

Cataract surgical blitzes: an Australian anachronism

Surgical blitzes may achieve short-term gains, but they inhibit the development of sustainable local services

Surgical blitzes to treat eye disease are often used to redress shortfalls in service provision. In developing countries with scarce human and financial resources, such periodic visits from local or overseas health teams may be justified, as they are generally combined with building local capacity. However, Australia has no such resource constraints. Despite this, surgical blitzes occur year after year in some rural and remote locations in Australia, without concurrent development of sustainable local services. We see this as a particular problem for eye health in Indigenous people.

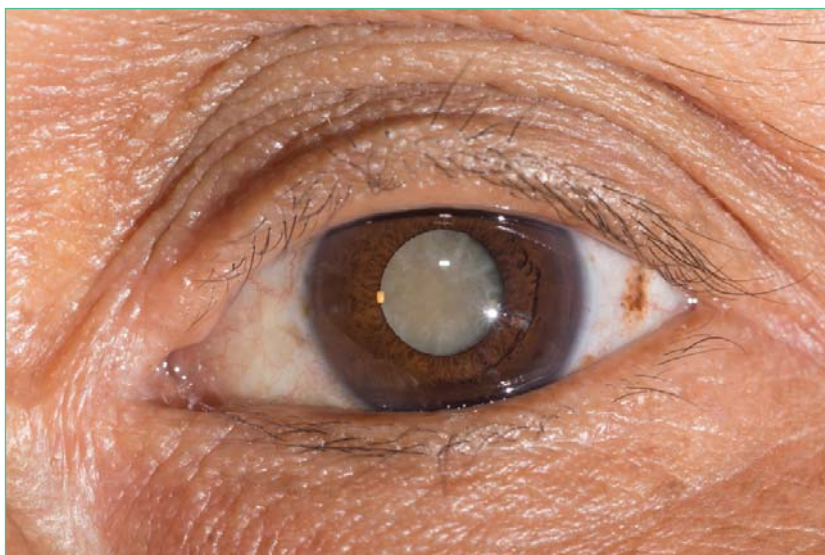
The first eye surgical blitzes in Australia occurred during the National Trachoma and Eye Health Program in the 1970s. At each site, an Australian Army field hospital team worked for a week, and about a hundred Aboriginal people had sight-restoring eye surgery.¹ Over the years, similar army exercises were repeated across the Northern Territory, including, on one occasion, a tented field hospital being put up in a hospital car park.²

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Everyone felt a very good job was being done, but nothing really changed. More recently, regular surgical blitzes, rebranded as “surgical intensives”, were started in Alice Springs and elsewhere in the NT; but these were also short-term fixes.

There is an ongoing need for more eye surgery in these areas.³ Aboriginal and Torres Strait Islander people have a sixfold greater rate of blindness than non-Indigenous Australians.⁴ They have 12 times higher rates of cataract blindness, but receive seven times less cataract surgery. A blind Indigenous person needing cataract surgery should be put on a surgical waiting list and operated on within 3 months.⁵ However, those who manage to get onto a waiting list will wait almost twice as long as non-Indigenous Australians,⁶ sometimes waiting several years or more before receiving surgery.

There are complex factors affecting Indigenous Australians’ willingness to attend for surgical treatment, but once a patient is ready for surgery, he or she should receive it promptly. Surgery may need



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to be delivered opportunistically for patients with competing community and cultural priorities. Multiple things can be done to prevent Indigenous patients from dropping out of the system: 35 such key points have been identified in the patient journey for cataract surgery.⁷

Blitzes seem to provide a quick and rewarding solution. Surgery gets done, patients get their vision back, and surgeons and staff feel satisfied. Blitzes usually receive government and private funding, so the investors feel good that something is being done and they obtain positive publicity. But the patients who turn up the next week do not feel so good. They do not know how long they will have to stay blind while awaiting another blitz. Those who were already on a waiting list but could not forgo family, community or cultural responsibilities for the surgery have to wait longer. The staff who worked so hard to make the blitz possible understandably need a break; until it is time to start planning the next one. The end result is that the system is never fixed and rolling blitzes become the norm in dealing with the aching unmet need.

Although there is still a long way to go, Indigenous life expectancy is improving. With an ageing population, the burden of age-related cataract is likely to double in the next 20 years,^{8,9} and an increasing number of older Indigenous Australians will need sight-restoring cataract surgery. We must ensure that Indigenous people do not experience unnecessarily prolonged visual impairment and blindness, to enable them to maintain quality of life and independence in these additional years of life.¹⁰ While poor vision is not the only unsolved problem in Indigenous health, it causes

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11% of the health gap.¹¹ Unlike many other conditions, most of this vision loss can be cured overnight with spectacles or cataract surgery.

What is required is adequate provision of sustainable, ongoing services.¹² Surgical blitzes on their own are neither a long-term nor a sustainable solution. They may show what is possible with adequate resources over the short term, but no lasting change is implemented and the underresourced local service struggles on. Blitzes alone will not clear the growing backlog or provide sufficient volume of services to meet the increasing need for surgery; although targeted blitzes to clear a regional backlog, with concurrent development of ongoing coordinated surgical services, make sense.¹³ With the backlog reduced, the local service then requires appropriate resourcing to meet the ongoing need for surgery in a timely manner and to provide the direct personal interaction that is so highly valued by the Indigenous community and patients.

Unfortunately, despite the best of intentions and attempts at gaining government commitment through

agreements and memoranda of understanding, the diversion of resources to arranging surgical blitzes means there are limited resources allocated to developing local services. So, paradoxically, blitzes prevent the development of the sustainable solutions needed to provide equity of care and to close the gap in Indigenous eye health.

Australia in 2015 has a sophisticated health system with the capacity to provide the services required. We cannot afford repeated short-term and unsustainable surgical blitzes. We are lucky that strong advocacy exists among vision care organisations to raise awareness of the need for long-term solutions and sustainable regional eye services.¹⁴ Australia should be leading the way in showing how to deliver eye care, rather than consistently showing how not to.

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