THE VALUE OF EXPANDING OPTOMETRISTS' PRESCRIBING RIGHTS IN AUSTRALIA

Report prepared by **HT**ANALYSTS
Sponsored by Optometry Australia

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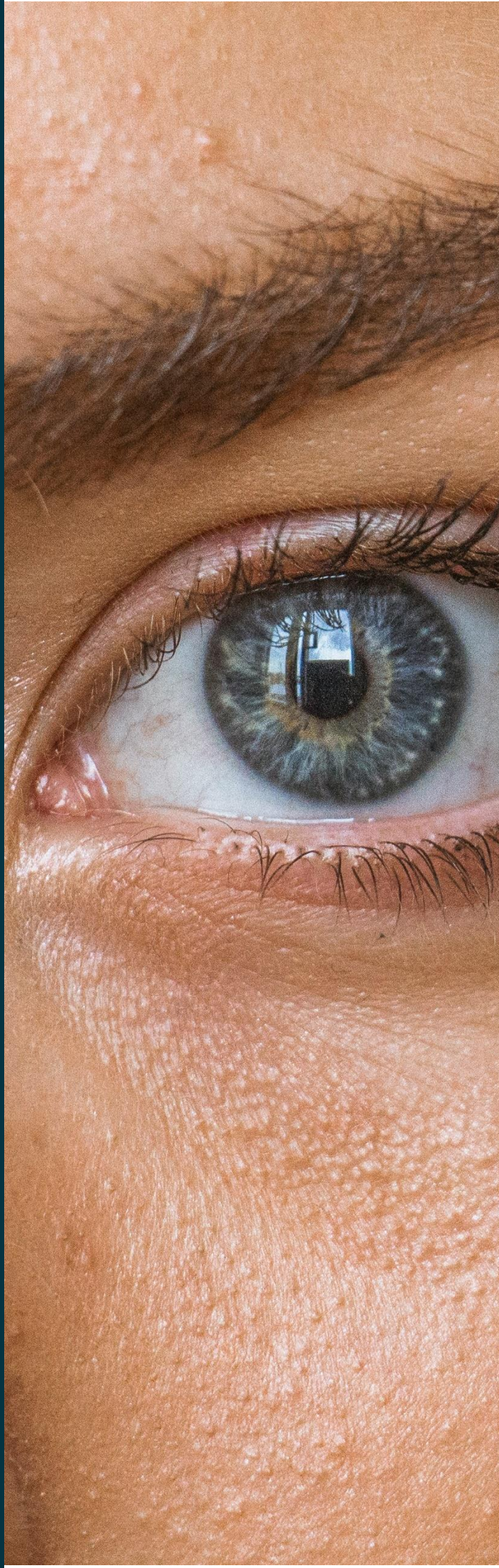


EXECUTIVE SUMMARY

This report investigates the potential benefits of expanding optometrists' prescribing rights to include oral medications for eye conditions in Australia. Currently, optometrists are limited to prescribing topical treatments, which requires patients to visit GPs or specialists for oral medications when needed. This system results in delays in care, additional healthcare costs, and increased strain on healthcare resources.

Australia's optometrists are significantly under-utilised compared to their counterparts in similar nations such as the United States, the United Kingdom, and New Zealand. The *Working Together for Better Eye Care* report identified actionable steps that would better leverage the skills of optometrists to improve patient access and increase the efficiency of Australia's eye health system.

This report examines several case studies of common ocular conditions. Cost estimates were applied to the Australian context to capture both the direct and indirect financial benefits of reducing GP and specialist referrals. Expanding optometrists' prescribing rights would not only lead to cost savings but also promote more timely diagnosis and treatment.

Greater collaboration within the healthcare system and empowering optometrists to prescribe oral medications will enhance access to timely eye care, improve health outcomes, and make better use of Australia's highly skilled optometry workforce.

INTRODUCTION

In Australia, optometrists with therapeutic endorsement are currently only authorised to prescribe topical ocular medications, such as eye drops and ointments. This prescribing restriction means patients requiring oral medications for ocular conditions must be referred to a general practitioner (GP), ophthalmologist, or hospital eye service [1]. This model of care results in unnecessary treatment delays and additional costs for both patients and Medicare. These challenges are amplified in rural and remote areas where specialist services are less available, with patients facing longer wait times and significant travel burden for those who need to travel long distances to attend appointments. These barriers not only compromise timely treatment but may also discourage patients to seek treatment, posing a risk to patients' ocular health [2].

Optometry Australia produced a position statement as part of the *Working Together for Better Eye Care* report, which included a recommendation to "Permit optometrists to prescribe oral medications for eye health conditions" [3]. This is one of the achievable steps to utilise optometrists to work collaboratively with other health professionals to make a genuine difference in providing timely eye care for Australians [3]. Expanding the scope of practice for optometrists to include oral medication prescribing would streamline access to treatment, reduce costs for patients and Medicare, and alleviate the burden on GPs and specialists, allowing them to prioritise urgent cases and manage patient volumes effectively.

In countries such as New Zealand, the United Kingdom, Canada, and the United States, therapeutically endorsed optometrists are authorised to prescribe oral medications. In New Zealand, optometrists have been authorised to prescribe oral medications for eye conditions since 2014. The scope of practice for optometrists in Australia and New Zealand are largely comparable and Australian-trained optometrists can automatically gain registration in New Zealand and prescribe oral medications. Since the implementation of this in practice, there have been no reports of out-of-scope prescribing or any adverse events related to therapeutic prescriptions issued by optometrists in New Zealand [4].

To meet the evolving demands of healthcare and improve access to eye care across Australia, it is essential that national, state, and territory laws and regulations support contemporary practices by empowering therapeutically endorsed optometrists to prescribe within their expertise. This shift aligns with modern healthcare standards and the Australian Government's vision for strengthening the primary care system by enhancing healthcare professionals' capabilities and improving patient access, quality of care, and health outcomes [5]. Enabling qualified optometrists to prescribe oral medications offers significant community benefits, particularly in regional and remote areas with limited access to specialist services [6].

The report presents key potential financial and health outcome benefits of expanding optometrists' authorisation to prescribe oral medications for ocular conditions in Australia. The analysis is based on common cases of ocular conditions. Prevalence and incidence of each condition were sourced from the literature to inform utilisation estimates. Costs were based on Medicare Benefits Schedule where appropriate for government costs and published data for patient out-of-pocket costs. By extrapolating this data to the Australian context, this report estimates the potential savings for both the Government and patients through reduced referrals to GPs and specialists, as well as improved public health outcomes, at no extra cost to the system. Such regulatory change would alleviate pressure on an overburdened healthcare system, promote holistic care, and enhance patient outcomes.

CASE STUDY 1: SEVERE DRY EYE

CLINICAL CONDITION

Meibomian gland dysfunction (MGD) is a prevalent eye condition characterised by inadequate oil secretion from the meibomian glands and is the leading cause of evaporative dry eye disease [7, 8]. Symptomatic MGD is a chronically recurring condition. Patients may experience temporary relief from symptoms however, these symptoms usually reappear over time. MGD is particularly common among older adults, with prevalence increasing after the age of 40. Symptoms may include redness and irritation, increased light sensitivity and blurred vision [8]. Treatment typically involves a warm compress, topical lubricants or oral antibiotics such as azithromycin or tetracycline which can be administered over a period ranging from a few weeks to several months depending on severity [7]. Effective management is essential to alleviate symptoms and prevent potential complications. In New Zealand, oral antibiotics account for 60% of all oral prescriptions issued by optometrists, with the majority prescribed for the treatment of MGD [4].

PATIENT JOURNEY

A patient with severe dry eye symptoms has been diagnosed with chronic evaporative dry eye disease secondary to MGD. They have been treated by their optometrist initiating Step 1 of the DEWS II treatment algorithm, including the use of ocular lubricants and warm compresses [9]. The patient's symptoms persist, therefore, based on best practice guidelines, the optometrist recommends Step 2 of the treatment algorithm with oral azithromycin or tetracycline. The patient is referred to GP to obtain an antibiotic prescription. However, the GP choses to refer the patient to an ophthalmologist for further evaluation. The patient experiences further delay in access to treatment (several months) and incurs extra costs of GP and specialist appointment.

NEW PROPOSED MODEL

The optometrist prescribes an oral antibiotic as Step 2 of the treatment algorithm, avoiding a GP appointment and an ophthalmologist appointment. The patient receives more timely access to treatment, enhancing patient care.

ESTIMATING THE COST

POPULATION

The prevalence of MGD was sourced from Melbourne Visual Impairment Project [10]. Based on a prevalence rate of 19.9%, it was estimated that 4,221,954 people over the age of 18 in Australia have MGD. However, not all patients require antibiotics to manage their symptoms. To estimate the number of patients who may not respond to Step 1 of the DEWS II treatment algorithm and subsequently need to be referred to a GP for antibiotics, the proportion of patients with moderate to severe dry eye (16.60%) as reported in the Australian Blue Mountains Eye Study, was used [11]. This estimated approximately 700,844 patients would be referred to a GP over 1 year.

Additionally, data from a population-based Eye and Ear Health Survey in Australia found that 28% of patients with dry eye symptoms visited an ophthalmologist [12]. This proportion was applied to the estimated number of patients attending a GP to determine how many patients would likely be referred to an ophthalmologist, corresponding to approximately 196,236 patients over 1 year.

DIRECT COSTS

In the proposed model of care, optometrists can directly initiate Step 2 of the treatment algorithm by prescribing oral antibiotics, allowing patients to receive timely treatment without needing GP or ophthalmologist visits. This results in direct costs savings for both the government and patients by reducing reimbursement and out-of-pocket expenses.

Direct costs were defined as the annual healthcare costs associated with avoided GP and specialist appointments for patients with symptomatic MGD.

700,844 fewer GP visits saving $38 million per year

$30 million saved by the government

$8 million saved by patients

196,236 fewer ophthalmologist appointments saving $36 million per year

$17 million saved by the government

$18 million saved by patients

INDIRECT COSTS

There are also indirect savings for the government through increased productivity. By avoiding GP and specialist appointments, patients spend less time away from work, leading to reduced work absences and greater economic output. Indirect savings were defined as the annual economic benefits from reduced work absences due to avoided GP and specialist appointments.

The estimated cost savings were calculated by multiplying the proportion of patients living in metropolitan, regional and remote areas by the travel time required to attend appointments. For patients in regional and remote areas, travel times to specialist appointments can be up to 4 hours [13].

Improved productivity

1 hour less taken away from work to attend a GP appointment

$35 million avoided productivity losses

Improved productivity

1 hour less taken away from work to attend a special appointment for patients in metropolitan & regional areas

4 hours less taken away from work to attend a special appointment for patients in rural areas

$7 million avoided productivity losses for patients in metropolitan areas

$2.5 million avoided productivity losses for patients in regional areas

$779 thousand avoided productivity losses for patients in rural areas

NON-FINANCIAL BENEFITS

The proposed model of care will provide more timely access to treatment, especially in regional and remote areas where specialist services are limited and wait times can be long, with wait times for private services ranging from 2 to 6 months [6], and significantly longer waits for public ophthalmology services. Authorising optometrists to prescribe oral medications will also free up GP and specialist time, allowing them to see more patients, enhancing the efficiency of the healthcare system. The time saved was calculated based on the average appointment durations for GP (14.8 minutes) and ophthalmologist (17 minutes) appointments in Australia [14, 15].

Time saved for healthcare professionals over 1 year

172,875 hours saved for GPs

54,423 hours saved for ophthalmologists

CASE STUDY 2: HERPES ZOSTER OPHTHALMICUS

CLINICAL CONDITION

Herpes zoster ophthalmicus (HZO) is a viral infection that manifests as a painful rash on one side of the forehead and around the eye. Symptoms include eye redness, fever, headache, eye pressure, and in some cases, vision loss. It is considered an ophthalmic emergency and should be treated within 72 hours to reduce the severity of pain and risk of complications like corneal damage, glaucoma, and scarring [16, 17]. A common complication of HZO is post-herpetic neuralgia (PHN), which can occur if HZO causes persistent pain lasting more than three months after the initial infection and would require ongoing follow-up with a GP or pain specialist [18]. Patients less likely to seek GP care are at particular risk of complications for HZO. HZO occurs typically in older adults but can present at any age [16, 17, 19], with the incidence is ranging from between from 4.8 to 131.6 per 100,000 people per year, varying by age group [20]. In New Zealand, antiviral medications account for 7.4% of oral prescriptions issued by optometrists and are most commonly prescribed for HZO [4].

PATIENT JOURNEY

A patient presents to their optometrist with pain and discomfort on their eye and surrounding region. A blister is also seen on the tip of the nose, strongly suggesting ophthalmic involvement as part of a herpes zoster infection. The optometrist confirms the diagnosis through further testing and slip lamp examination. The optometrist refers the patient to a GP for a prescription of an oral antiviral. However, the GP refers the patient to an ophthalmologist for further evaluation, given the patient's clinical presentation and the potential for ocular complications. The patient experiences a delay in access to treatment posing them at risk of complications and incurs the extra cost of a specialist appointment.

NEW PROPOSED MODEL

The optometrist is able to immediately prescribe the patient an oral antiviral to treat HZO. The patient avoids the initial referral to the GP and visits their GP for ongoing follow up for systemic management, if necessary.

ESTIMATING THE COST

POPULATION

The incidence of HZO was estimated based on an Australian study which estimated the rate of antiviral prescriptions from 2016-2021 [21]. This study found a prescription rate of 49.3 prescriptions per 100,000 people, corresponding to approximately 13,358 people with HZO per year.

Ocular involvement develops in approximately 50% of patients with HZO [22]. This proportion was applied to the estimated number of patients with HZO to determine how many patients would likely be referred to an ophthalmologist, corresponding to approximately 6,679 patients over 1 year.

DIRECT COSTS

In the proposed model of care, optometrists can prescribe oral antiviral medication immediately, reducing the risk of prolonged infection and complications. This model of care results in direct costs savings for both the government and patients by reducing reimbursement and out-of-pocket expenses.

Direct costs were defined as the annual healthcare costs associated with avoided GP and specialist appointments for patients with HZO.

13,358 fewer GP visits saving $722 thousand per year

$572 thousand saved by the government

$150 thousand saved by patients

6,679 fewer ophthalmologist appointments saving $1.2 million per year

$563 thousand saved by the government

$639 thousand saved by patients

INDIRECT COSTS

There are also indirect savings for the government through increased productivity. Indirect savings were defined as the annual economic benefits from reduced work absences due to avoided GP appointments.

Improved productivity

1 hour less taken away from work to attend a walk-in GP clinic

$663 thousand avoided productivity losses

NON-FINANCIAL BENEFITS

The proposed model of care alleviates burden on GPs, allowing them to see other patients. The time saved was calculated based on the average appointment durations for GP in Australia of 14 minutes per patient [14].

Time saved for healthcare professionals over 1 year

3,295 hours saved for GPs

CASE STUDY 3: ACUTE ANGLE CLOSURE GLAUCOMA

CLINICAL CONDITION

Acute angle-closure (AAC) occurs when the drainage angle of the eye becomes blocked, leading to elevated intraocular pressure (IOP). This sudden increase in IOP can damage the optic nerve, potentially causing permanent vision loss if not promptly treated [23]. The incidence of AAC varies significantly between ethnicities, with notably higher rates observed in Asian populations, ranging from 6–12 per 100,000 [24, 25] compared to 3.4 per 100,000 in predominantly white Caucasian populations [26].

The management of AAC focuses on rapidly lowering IOP to prevent optic nerve damage and improve patient comfort. Initial pharmacological management, including topical and oral medications, should be administered concurrently. Once AAC is diagnosed and initial treatment is initiated, the patient must be referred immediately to an ophthalmologist for further evaluation and management. Close monitoring is essential, with IOP checks every 15–30 minutes during the acute phase. Once IOP is stabilised, a laser peripheral iridotomy is required to prevent recurrence. Lifelong follow-up care is necessary, as these patients are considered glaucoma suspects [27]

Oral carbonic anhydrase inhibitors are used to treat ACC by reducing IOP and account for 2.7% of oral prescriptions prescribed by optometrists in New Zealand [4].

PATIENT JOURNEY

A patient in rural/remote Australia attends an optometric review with reports of severe eye pain, a red eye and blurred vision. IOP measurement and slit-lamp examination suggest that an acute angle closure has occurred. Recognising the emergency, the optometrist provides topical IOP-lowering medication and contacts the GP to dispense oral acetazolamide. During the wait time for the GP to issue the prescription, the patient's IOP continues to rise. There is no ophthalmologist available within a two-hour drive and the patient returns to the clinic for monitoring. Once IOP is stabilised, the patient is referred to the ophthalmologist for a peripheral iridotomy to minimise the chance of recurrence. The delay in lowering the IOP increases the risk of long-term complications including glaucoma and worse visual outcomes.

NEW PROPOSED MODEL

IOP measurement and slit lamp examination indicate that an angle closure has occurred, the optometrist immediately administers topical IOP-lowering medication and provides a prescription for oral IOP medication to be dispensed at the pharmacy. There is no ophthalmologist available within a two-hour drive and the patient returns to the clinic for monitoring. Once IOP is stabilised, the patient is referred to an ophthalmologist for a peripheral iridotomy to minimise the chance of recurrence. Prompt lowering of IOP reduces the risk of developing chronic glaucoma and preserves vision.

ESTIMATING THE COST

POPULATION

The proportion of people living in rural and remote areas (28%) was sourced from the AIHW website and applied to the population aged 30 years and older, estimating approximately 16,961,990 people [28]. Given the higher incidence of AAC in Asian populations, the proportion of Australians of Asian ethnicity (17%) was sourced from the 2021 Australian Census [29]. The median incidence of AAC in Asian populations from published literature (between 6–12 per 100,000) was applied to the Asian population, resulting in approximately 75 cases annually [24, 25]. The lower incidence of 3.4 per 100,000 derived from a predominantly white Caucasian population, was applied to the remainder population, yielding approximately 133 cases per year [26]. This resulted in a total estimate of 208 AAC cases annually.

DIRECT COSTS

In the proposed model of care, optometrists can immediately prescribe oral acetazolamide, providing faster treatment to lower IOP. Timely intervention reduces the risk of patients developing chronic glaucoma, which is crucial as delayed presentation (≥3 days) has been associated with a significantly higher rate of glaucoma at follow-up (60.8% vs 22.6%) [26]. Faster presentation and treatment can therefore prevent an estimated 126 patients from developing chronic glaucoma (60.8% of 208 cases), thereby avoiding the long-term, ongoing costs of glaucoma care, such as regular eye exams, medications, and potential surgical interventions.

Although this model focuses on one-year financial outcomes, the lifetime direct costs for glaucoma care per patient can be substantial. The estimated annual direct treatment cost was calculated using figures from the Glaucoma Australia 2022 report, which included the cost of glaucoma-related medicines and interventions such as topical medications, trabeculoplasty, and surgical procedures. These costs were estimated at $8,115.97 per patient in 2022. This figure was inflated to 2023 values, resulting in an estimated $8,570.22 per year [30].

Preventing 126 glaucoma cases per year

$8,570.22 saved per patient in ongoing treatment cost

Preserved visual outcomes

CASE STUDY 4: PRESEPTAL CELLULITIS

CLINICAL CONDITION

Preseptal cellulitis is an infection of the eyelid and surrounding tissue, causing eyelid swelling, redness, and tenderness, often accompanied by fever and malaise. It can result from trauma, insect bites or sinus infections. It most commonly affects children, with an incidence of 1.6 to 6 per 100,000, and 0.6 to 2.4 per 100,000 in adults. Treatment typically involves oral antibiotics and close monitoring to prevent the infection from spreading [31].

PATIENT JOURNEY

A patient presents to their optometrists with an acutely inflamed right upper eyelid which started a few days ago. The lid is red, tender and painful to the touch and appears to be worsening. The patient is otherwise well, with no other symptoms such as fever, pain on eye movements, decreased vision or ocular discharge. Given the presentation, a diagnosis of an infection of the eyelids (preseptal cellulitis) is made. The patient is referred to the GP, with a recommendation of an oral penicillin antibiotic such as amoxicillin/clavulanic acid as the most appropriate therapy for infections of the eyelids. The oral antibiotic is provided. The patient follows up with the optometrist after a few days and shows improvement, but the patient mentions they are having severe adverse effects such as diarrhea. The patient is referred back to the GP to modify and lower the antibiotic dose.

NEW PROPOSED MODEL

The optometrist writes a prescription for amoxicillin/clavulanic acid after discussion with the patient. The patient returns for a follow up with the optometrist after a few days and reports severe adverse effects such as diarrhea. The optometrist writes a new prescription for a lower antibiotic dose to manage this adverse effect and follows up regularly over the next week until resolution.

IMPROVED ACCESS TO CARE

Based on incidence rates derived from UK data, the projected number of cases of preseptal cellulitis in Australia over one year is approximately 541 patients [31]. While preseptal cellulitis is not highly prevalent, the proposed model demonstrates how optometrists can effectively manage the condition, eliminating the need for a separate GP visit and providing patients with faster, more convenient treatment. This model of care not only reduces patient wait times but also improves access to care without adding extra costs to the healthcare system. Additionally, by enabling optometrists to treat conditions early can help prevent complications, adding significant value beyond just cost savings.

Patients can be effectively managed at no additional cost

Fewer GP appointments

Timely access to treatment

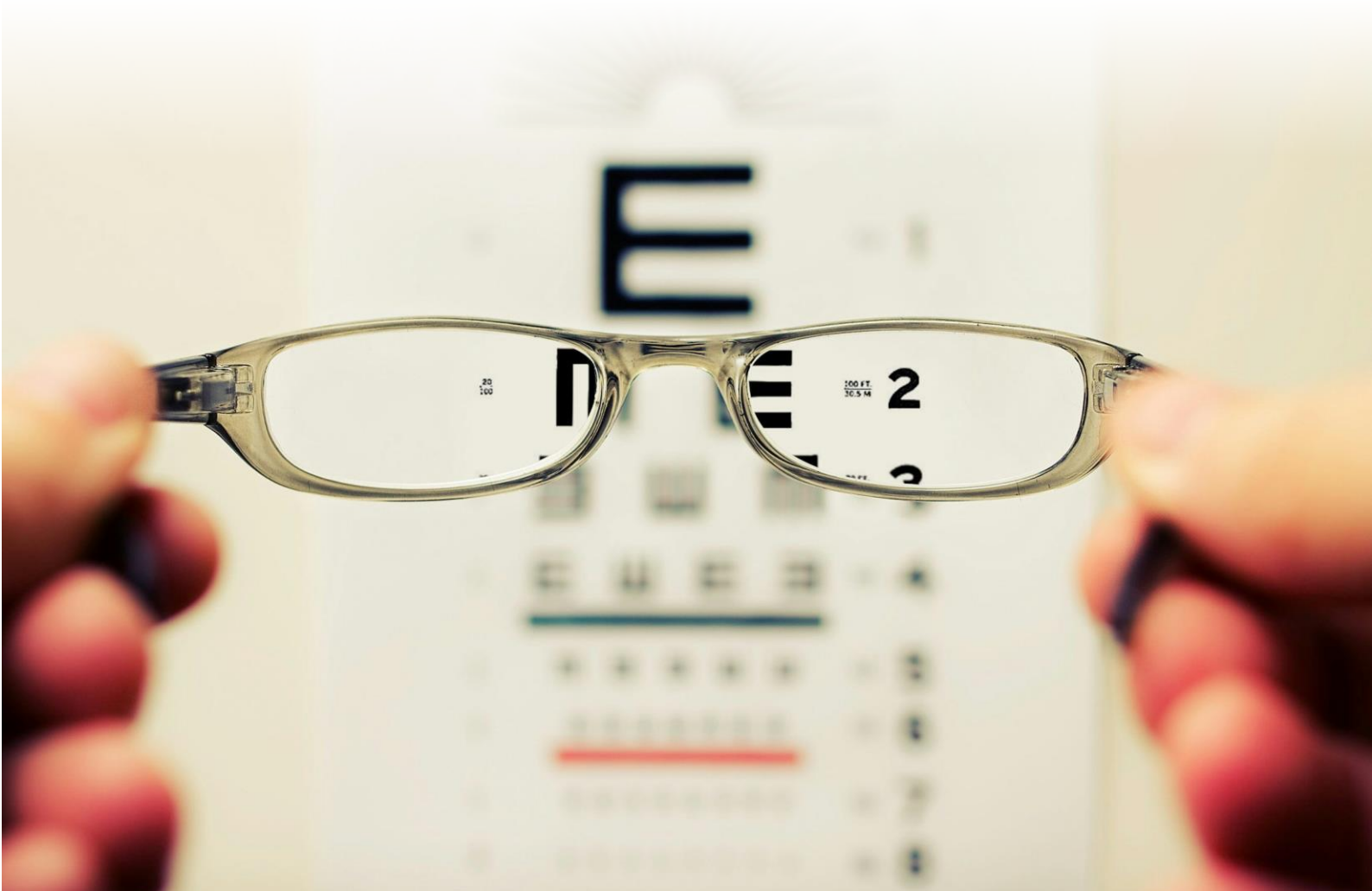
CONCLUSION

The expansion of prescribing rights for optometrists in Australia is a critical step towards improving access to timely eye care, especially for those living in regional and remote areas where services are often limited. Current restrictions limit optometrists to prescribe topical ocular medications, leading to unnecessary delays and additional healthcare costs as patients are required to visit a GP or specialist for oral medications. International examples, such as New Zealand, demonstrate that optometrists can effectively prescribe oral medications without compromising patient safety.

The case studies presented in this report illustrate the tangible benefits of authorising optometrists to prescribe oral medications. For conditions like MGD and HZO, significant direct financial savings can be achieved by reducing the need for GP and specialist referrals. This results in millions saved for both Medicare and patients, while alleviating pressure on an overburdened healthcare system. The indirect cost savings from reduced work absences and travel burden, further highlight the societal benefit.

In cases such as acute angle closure and preseptal cellulitis, allowing optometrists to provide timely treatment can improve health outcomes and decrease the risk of complications and associated long-term costs.

Expanding the scope of practice for optometrists to include prescribing oral medications aligns with modern healthcare standards and better utilises optometrists' skills. This will promote a more efficient and patient-centred system, addresses gaps in access to care and results in significant cost-savings.



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Our purpose is to have a powerful impact on the health of society by connecting people with the best treatments in the fastest amount of time.

This report presents the potential benefits of expanding optometrists' prescribing rights to include oral medications for eye conditions in Australia. Greater collaboration within the healthcare system and empowering optometrists to prescribe oral medications will enhance access to timely eye care, improve health outcomes, and make better use of Australia's highly skilled optometry workforce.