The roadmap to close the gap for vision

Ensuring equitable access to eye care for Indigenous Australians requires multiple small changes

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Indigenous Australians have six times more blindness than the national average, and 94% of the vision loss is preventable with eye examinations and timely access to treatment.[1] There remain gaps in service delivery, and a shortage of specialist services in remote areas and poor utilisation of eye services in urban areas contribute to the disparity.[2] Moreover, 35% of Indigenous adults have never had an eye examination. Only 20% of Indigenous people with diabetes have the requisite annual eye examination.[3] Although much basic eye care is provided within primary health care, referrals to specialist services to treat complex eye issues and links to hospitals for cataract surgery need to be developed.

Between 2007 and 2012, we undertook the National Indigenous Eye Health Survey,[1] as well as qualitative investigations to identify barriers and solutions to the provision and utilisation of eye services for Indigenous Australians.[2,4] The objective was to develop a set of policy recommendations with the goal of closing the gap for vision.[4] The full report of our findings and recommendations, *The roadmap to close the gap for vision*, is available online.[5]

The lessons learnt are likely to be highly relevant for all services providing visiting specialist care to Indigenous Australians.

Defining the gaps

As a part of our research, we conducted semi-structured interviews with 289 people providing Indigenous eye care in 21 sites across Australia to collect information on provision of services and pathways of care.[5] Ten focus groups with 81 Indigenous community members were held in seven urban and rural organisations in Victoria. Focus groups discussed barriers to use of eye care services and how to improve access to local eye services.

We collated research findings into draft recommendations, which were discussed at three workshops with 86 stakeholders. We obtained further feedback through face-to-face meetings with 32 stakeholder organisations, including community-controlled organisations, politicians and government department staff.

Correctable causes: refractory errors and cataract

Poor vision in Indigenous Australians causes 11% of the "Health Gap",[6] and much of it can literally be reversed overnight: good vision is restored immediately with a new pair of spectacles, or overnight with modern cataract surgery.

Lack of spectacles causes over half of the vision loss in Indigenous Australians. The high and uncertain cost of spectacles is a major barrier to use of optometric services. The low-cost spectacles schemes in each jurisdiction differ in eligibility criteria, method of operation and cost.[5] Two successful programs are in New South Wales, where glasses are provided at no cost, and in Victoria, where community-approved frames and prescribed lenses are provided for $10.[7]

Indigenous Australians have 12 times more blindness from cataract than the general population, and yet, cataract surgery is undertaken seven times less frequently.[4] Indigenous Australians who do access cataract surgery wait twice as long for it and are four times more likely to wait for over a year.[8,9] Some practitioners charge considerable gap fees, which further discourages people from seeking specialist care.

The inadequate provision of cataract surgery has major negative impacts. It is grossly inefficient — the costs of multiple visits to eye care services bring no benefit to those who do not have surgery. Long delays make it inevitable that many people will drop out of the system. They continue to suffer poor vision and the loss of quality of life.

Recommendations to improve Indigenous eye care

1. The importance of primary care

The primary care clinic is the start of the referral pathway. Most common eye conditions are managed well by primary care staff. However, assessments for distance and near vision and diabetic retinopathy are rarely performed. Many Indigenous people consult an optometrist only on referral from a primary care clinic. Therefore, primary care staff need to initiate referrals for those with poor vision or those who need an annual diabetic eye examination. The inclusion of eye assessment prompts in health assessment and clinical software tools reinforces this.

Funding is needed for more effective detection of diabetic retinopathy in primary care settings,[10] especially for non-mydriatic retinal photography, which is acceptably quick, requires no drops and can be performed opportunistically by non-specialist staff.[11]

2. Indigenous access

Visiting services should be delivered within the cultural safety of Aboriginal Health Services (AHS) wherever possible.[12] Mainstream services need to be culturally sensitive to encourage use by Indigenous clients.

Given the existing inequities, we need priority mechanisms to recognise Indigeneity and the high levels of comorbid conditions to ensure that cataract surgery is

not delayed. Case management to support high-need patients accessing treatment is also required.

There is a need for nationally consistent spectacles schemes to ensure cost-certainty and an adequate and timely supply of acceptable spectacles.

3. Coordination of services

Without good coordination, service delivery is inefficient and wasteful. Eye services need to be planned regionally to meet local needs.[13] Clear referral protocols and local or regional service directories facilitate coordination. Medicare Locals, Local Hospital Networks and AHS must collaborate with eye care providers to ascertain the additional services needed and how to coordinate delivery.

Coordination of services and patient case management involve many responsibilities, including patient liaison, transport, booking appointments, scheduling clinics, arranging surgical lists and so forth. Posts for regional eye health coordinators have been established at a local or regional level to facilitate eye care for Indigenous people.[14] They have an important role, but need support from many others.

4. Eye health workforce

Needs-based planning should be used to determine the workforce required. Initial estimates of need can be made from national data[1,15] and refined as local data become available.

We estimate that in a population of 10 000 Indigenous people, 640 patients would need glasses examinations, 962 would need diabetic eye examinations and 98 would need other eye examinations each year, which could be provided by one optometrist (1.0 full-time equivalent [FTE]). One hundred and twelve patients would need diabetic laser treatment, 95 would need cataract surgery and 36 would need trichiasis surgery, requiring a part-time ophthalmologist (0.3 FTE). The coordination of services and patient case management would require 8.4 FTE staff each year. This includes 3.7 FTE staff for patient liaison (appointments etc), 1.8 FTE for patient transport, 1.4 FTE for organising eye clinics and hospital and 1.5 FTE for eye clinic support (excluding surgery).

The Medical Specialist Outreach Assistance Program (MSOAP)[12] and Visiting Optometrists Scheme (VOS)[14] should be organised according to gaps in regional service provision, considering locally available services and population needs. Additionally, VOS support should be made available for optometrists working in urban AHS.

Optometry and ophthalmology trainees should be supported to work under supervision in providing eye care to Indigenous populations so that this becomes regarded part of normal practice and develops their skills in cultural competence.

5. Elimination of trachoma

The SAFE (Surgery, Antibiotics, Facial cleanliness, and Environmental improvement) strategy needs to be implemented consistently in all endemic areas.[16] The ongoing monitoring of national data must continue until the elimination of trachoma can be certified. Recent data show that the prevalence of trachoma is starting to fall,[16] but not all endemic communities have been identified and this needs to be done without delay.

> “The overall cost of implementing these changes is almost trivial when compared with other expenditure in health”

6. Monitoring and evaluation

Collecting local service data is essential for monitoring workload, program implementation and to effectively plan and adjust service delivery. These data should be aggregated and reviewed at jurisdictional and national levels using existing sources wherever possible.

Clear performance targets based on national guidelines are needed, as are simple tools to empower primary care and AHS staff to easily monitor and assess performance and to develop quality assurance.

7. Governance

Regional, jurisdictional and national oversight and governance are needed. Services need to be planned and provided at a local or regional level and be supported by and accountable to jurisdictional oversight with national support. Eye care should be integrated with existing governance structures.

8. Health promotion and awareness

Given the large unmet need for eye care, we need to develop health promotion and social marketing campaigns through community consultation to promote the use of new eye services. Equally, health personnel need continuing education about their roles, skills and responsibilities in providing eye care.

9. Health financing

Estimated additional annual capped costs include $2.92 million for VOS and MSOAP and $1.25 million for governance and evaluation.[5,17] Jurisdictional costs total $2.01 million per annum for subsidised spectacles and patient transport. Coordination and case management will cost $13.32 million shared between the federal government and jurisdictions. These annual capped costs total $19.5 million.[15] In addition, $4.5 million a year is required for trachoma elimination.

Conclusion

The roadmap to close the gap for vision recommendations bring together research conducted from 2007 to 2012. This includes the National Indigenous Eye Health Survey,[1] service reviews[4] and case studies.[2] These evidence-based recommendations are a continuum. If there were a simple fix, it would have been implemented long ago. Many of these recommendations are not new, but previous implementation attempts lacked accountability and oversight, so they were not sustained.[18]

The overall cost of implementing these changes is almost trivial when compared with other expenditure in health. The demand this places on existing services is small. About 250 000 cataract operations are performed in Australia each year and less than 3000 extra operations would be needed.[4]

The strengths of our research include the comprehensive approach and extensive stakeholder

consultation. The research is limited by the paucity of regional service and costing data.

The Roadmap emphasises regional needs-based planning for service delivery and accountability in line with national health reform.[13] Implementation of The Roadmap over 4 years would close the gap for vision in 5 years at a cost of $68.5 million.[5]

Vision loss is not the only issue in Indigenous health, but it might be the most amenable to being fixed. We call on the federal government, states and territories to adopt and implement *The roadmap to close the gap for vision* and significantly improve Aboriginal health.

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