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EDITORIAL

There are people in Australia who have poor vision or eye disease that is avoidable. What more can we do?

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Are we doing all we can to identify and provide eye care to those individuals and groups in our community who have poor vision and eye disease? It has been almost twenty years since two significant population-based surveys of eye disease and visual loss were conducted in Australia, namely, the Melbourne Visual Impairment Project and the Blue Mountains Eye Study. The accumulated data of these two major surveys estimated that in 2004, there were 480,300 Australians with low vision, including 50,600 Australians who were blind. About 9.4 per cent of Australians aged 55 years and over have low vision and about 1.2 per cent are blind.[1] Importantly, many of these cases are preventable or treatable.[2]

These studies showed that 62 per cent of the presenting low vision and four per cent of the presenting blindness was caused by correctable refractive error.[3] Cataract is the second major cause of visual impairment (14 per cent) and it is readily treatable. The other major causes, age-related maculopathy (10 per cent), glaucoma (three per cent) and diabetic retinopathy (two per cent), can be treated to slow the progression of visual loss. Presbyopia is also a correctable cause of visual loss that has not been included in these population studies; however, it is an important additional contributor to visual impairment.[4]

The high prevalence of treatable visual impairment in Australia is surprising. Australia is a well-resourced country and has a relatively sophisticated and advanced health system.[5] There are excellent primary, secondary and tertiary eye-care services. There is a well-developed eye-care workforce and a reasonable supply of optometrists and ophthalmologists in most areas.[6] All Australians have access to Medicare, a universal health insurance scheme, which provides support for patients to reduce the cost of eye examinations often with no out-of-pocket expense. Public hospital eye clinics are available around the country, with resources for surgery and treatment for a range of eye conditions. Spectacle subsidy schemes are available in all states to support people who are financially disadvantaged to access glasses.[7] We have all the elements for a comprehensive eye-care system and in international terms would be seen as doing well; however, we seem to be failing to reach everyone who needs eye care. Further, the Australian health system is currently challenged by increasing costs and demand, elective surgery waiting times, emergency response timeliness and health service integration and priorities.[8]

Socio-economically disadvantaged people in our community experience more ill health and are more likely to engage in behaviours that negatively affect their health.[9] People with disabilities, Aboriginal and Torres Strait Islander peoples, homeless people and refugees are more likely to be living in disadvantage and lack access to the social, geographic and economic resources for good health and well-being.[10] There is a close relationship between social inequalities and health inequalities resulting in disadvantaged people also having poorer health across a range of measures.[11] A report into the risk factors for eye disease and injury in 2008 noted that poor living conditions are linked to trachoma and may be linked to a higher risk of diabetic retinopathy and glaucoma.[12]

We contend that there are still individuals and groups in Australia, who have avoidable poor vision and eye disease and, disturbingly, an unequal access to currently available eye-care services. There is some evidence to support this for older people and those with lower incomes.[13,14] Aboriginal and Torres Strait Islander people are known to experience eye health inequalities and eye-care inequities.[15] Older people, people with diabetes and marginalised or disadvantaged people are known to be at greater risk of developing eye disease or having uncorrected

refractive error.[16] The proportion of the Australian population aged 55 years and over is projected to rise considerably and this has important implications for how we might meet future needs; however, there is a lack of information regarding the visual status and access to eye care of other disadvantaged communities and groups in Australia. How can we better provide support and services to individuals and groups in Australia that are not or have difficulty receiving eye care and what can optometrists and optometry do to help address these?

Vision is regarded as one of the most precious senses and vital to an individual's health and well-being, quality of life, employment, education and community participation.[17] Fear of visual loss is reported as second only to cancer in health surveys.[18] Eye health is also an important factor in overall public health. Visual impairment has significant financial and social costs to the individual and the wider community. It prevents healthy ageing and significantly increases the risk of falls, depression, hip fractures and the early admission to residential aged care.[2]

The main goal of Australia's eye-care professions should be to serve the community to eliminate visual impairment and blindness by prevention where possible and effective treatment. The elimination of visual impairment and blindness and the improvement of visual function will provide both economic and social benefits to society. Codes of ethics from the professional associations proffer the expectation of a responsibility to care for all in our community and the World Council of Optometry vision is 'a world where optometry makes high quality eye health and vision care accessible to all'. The goal advanced is health equity. Are we doing all that we can to ensure that everyone in our community is served by the eye care professions? The dominance of a private enterprise model in our sector would suggest that those who are financially and socially disadvantaged may have greater difficulties accessing and participating in care.

Optometry is well placed to help improve access to eye care for all in the community. Optometrists already play a key role in identifying, monitoring, treating and referring eye conditions and providing community education about eye health and vision care. There are opportunities for optometry to play a greater role in public health and make further contributions to our communities. Additional endeavour is required in the following areas:

1. Build a knowledge base about inequalities and inequities in eye health and eye care, including barriers and difficulties faced by those accessing services
2. Network support agencies for disadvantaged community groups to establish needs and obtain their help in overcoming barriers to accessing eye care services
3. Devise new programs and increase funding to existing services that increase accessibility for individuals and groups who do not or cannot access conventional providers of eye care
4. Workforce development of optometrists skilled, experienced and committed to providing care to disadvantaged and marginalised people.

Optometry, other eye-related professions and the health system require some changes to achieve the goal of providing 'eye care for everyone'. A broader model of delivery of optometric services could be developed to include increased public employment of optometrists, for example, in community health and hospital structures. The new federal government health reforms with Medicare Locals could support a population needs-based approach to service development and delivery. Optometry must be involved. Greater integration of optometry within broader health structures to become more closely linked with others in the health system will facilitate improved eye-care outcomes. We can improve the support systems for private practice to be involved in the local delivery of care to disadvantaged people. All optometrists can participate in these strategies and work towards the goal of eliminating avoidable visual loss.

We argue that the profession of optometry should accept greater responsibility for the eye care of those in our community who are not able to access or are not receiving care. There should be no vision impairment due to uncorrected refractive error and uncorrected presbyopia. We have the means and we have the capacity to deliver the services required to ensure that all are receiving eye care. We may not yet be organised or structured in a way that allows this to happen and leadership within our profession will be essential in helping to drive the necessary changes. There will be challenges along the way and a need for us to operate differently and think differently about our work. We will need to address additional issues, including those related to the cultural diversity of Australian society[19] and service deficiencies elsewhere in the eye care pathways. By actively pursuing the goal to eliminate the preventable causes of visual loss, we can add strength and purpose to our profession and our work.

REFERENCES

1. Australian Institute of Health and Welfare. Vision Problems Among Older Australians. Canberra: AIHW, 2005.
2. Access Economics. Clear Focus. The Economic Impact of Vision Loss in Australia in 2009. Melbourne, 2010.
3. Taylor HR, Keeffe JE, Vu HTV, Wang JJ, Rochtchina E, Pezzullo ML, et al. Vision loss in Australia. *Med J Aust* 2005; 182: 565–568.
4. Holden BA, Fricke TR, Ho SM, Wong R, Schlenther G, Cronjé S, Burnett A et al. Global Vision Impairment Due to Uncorrected Presbyopia. *Arch Ophthalmol* 2008; 126: 1731–1739.
5. Australian Institute of Health and Welfare. Australia's Health 2006: The tenth biennial health report of the Australian Institute of Health and Welfare. Canberra: Australian Institute of Health and Welfare, 2006.
6. Australian Institute of Health and Welfare. Eye Health Labour Force in Australia. Canberra, 2009.
7. Taylor HR, Anjou MD, Boudville AI, McNeil RJ. The Roadmap to Close the Gap for Vision: Full Report. Melbourne: Indigenous Eye Health Unit, The University of Melbourne, 2012.
8. Australian Government, Department of Health and Ageing. National Health Reform.
9. Turrell G, Stanley L, de Looper M, Oldenburg B. Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use. Canberra: Queensland University of Technology and Australian Institute of Health and Welfare, 2006.
10. VicHealth. Burden of disease due to health inequalities. Melbourne: VicHealth, 2008.
11. World Health Organization. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva: World Health Organization, 2008.

12. National Health and Medical Research Council. Risk factors for eye disease and injury. Literature review. Final report. Canberra: Australian Government, 2008.
13. Thiagalingam S, Cumming RG, Mitchell P. Factors associated with undercorrected refractive errors in an older population: The Blue Mountains Eye Study. *Br J Ophthalmol* 2002; 86: 1041–1045.
14. Livingston PM, McCarty CA, Taylor HR. Visual impairment and socio-economic factors. *Br J Ophthalmol* 1997; 81: 574–577.
15. Taylor HR, Xie J, Fox S, Dunn RA, Arnold AL, Keeffe JE. The prevalence and causes of vision loss in Indigenous Australians: the National Indigenous Eye Health Survey. *Med J Aust* 2010; 192: 312–318.
16. Australian Government, Department of Health and Ageing. Eye health in Australia. A Background Paper to the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss. Canberra: Commonwealth of Australia, 2005.
17. Resnikoff S, Pascolini D, Mariotti SP, Pokharel GP. Global magnitude of visual impairment caused by uncorrected refractive errors in 2004. *Bull World Health Organ* 2008; 86: 63–70.
18. McCarty CA, Keeffe JE, Livingstone PM, Taylor HR. The importance and state of medical and public health research related to vision in Australia. *Aust N Z J Ophthalmol* 1996; 24: 3–5.
19. Truong M, Fuscaldo G. Optometrists' perspectives on cross-cultural encounters in clinical practice: a pilot study. *Clin Exp Optom* 2012; 95: 37–42.