Submission to the Senate Select Committee on Health

About Optometry Australia

Optometry Australia is the national peak body for the optometry profession, comprising a membership base of over 90% of all registered optometrists within Australia. With an individual workforce of approximately 4,700 optometrists nationally, optometry continues to be the cornerstone of primary eye care in Australia, playing a key role in the eye health and the prevention, early detection and management of eye disease and vision loss, including refractive error.

Introduction: the role of optometry in population heath

Given around 80% of vision loss is either preventable or treatable, optometrists play a crucial role in the prevention and early detection of avoidable blindness and vision loss. The estimated total economic cost of vision loss in Australia is $16.6 billion or $28,905 per person with vision loss aged ≥40 years, underlying the importance of timely access to primary eye care.[1] For many, an optometric eye examination is their entry point into the health care system as those who avoid other forms of health care. These patients tend to seek primary eye health care due to the significant impact poor sight has on their daily life. In addition to community-based practice, optometrists deliver care in other settings which facilitate access for disadvantaged population groups including visiting outreach programs in remote and very remote areas, Aboriginal medical services and in domiciliary settings such as residential aged care facilities.

Comment against inquiry terms

Our submission addresses a number of the Terms of Reference for this inquiry. We welcome the opportunity to put forward this submission.

Interaction between elements of the health system, including between aged care and health care

Best use of existing health workforce

Optometry Australia believes that when health systems are working well, they support quality patient care, optimal use of the available health workforce and a smooth 'patient journey.' We believe this is supported by well-coordinated care, and sound communication between, and integration of, health services, at primary and tertiary levels.

There are great opportunities to improve health system efficiency and timely patient access to care by maximising the use of community-based optometry services. Anecdotally, it is well-established that many referrals from general practice to tertiary eye care are for presentations that can be safely and effectively managed within community-based optometry practices. Pilot programs in Victoria have

[1] Access Economics. Clear Focus: The Economic Impact of Vision Loss in Australia in 2009. Commissioned by Vision 2020 Australia. June 2010.

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demonstrated that effective triage of patients referred to specialist eye care can enable high proportions of patients to be safely and effectively managed by optometrists whilst maintaining patient satisfaction.[2] Such approaches can support more timely access to care for patients, reduce waiting periods for specialist care and supports more cost-effective eye care.

Similarly, ophthalmology out-patient clinics providing services in conjunction with jurisdictional hospital systems, commonly have waiting periods for access to care that well exceed clinical recommendations. Some aspects of the care offered through these clinics can be undertaken within community optometry practices, for example, monitoring of diabetic retinopathy in patients with diabetes, which is a service commonly offered by optometrists in the community, with a Medicare rebate. Pilot programs undertaken in Queensland have demonstrated the benefits for patients and services in re-channeling patients requiring this sort of care to community optometry. These matters are under discussion between our state based offices and the relevant health departments in those States.

We are aware that a number of jurisdictions are exploring opportunities to improve system efficiency by maximising the use of community optometry practices. Where it accords with the established scope of practice for optometrists, this offers safe and effective care with greater efficiency. We believe maximal use of community-based primary eye care services should be encouraged and barriers to doing so reduced.

Aged care

The current integration of optometry within aged care systems is sub-optimal and has significant scope for improvement. Fostering improved access to primary eye care is vital for older Australians whose frailty, mobility or social isolation prevents them attending an established optometry practice. Maintaining good eye health and vision can have a significant impact on the health and wellbeing of these patients, including their mobility, independence, mental health and overall quality of life. For example, vision loss is associated with four times the risk of falls within residential aged care facilities and three times the risk of depression.[3,4] Further, domiciliary optometry services (that is, services provided in a patient's home or residential aged care facility) can significantly contribute to reducing the overall costs of health care by reducing downstream costs associated with acute and sub-acute care.

Currently, provision of domiciliary eye care occurs at very low rates. Optometry Australia data suggest less than 5% of optometrists regularly provide services in residential aged care facilities and less than 2% in a person's home.[5] Research undertaken by Optometry Australia suggests barriers include systems that make it challenging for optometrists to provide services in residential aged care facilities, low levels of awareness amongst aged care staff regarding the importance of regular patient access to optometric care and poor remuneration systems that do not cover costs associated with providing domiciliary

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[2] See: Turner, N., Jackson, J. and Beltz, J. for the Australian College of Optometry and the Royal Victorian Eye and Ear Hospital. Outcomes of the RVEEH/ACO Collaborative Workforce Project, Outcomes presented to the GP Hospital Liaison Conference 2013. Accessed 27/10/2014 via:
http://www.checkup.org.au/icms_docs/160974_Outcomes_of_the_RVEEHACO_
Collaborative_Workforce_Project_-_Neville_Turner_Jonathan_Jackson__Dr_Jacqui_Beltz.pdf

[3] Rubenstein L, Josephson K and Robbins A (1994). 'Falls in the nursing home.' *Annals of Internal Medicine* 121(6):442–451.

[4] Napper G, Truong M, Anjou M. 'There are people in Australia who have poor vision or eye disease that is avoidable. What more can we do?' *Clin Exp Optom* 2012; 95:569-571.

[5] Optometry Australia. Member survey 2012. (unpublished)

services. To begin addressing these barriers, Optometry Australia has recently put a proposal to the Commonwealth Government to increase the loading for domiciliary care to more fairly represent the time invested and costs incurred in the provision of optometric domiciliary services, with overall relative cost to remove the financial barrier to domiciliary eye care predicted to be very low. We believe there are also opportunities for the forthcoming Primary Health Networks to enhance linkages between residential care facilities and optometry services, as some Medicare Locals and before them, Divisions of General Practice, have done with regard to general practice and other allied health providers.

Improvements in the provision of health services, including Indigenous health and rural health

Targeted effort is needed to address the inequities in access to eye health services for those in rural and remote areas and the inequitable gap in eye health status between Indigenous and non-Indigenous Australians.

Opportunities to enhance access in the bush

Most optometry services are provided through private practice arrangements, and private practices are commonly unsustainable in rural areas, with established wisdom suggesting a local population of at least 8,000 is generally required for a sustainable practice. The Commonwealth Government's Visiting Optometrists Scheme (VOS) is an invaluable program which helps deliver timely access to primary eye care to patients living in remote and very remote areas of Australia, including Aboriginal and Torres Strait Islander communities, where practices are not sustainable. Optometry Australia strongly supports the continuation of the VOS to maintain the provision of optometry services for people who are geographical isolated. With the current transition from Commonwealth to jurisdictional fundholders still in process, it is essential VOS services are allowed to seamlessly continue to ensure continuity of care to remote communities.

Telehealth also provides opportunity to extend the reach of eye health services to those in the bush. It provides an effective way to support patients to access specialist eye care from an ophthalmologist, with cost effective benefits to the accessibility of care, the timeliness of care, and continuity of care, particularly for those for whom distance, travel and associated costs may preclude timely access to specialist services.

Currently the Government supports patients through the MBS to video conference with specialists, including ophthalmologists, if they are located more than 15 km apart and are in an eligible area, and provides a rebate for GPs, nurses and Aboriginal Health Workers to support patients in these consultations. The physical presence of an experienced health professional can enrich the consultation with the distance based specialist by providing 'in-place' clinical input and feedback to the specialist in real time.

There is evidence that having an optometrist support a patient in a tele-ophthalmology consult can enhance the consultation - optometrists have the experience and equipment to support ophthalmologists with quality observations – and that optometrists are more likely to participate in such consults. A 2013 review commissioned by the previous Government recommended the extension of MBS telehealth items to support optometrists accompany patients in tele-ophthalmology consults. We strongly support this recommendation and the introduction of a MBS telehealth item to support

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optometrists to accompany patients in tele-ophthalmology consults and are in active discussions with the Australian Government to extend the scheme as proposed above.

Opportunities to improve Indigenous eye health through primary eye care

The gap between eye health status for Indigenous and non-Indigenous Australians is great. Eye health is estimated to account for over 10% of the 'health gap' between Indigenous and non-Indigenous Australians. Compared to the broader community, Aboriginal and Torres Strait Islander people experience 2.8 times the rate of vision loss and 6 times the rate of blindness.[6] It is also estimated that more than 94% of vision loss in Indigenous Australians is preventable or treatable more than one in three Aboriginal and Torres Strait Islander Australians over 40 have never had an eye examination by a trained eye health professional.[7] There is an obvious need to enhance access to primary eye care and, when required, tertiary services, for Indigenous Australians.

In recognition that the outreach model enabled under VOS supports better access to vital eye care for Indigenous Australians in all geographical settings as it enables optometrists to provide clinics in Indigenous Health Services, where the environment is culturally safe, the scheme has been extended to support service provision through Indigenous Health Services in some regional areas also. There are a number of innovative models across the country supporting the provision of eye care through Indigenous Health Services in urban settings. However, to support the systematic provision of such services, and improve primary eye care access for all Indigenous Australians, a funding model to support optometrists to provide sessional services in Indigenous Health Services is required. This is necessary to remove the current fiscal barriers to doing so for private practitioners, including travel costs, and time away from practice.

Uncorrected refractive error accounts for the majority of low vision, and an estimated 14% of blindness amongst Indigenous Australians. In most case, refractive error can be corrected and vision restored through timely access to prescription glasses. The cost of prescription glasses is an established barrier to Indigenous Australians accessing the spectacles they need to restore vision, and often with it, their ability to full participate in social, familial and employment activities. Well designed and targeted subsidised spectacle schemes have been shown to be effective in overcoming this barrier and reducing rates of uncorrected refractive error in Indigenous communities. An effective and cost-efficient scheme is currently in place in Victoria. The extension of such a scheme, or a similar approach, on a national level offers the opportunity to make a significant difference to Indigenous eye health status and individual lives, in a relatively short timeframe and at a relatively low cost. Optometry Australia is in discussions with various State Governments to improve their schemes in lieu of a national scheme.

Changes affecting timeliness of access to optometry services under Medicare

A regular eye examination is one of the most effective and efficient ways to detect ocular disease and vision complaints before the onset of irreversible vision loss and blindness. As part of the federal budget for 2014-15, the Commonwealth Government flagged changes to the permitted frequency with which

[6] Indigenous Eye Health Unit and CERA. National Indigenous Eye Health Survey. Minum Barreng (Tracking Eyes) Full Report 2008.
[7] Indigenous Eye Health Unit, Melbourne School of Population Health, the University of Melbourne. The Roadmap to Close the Gap for Vision. April 2013.

patients considered 'asymptomatic' are able to access a Medicare rebate for a comprehensive eye examination provided by an optometrist. These changes are:

- Moving to annual comprehensive eye examinations for patients 65 years and over; and
- Extending the allowable time period to access a comprehensive eye examination from every two years to every three years for patients less than 65 years.

Given the strong association between ageing and prevalence of eye and vision problems, Optometry Australia welcomes the move to yearly comprehensive eye examinations for people over 65 years. However, we consider there to be no sound evidence or rationale to support an extension to the allowable time period to a comprehensive eye examination for patients under 65 years. The progressive nature of ocular disease and impact on vision, particular after the age of 40 years, should lend itself to establishing criteria that encourage timely access to preventative eye care rather than discouraging it. Government policy in Australia and internationally have long recognised the need for comprehensive eye examinations for adults at least every two years, and epidemiological evidence supports the necessity of biennial access for adults over the age of 40 years.

This intended change will also only further compromise access to preventative eye care for Aboriginal and Torres Strait Islander Australians. Given the significant eye disparity experienced by Indigenous Australians, we recommend the Commonwealth Government carefully examine ways of continuing to support and encourage Aboriginal and Torres Strait Islander patients to access preventative eye health and vision care, including allowing Aboriginal and Torres Strait Islander patients to access a full comprehensive eye examination from an optometrist under Medicare every year.[8]

Better integration and coordination of Medicare services, including access to services

Optometry services have been supported through Medicare since 1975 which has ensured timely access to primary eye care for all Australians and played a key role in minimising avoidable blindness and vision loss.

Since 1975, optometrists providing services eligible for a Medicare rebate have been unable to charge above the scheduled fee set by the Government for these services. This stands contrary to the practice for all other health disciplines under Medicare and, following decades of inadequate indexation of Medicare services, has also threatened the sustainability of some optometry practices, and, particularly the provision of primary eye care services unlikely to be associated with a prescription for an optical appliance. Through the 2013-14 Budget, the fee cap was removed for all optometry services, effective 1 January 2015, a decision welcomed by Optometry Australia. This decision was made following a review of competition in the optometry sector.[9]

Two other budget measures were also announced which Optometry Australia expressed concern about during the budget period, and continue to do so. These changes were: a 5% reduction in the Medicare

[8] As recommended by: Royal Australian College of General Practitioners, 2012. National guide to a preventative health assessment for Aboriginal and Torres Strait Islander people, 2nd edn. (Ch. 6. Eye health). Accessed 27/10/2014 via : http://www.racgp.org.au/your-practice/guidelines/national-guide/

[9] ACIL Allen Consulting, 2014. Optometry Market Analysis. Accessed 27/10/2014 via: http://www.acilallen.com.au/cms_files/0ACILAllen_optometry2014.pdf

rebates patients can access for optometric services (currently 85% of the scheduled fee); and a further two year freeze on indexation of optometric consultations supported by Medicare. The optometry profession has significant concerns about the impact these two measures will have on population eye health, and believes negative impacts will be disproportionately borne by those already socially disadvantaged.

Optometry has historically been a high bulk-billing profession. However, with the reduced rebate and extension of the freeze on Medicare indexation many optometrists will not be able to sustainably provide bulk – billed services with a reduction in the fees they receive for these services.
For optometrists providing care in areas of social disadvantage, where the majority, or high proportions, of patients cannot afford out-of-pocket costs, their ability to keep providing services in these areas has being drawn into question by the reduction in the rebate. With patients unable to afford to pay for necessary eye care in these areas and the viability of optometrists being able to provide it in a sustainable manner being drawn into question, it's expected that in the near future patients in socially disadvantaged areas may have reduced access to primary eye care. These are often the patients who need it most.

Optometry Australia believes that the rebate must be maintained at 85% for optometry services or, at a minimum, alternative solutions found to prevent the loss of services for patients in low socio-economic areas.

Administrative changes to Medicare billing practices could also minimise negative effects on patient access, in particular enabling optometrists to minimise out-of-pocket expenses for patients by bulk billing and charging a small additional fee, with the Medicare fee going directly to the optometrist. This enables the optometrist to levy a fee necessary to sustainably provide services whilst minimising out-of-pocket expenses for the patient. Whilst essentially a change to administrative practices, this is expected to have a significant positive impact on patient access to eye care, particularly for those at disadvantage.

Health workforce planning

We believe health workforce planning is paramount to support efficient community access to the care needed. Optometry Australia is concerned about the current lack of clarity regarding the absorption of the functions of Health Workforce Australia into the Department of Health, and the current uncertainty regarding which of these functions will continue.

We believe the Australian Government can facilitate an appropriate balance between the demand for, and the supply of, primary eye care services. Reviewing the current demand driven university framework is encouraged to ensure the supply of trained optometrists is matched to the actual demand for optometry services. Ensuring the sufficient number of optometrists practising that are required to meet population demand is paramount to supporting population eye health, including preventative care and early intervention, to minimise the risk of blindness and vision loss. Optometry Australia has undertaken workforce studies over a long period of time and is able to assist the Australian Government assess this matter.

Workforce projection modelling from Monash University suggests that even on highest service demand scenarios, the supply of optometrists will soon outstrip community demand for eye care services,

primarily as a result of an over-supply of graduates with entry-level qualifications from Australian universities.[10] For trained optometry graduates who cannot find work in their profession, there are risks of lost time and financial investment in undertaking study in the discipline. Given the Government makes a substantial financial investment to train optometrists and potential impacts on the Government's finances associated with potential increases in joblessness, there are also fiscal inefficiencies for the Government. Given the link between university funding systems and the number of graduates in any specific health discipline, we believe this aspect of workforce planning must also be considered.

As above, we also believe there are opportunities to increase efficiencies in use of the eye care workforce and improve timeliness of patient access by maximising the role of community optometrists and minimising the delivery of eye care through tertiary services that may be efficiently and safely provided within community-based optometry practices.

[10] Carter, H. 'Workforce report forecasts 1,200 excess by 2036.' Australian Optometry July 2014, p. 5. Accessed 27/10/2014 via: http://www.optometrists.asn.au/media/474484/ao_july_2014_-_archive_lr.pdf ; Healy E, Kiely PM, Arunachalam D. 'Optometric supply and demand in Australia: 2011–2036', submitted for publication to *Clinical and Experimental Optometry*.

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