saving just one hospital admission per lifetime for a person at risk of pressure ulcers justifies the investment.

Failure to provide the appropriate equipment in a timely manner results regularly in cost shifting from a relatively low-cost program (A&EP) to one of the most expensive – acute hospital care.

The intersection of other A&E funding sources and programs

There is no acknowledgement in the proposed model that consumers are able to source equipment on occasion from other publicly funded sources such as Post Acute Care, Residential Care, brokerage programs or DVA's RAP.

Given existing significant issues such as changing eligibility requirements between settings (home vs residential care) and finding funding for new equipment for people going into nursing homes when discharged from hospital at short notice, and the often significant negative impact the failure to secure vital equipment can have on their lives through reduced mobility, communication or access to the community, it is vital that this issue concerning the various sources be addressed through appropriate principles and practical policies that are aimed at ensuring consumers have the aids and equipment they require.

Currently there is more concern about bureaucratic boundaries and ‘neatness’ of rules, than there is about meeting the needs of consumers. Such a direction is in direct conflict with current strategic directions regarding consumer-focused service delivery. The complementarity of A&EP with other programs utilised by consumers is important in regard to eligibility criteria, co-funding and articulation of services. People with MS will generally utilise multiple service programs at various stages in their lives and the disease process, and their equipment will often be critical to them achieving the intended outcomes of these programs.

If the aim of A&EP as proposed in the Discussion Paper (or the modified version proposed above) is to be achieved, the perspective will need to change. A possible principle could read as follows:

‘Work constructively in relation to other aids and equipment funding programs to ensure that clients transitioning between programs and settings are not disadvantaged.’

Modifying the Discussion Paper’s proposed principles

Because timely access to the system is not a substitute for the timely delivery of assistance (the principle as proposed in the Discussion Paper could be achieved by simply putting people onto waiting lists), consideration should be given to modifying the first principle in the Discussion Paper (see page 11) to read as follows:

‘Streamlined and timely access to an integrated and coordinated *A&EP that meets the needs of people in a timely manner.*’

The second principle identifies several key issues, but must be modified to incorporate the concept of ‘prevention’ if the A&EP is to effectively meet the needs of people with disabilities in Victoria. There is a tendency throughout the Discussion Paper to assume that the nature of all disabilities (and people’s lives) are relatively static and not amenable to change or impacted upon by delays in providing assistance. The second principle should be modified along the lines of the following:

‘Transparent processing and prioritisation of assistance *based on equity of access in relation to need and the prevention of avoidable deterioration.*’

The third principle should also be strengthened to avoid any misinterpretation of what is meant by ‘efficient and cost effective’ as follows:

‘Efficient and cost effective use of *resources in relation to the Aims, Principles and Objectives of the program.*’

Proposed program objectives

Overall the proposed program objectives have been well crafted, but there is scope to improve them, and the need for additional objectives in line with the altered aim and principles as set out above.

Additional objectives

Additional objectives include:

‘Advice, strategic direction and information provided through the participation of a representative group of consumers and their families via a Consumer and Carer Advisory Council.’

‘The implementation of a transparent program-based complaints handling process and decision appeal process with oversight by the Disability Services Commissioner.’

‘The establishment of good-practice timeframes and implementation of appropriate measures of their achievement in relation to timeliness of provision of assistance to be publicly reported annually.’

‘The development and implementation of policies and procedures to ensure that consumers moving between programs and settings are not disadvantaged through the withdrawal of aids or equipment, changing eligibility requirements in transitions between programs, or through other barriers that prevent the timely provision of required aids and equipment.’

Standards and pricing

The reform of A&EP is a good opportunity to develop standards and service levels for suppliers and consumers. Currently these do not exist in the program but are critical to ensure a quality supply chain for consumers. Waiting times, repairs, pricing and manufacturing quality are all things that need to be covered by program standards. And processes need to be developed to incorporate these in the operation of the program. For the flagship aids and equipment scheme in Victoria to have no consumer or supplier standards or pricing agreements is a significant deficiency. In a program where value for money is so critical, these elements cannot be left out.

Some good examples of such standards currently exist in the TAC and DVA equipment schemes that work on a brokerage model, and are worthy of close examination by A&EP. We expect that standards will be one of the subjects of the harmonisation of State/Territory equipment schemes committed to by the Community Services Ministers in 2008.

An objective related to this issue might read:

‘The development and implementation of A&EP standards and service levels for suppliers and consumers in relation to waiting times, repairs, pricing and manufacturing quality.’

Strengthening objectives proposed in the Discussion Paper

There is also the need to modify and clarify several of the proposed objectives as outlined below.

1. Subsidised aids and equipment that support goals and plans, ***and/or prevent avoidable deterioration*** of an individual. (Additionally the phrase ‘at key life stages’ in the original proposal seems to add little and should be cut, or expanded to be meaningful).
2. A streamlined, single point of access for individuals irrespective of their place of residence (it must be clarified whether this term refers to geography or type of residential accommodation; both issues must be explicitly addressed, see the discussion following the next objective).
3. ***The timely and efficient provision of assistance for aids and equipment*** that is targeted to individuals most in need, ***including those at risk of avoidable deterioration and/or residential care placement***, and ensuring equal access throughout Victoria for people with permanent or long-term disability.

There are a number of complex issues bound up in objectives 2 and 3 above. The suggested changes partially address these. However, progress is unlikely unless the issues are clearly spelled out and dealt with effectively. As noted previously, it is vital to take a dynamic perspective when considering people with a disability – the nature of their disability may change rapidly or slowly, and likewise their living circumstances. An effective A&EP must be able to respond accordingly.

Effective and appropriate action would include avoiding placing young people in nursing homes due to a lack of available and timely equipment provision. Moving young people out of nursing homes also often involves a significant equipment component. For those under 65 who are in residential aged care facilities, inaccessibility to aids and equipment often restricts their lives considerably and unnecessarily – reducing contact and participation in the community, and the quality of their lives more generally. These individuals are already paying a high price for shortcomings in the service delivery system and their personal circumstances.

Consideration must be given to eligibility to A&EP for people with a disability under the age of 65 years residing in Commonwealth-funded aged care facilities for high cost and/or customised equipment that cannot generally be realistically provided via bed-day fees. Broadening eligibility in this way would help deliver on several of the principles and objectives outlined above, as well as the proposed aim of A&EP.

The approach to the supply of equipment for the Young People in Residential Aged Care target group by the My Future My Choice program (i.e. fully funding customised equipment for people at risk of placement) has been useful and needs to be taken up by A&EP as a fundamental reform to the program.

Clarification is needed regarding equity of access for geographically rural/remote locations and the range of community care facilities such as CRU (Community Residential Unit) and RAC (Residential Aged Care) facilities. As we have a number of young clients residing in RAC facilities due to their level of disability and the lack of appropriate facility options within the community, eligibility issues (particularly for those over 50 year of age and deemed ineligible for My Future My Choice support) remain a significant and unreasonable barrier.

Equity of access to trialling equipment both new and re-issued for clients in outer and non-metropolitan areas needs to be carefully considered especially if a system of preferred suppliers may be implemented. Suppliers are often reluctant to offer trials or a number of trials for complex equipment unless they are assured of sales.

For re-issue equipment, associated transport costs to enable trial and allocation need to be addressed. Regional storage of re-issue equipment needs to be considered and if it is not feasible, rural clients should be prioritised so as not to be disadvantaged in the timely allocation of equipment.

4. A cost-effective aids and equipment program, ***in relation to the A&EP aims, principles and objectives***, to maximise assistance to as many individuals as possible.

As well, as detailed program guidelines are developed regarding equitable access and cost-effectiveness, the progressive nature of MS and other progressive neurological conditions such as Motor Neuron Disease and Parkinson's Disease, must be considered. The need for ongoing changes/modifications/upgrades in equipment for many people with progressive disabilities is paramount to reduce the disease burden and optimise quality of life for individuals (and often their families).

For example, with the prescription and allocation of high cost items such as power wheelchairs, a greater cost in the first instance may be needed to enable adjustment and customisation over time without completely replacing the item. Planning for future changes is more cost effective in the longer term. The proposed Clinical Advisor can work with a therapist to ensure that the longer term equipment needs and costs for a client are considered so that the most cost-effective equipment is purchased.

Additionally, the extra costs and the concept of cost-effectiveness must be considered not just in relation to costs to the A&EP, or to the DHS disability budget, but in relation to the overall costs (financial, health, social, etc.) to the individual, their family and the community. Narrow definitions of cost-effectiveness will defeat the whole purpose of the program. When overall costs are properly taken into account, it becomes clear why people under 65 in residential aged care facilities funded by the Commonwealth should

have access to A&EP – the benefits to them, their families and the community far outweigh the financial costs to the A&EP.

5. Individuals with high quality aids and equipment that comply with relevant Australian Standards.

This objective focuses on a very valid and important point: all equipment needs to be of a high quality and to current Australian Standards. Hopefully the use of preferred suppliers as proposed will enable this objective to be achieved. However, we need to avoid situations where high quality and compliant equipment can ONLY be accessed through preferred suppliers. In instances where a preferred supplier cannot source the best equipment in a timely manner to meet a client's needs, an alternative supplier (of Australian Standards compliant equipment) should be accessible.

2. Which service delivery model option you prefer and why?

Our preference is for Option 1 – a single statewide issuing centre.

Our preference is based on the following advantages of Option 1:

- It locates responsibility for the scheme in one administrative location.
- It allows for the development of clear policy and procedures.
- It allows for more sophisticated data management and reporting.
- It creates the platform to better evaluate performance of the scheme.
- It allows the negotiation of inter- and cross-program protocols regarding the provision and funding of equipment.
- It is the most cost effective option.
- It promotes equality in response times for allocation of equipment state-wide.

3. Do you support the establishment of clinical advisor role?

We support the development and implementation of a Clinical Advisor role within the A&EP as outlined in the Discussion Paper. This function would need to be closely linked with specialist neurological expertise to ensure effective coverage of people with progressive neurological conditions.

Our exploration of resources listed in Appendix 1 of the Discussion Paper; contact with services in other states; and our experience in the practical side of A&EP for clients have emphasised to us the value of this role for a more effective A&EP.

Effectiveness of the role will to a large degree depend on the details of its development and implementation, and we look forward to working with the Department and other stakeholders to help ensure that we get it right.

4. Do you support the proposal that low cost items be treated as non-returnable?

Yes, we support this proposal, with the proviso that the client remains eligible for repair / maintenance and re-supply as necessary of these items, e.g. walking frames, shower chairs and over toilet frames.

Other relevant observations and suggestions include:

- The progressive nature of MS lead to the likelihood that equipment needs will change over time, and hence allowance is needed for re-assessment and new prescriptions/ additional customisation of existing equipment.
- On account of the long-term nature of MS, some equipment will simply pass its 'use-by date' and will need to be replaced. A potential function of the centralised database may be to flag equipment which is nearing the end of its lifespan according to date of issue and to recommend replacement if necessary.
- Experience of therapists in other schemes is that modified short application forms for replacement of standard items can be processed directly by administrative staff rather than requiring scrutiny by a Clinical Advisor.
- Self-management models of client intervention require some onus of responsibility to fall back on clients/carers to manage their own equipment needs, which may mean that written disclaimers (provided by legal advisors) are needed in regards to deterioration and changing need (progressive disability). Given the episodic nature of professional involvement in many instances, ongoing monitoring is not always possible and prescribing therapists are typically unable to be responsible for all changes in client status within a self-management model.

5. What is the best way of providing aids and equipment to children living with disability?

While MS does affect teenagers and young adults, few children have MS so we cannot offer an informed response to this question. However, the dynamic nature of progressive conditions requires a similar approach from a program such as A&EP to changes in a growing and developing child with a disability.

6. Should there be a different approach for rural and metropolitan areas?

This issue could be addressed by having regional clinical advisors and support so as to keep up with local knowledge as well as specialty knowledge, i.e. within the Option 1 proposed model of centralised intake, once calls/ applications are entered onto system, the case will be diverted to the relevant regional officer/clinical specialist. For example, QLD MASS has central office in Brisbane with 2 EFT clinical advisors, and a regional office in Townsville with 0.4 EFT clinical advisors. It may be feasible to have commonly used equipment bulk ordered and stored/shared with the local Community Health Service.

7. What key features should be included in the service specifications for the new service delivery model?

The new service delivery model needs to be client focussed, and must follow through on the aim, principles and objectives proposed above. Specific features are outlined below under four broad categories: centralisation, database, clinical advisors, and equipment.

I Centralisation

Centralising the system should result in:

- Central intake – 1800 number
- Improved communication – i.e. notification to the client and therapist regarding the status of the funding application and status of progress toward delivery
- Consistency of processes
- Central budget – flexibility and reduced waiting times
- Central phone contact for maintenance of equipment that is user friendly for clients and their carers and families.

II Database

The central database needs to be:

- User friendly, properly designed for its purpose and functioning well at implementation of new processes
- Available to therapists so they can access lists of approved items for prescription
- Available to therapists/clinical advisors so they are aware of re-issue equipment availability. It is agreed that a central database for re-issue and allocation of equipment would be helpful and maximise resources. However, it is paramount that the central database is developed specifically to meet the required functions of the service needs rather than the service trying to fit the functions of an existing/ non specific database/management system.

III Clinical advisors

Based on our investigation of the clinical advisor role in other states, the aims of the role should be to:

- Review and approve prescriptions/ applications for complex customised and high cost items to reduce potential for errors or inappropriateness of equipment, including ensuring that all equipment provided meets Australian Standards, and other standards where appropriate
- Provide support to prescribing therapists – preferably some flexibility for face-to-face contact rather than telephone support only, e.g. QLD MASS
- Assist in interpretation of guidelines
- Provide some coverage of specialist areas, as each advisor can also carry specialty area, e.g. neurology

- Ensure value for money for items to best meet client need; advisors are in the unique position of generally seeing what therapists order and which items have fewer maintenance issues and/or best after-sales follow-up
- Develop/update effective prescription forms and guidelines
- Provide therapist training and/or link inexperienced therapists with mentors

IV Aids and equipment

In setting up the new service delivery model, various issues and outcomes need to be kept in focus:

- Aids and equipment must be provided in line with the objective we have proposed above in relation to the development of A&EP standards and service levels for suppliers and consumers regarding waiting times, repairs, pricing and manufacturing quality
- An endorsed list of equipment needs to be developed; core products may need to be recommended as to certain brands and suppliers, i.e. preferred suppliers as warranted may assist in ensuring good quality products and good follow-up by suppliers.
- The database of stocked items needs to be made accessible to appropriate service providers.
- Flexibility is needed in regards to customisation of aids and equipment – the nature of MS impacts different people in different ways and what works for one person doesn't work for another.
- The budget needs to be sufficient to cope with demand for provision of required items in timely manner
- Realistic subsidy levels need to be established for high cost equipment, e.g. provision of specialised manual wheelchairs may be more appropriate than power chairs and cost similar amounts but currently receive a significantly lower funding allowance.
- Adequate funding needs to be made for the maintenance and replacement of high cost items.
- The provision of discretionary top-up funding schemes should be considered for clients requiring expensive specialised equipment – e.g. QLD MASS scheme provides full funding to enable purchase of products and the client pays back 'gap funding' over a period of time through a credit agreement. Currently in Victoria, therapists use up valuable time seeking the gap funding. It is recognised that having no limit would mean fewer people would get the equipment.
- Limiting prescribing rights for complex equipment – e.g. powered wheelchairs – should be investigated (and would probably be controversial). The success of restricting prescribing rights will depend on access to suitable seating clinics and has implications for regional clients. The process may contribute to longer wait lists for some items depending on volume/demand, but the advantage is that selected specialist therapists will potentially be more efficient in trialling products and more aware of new products.

8. What are the key factors to focus on in the transition phase?

In rolling out the program reforms, training and managing staff and establishing appropriate timeframes will be crucial.

- In the rollover of staff from the old system to the new, there will need to be incentives for current coordinators and administration /support staff to continue in their roles until changes are implemented.
- Numerous small, regionally based information/training sessions will need to be organised for VA&EP staff and clients and prescribers.
- Timeframes need to be clear and to include opportunity and processes for review.

References

- Access Economics 2005, *Acting Positively: Strategic Implications of the Economic Costs of Multiple Sclerosis in Australia*. Access Economics, Canberra.
- Australian Wound Management Association 2001, *Clinical Practice Guidelines for the Prediction and Prevention of Pressure Ulcers*. Cambridge Publishing, West Leederville, WA.