Evolving the Optometrist Workforce Together

Workforce Consultation Paper

Building on Optometry 2040, Working Together Better and the 2025–26 workforce evidence base.

Have your say: https://www.optometry.org.au/advocacy/optometry-workforce-consultation/

Consultation closes 18 December 2026

Optometry AUSTRALIA

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Forward

Australia's healthcare system is evolving.

Across the country, primary healthcare providers face growing demand driven by an ageing population, rising rates of chronic disease, pressure on hospitals and specialist services, evolving care models and technological advancements.

At the same time, workforce pressures are being felt across the health system.

These developments are already influencing the experience of our members, patients and practices. Yet many Australians still struggle to access the eye care they need.

Regional and remote communities remain underserviced, while public ophthalmology waiting lists continue to grow across metropolitan and regional areas.

For many years, workforce discussions within optometry have focused primarily on supply, including the number of optometrists practising in Australia and where they are located.

More recently, attention has also turned to the growth in the number of optometry schools and signs of oversupply in some metropolitan areas.

These are important considerations and will remain part of the conversation. However, they are only part of a much broader workforce picture.

A sustainable workforce requires us to consider not only how many optometrists we have, but how their skills and expertise are being used, where demand for care exists, the conditions in which optometrists practise and what is needed to support rewarding and sustainable careers.

There is also an opportunity to consider how optometry can contribute more fully to a health system increasingly focused on professionals working to the top of their scope, connected models of care and better access to services.

Reducing barriers that prevent health professionals from fully utilising their skills and expertise is an important part of this broader conversation.

Funding is another critical part of the picture. For more than 50 years, Medicare has underpinned accessible primary eye care in Australia.[1]

Medicare-supported optometry services have enabled millions of Australians to access timely eye care and have helped establish optometry as an important part of the health system.

At the same time, the way optometry is practised has continued to evolve. Optometrists are increasingly involved in the therapeutic diagnosis and management of complex clinical

[1] Services Australia, Medicare Benefits Schedule (MBS) indexation fact sheet, https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-MedicareIndexationSchedule; Optometry Australia (2019), Medicare freeze lifted: 1.6% increase for MBS optometry items, https://www.optometry.org.au/advocacy_government/medicare-freeze-lifted-1-6-increase-for-mbs-optometry-items/.

presentations, while the costs and complexity of delivering contemporary care have also increased.

Current funding settings do not adequately recognise this changing role, and Medicare reform remains a priority for Optometry Australia.[2]

Beyond Medicare reform, there is also an opportunity to explore new funding models that better support collaborative care, chronic disease management, aged care, low vision services and other emerging areas of practice and appropriately recognise the value of optometric care.

At the same time, funding reform needs to consider equity of access.

For some patients, particularly Aboriginal and Torres Strait Islander peoples, bulk billing can help ensure they can access essential eye health services.

Any changes to funding arrangements need to recognise patients' different circumstances and avoid creating additional barriers to care.

Sustainable funding needs to support both accessible care for patients and viable optometric practices.

These objectives are closely connected: a sustainable profession is essential to ensuring Australians can continue to access high-quality eye care, while equitable funding arrangements are important to ensuring that access is available to those who need it most.

Healthcare delivery is also becoming increasingly connected. Digital interoperability initiatives and developments in My Health Record and AU Core FHIR are creating opportunities for better information sharing, stronger care coordination and more integrated models of care.

These developments have implications for how optometry works with general practice, ophthalmology, hospitals, aged care and other parts of the health system.

Against this backdrop, there is an opportunity for our profession to consider some important questions together:

- How can optometry respond to the evolving health system and make the most of emerging opportunities?
- What role can the profession play in addressing unmet eye health needs?
- How can optometrists be better supported to deliver high-quality care, build rewarding careers and contribute fully to Australia’s healthcare system?
- Where can Optometry Australia focus its efforts to make the greatest difference for members, patients and the broader community?

There will be different views on these questions, and that is both expected and valuable.

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[2] Cappuccio, S. (2022). What to do about Medicare? Insight. https://www.insightnews.com.au/what-to-do-about-medicare-skye-cappuccio/

This consultation is an opportunity to bring those perspectives together, build our understanding of the workforce and explore practical solutions.

The best workforce solutions will be developed by optometrists, for optometrists; shaped by the profession, not simply for the profession.

Our role as Optometry Australia is to listen, bring together the evidence and experience of our profession and stakeholders, and use that insight to inform policy and advocacy that makes a meaningful difference.

I encourage all members and stakeholders to take part in this conversation.

Your experience, expertise and ideas will be an important part of understanding where we are now and where we could go next.

Mark Nevin

Chief Executive Officer,

Optometry Australia

Background

Why this paper, and why now

Optometry Australia has been building an evidence base about the optometry workforce with Members, universities, researchers, governments and health system stakeholders since 2014.

The findings from this research resulted in initiatives such as:

- Optometry 2040,
- Working Together Better,
- Optometry 2040 Revisited.

More recently the 2025–26 workforce research, partly funded by OA explored current issues. Based on the research, Optometry Australia developed then published the 2025 Position Statement on appropriate workplace conditions and set out what a sustainable, ethical workplace should look like.[3]

That 2025 statement was informed by, and has now been tested against, a national workforce survey, which was first reported in a preliminary form in early 2025 and has since been published as a peer-reviewed study, *Working Conditions of Employee Optometrists in Australia* (Cheung et al., Ophthalmic and Physiological Optics, 2026).

At the same time, as noted in the *Foreword*, healthcare demand is increasing.

Australia has a growing and ageing population, rising rates of chronic disease and increasing demand for timely, accessible healthcare services.

Governments are pursuing reforms designed to ensure health professionals can work to the full extent of their scope,[4] while digital health interoperability initiatives are creating new opportunities for more integrated and connected models of care.

These changes are creating significant opportunities for optometry, which has never been better placed to contribute to Australia's health system.

Optometrists are fundamental to primary eye care, disease prevention, early detection, chronic disease management and collaborative care. Advances in therapeutics, clinical capability and technology have expanded the contribution optometrists make to improving patient outcomes and supporting broader health system objectives. There are also long waiting lists for eye care in public hospitals and high out of pocket costs for ophthalmology[5], coupled with shortages in other healthcare professions.

However, these opportunities sit alongside significant workforce challenges.

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[3] Optometry Australia (2025). Position Statement: Appropriate Workplace Conditions for Clinical Optometrists. February 2025.

[4] Australian Government Department of Health, Disability and Ageing (2026). Have your say on how to unleash the potential of our health workforce. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/have-your-say-on-how-to-unleash-the-potential-of-our-health-workforce

[5] Breadon, P., Geraghty, J., Jones, D., and Baldwin, E. (2025). Special treatment: Improving Australians' access to specialist care. Grattan Institute. https://grattan.edu.au/report/special-treatment-improving-australians-access-to-specialist-care/

Optometrists are reporting concerns regarding:

- workforce sustainability,
- remuneration,
- workplace conditions,
- career progression, and
- increasing competition for jobs in some metropolitan areas.

At the same time, many Australians continue to have trouble accessing eye care, particularly in regional and remote communities and among populations experiencing poorer health outcomes.

This raises an important question:

Why do workforce pressures exist in some parts of the profession while significant unmet eye health need continues to exist across the community?

Understanding and responding to this is one of the central challenges facing optometry today.

Historically, workforce discussions have often focused on supply, asking whether Australia has too many or too few optometrists. While the number of optometrists practising in Australia remains an important consideration, it is only one part of a much broader picture.

This consultation paper builds on the previous workforce analysis, policy development, advocacy and engagement with Members and stakeholders to ask and understand:

- what matters most now,
- where opportunities exist today, and
- what actions should be prioritised to strengthen the profession

Insight

This consultation paper builds on Optometry Australia's existing workforce initiatives by:

- Updating OA's economic framing of workforce supply and demand with a clearer job demands–resources (JD-R) lens on the working environment;
- Synthesising the 2025 Position Statement and the 2025–26 workforce survey into a single, plain-language evidence base;
- Setting out a proposed workforce model built on a generalist foundation with structured special interest pathways;
- Opens formal consultation and discussion on special interest pathways, and

- Asking what should be prioritised to enable the optometry workforce to be further recognised to meet the community demands for eye health in Australia.

This understanding will inform Optometry Australia's Workforce Roadmap to help determine the priorities, partnerships, advocacy and investments required to support the profession both now and, in the years ahead.

How to use this consultation paper

This paper is structured in four parts. Each part concludes with a short set of illustrative "Have your say" questions for Members of Optometry Australia and partner stakeholders. These provide examples of the topics explored in the accompanying consultation links and are not intended to be exhaustive.

Please submit your responses via the consultation.

Part	Focus	Core Question
1. Understanding the workforce environment and the economics of eye care	What the evidence tells us about supply and demand for optometrists and their working conditions	What is really driving workforce sustainability?
2. A proposed new workforce model	A generalist foundation with structured special interest pathways Defining and prioritising clinical and non-clinical special interest areas	What should the optometry workforce look like? Which pathways should Optometry Australia formalise and how?
3. Strengthening the supports and building the enablers	Practices and Hospitals, Clinical Workforce, Medicines and Medical Devices, Funding, Technology and Digital health, Clinical Governance	Which supports and enablers would most improve working conditions or career prospects if Optometry Australia prioritised it in Year 1?
4. Next steps	Timeline, prioritisation and implementation	What happens after this consultation?

Part 1 — Understanding the workforce environment and the Economics of Eye Care

Workforce sustainability in optometry has traditionally been discussed as a supply question: how many optometrists does Australia need?

Optometry Australia's own work, and the 2025–26 workforce evidence, both point to a more useful frame: eye care workforce sustainability is an economic system made up of three interacting markets:

- **Workforce supply**: Do we have the right number of optometrists and are they located where they are most needed?
- **Workforce demand and utilisation**: Are optometrists being used to their full capability and are Australians accessing the eye care they need?
- **Workforce sustainability**: Are careers in optometry professionally rewarding, and financially sustainable across a practitioner's career?

The supply of optometrists, the demand for eye care, and the working conditions that determine how much workforce supply translates into clinical capacity, together provide a broader economic and health system perspective on workforce than workforce numbers alone.

A workforce can be numerically adequate and still fail to deliver patient care if working conditions drive experienced optometrists:

- out of the profession,
- push them to reduce hours,
- to avoid follow-up care, or
- leave the workforce altogether.

Another key dimension of supply is the clinical expertise of optometrists available across Australia. Optometry is an increasingly broad discipline practised in a variety of clinical contexts, including:

- primary care,
- public hospitals and
- private ophthalmology clinics.

This necessitates specialisation across the profession to support optometrists in advancing their collective and individual scope of practice along structured career pathways. This concept of ‘special interests’ in optometry is explored in Part 2.

1.1 Supply: more optometrists is both a challenge and opportunity

Australia now graduates more optometrists than ever, from more university programs, and the numbers of registered optometrists have grown considerably in the past ten years. About 400 optometrists are graduating from the seven optometry schools in Australian universities and approximately 50 overseas trained optometrists become registered after sitting the OCANZ exams. In metropolitan areas, members report growing competition for jobs, downward pressure on remuneration and fewer opportunities to progress.

Metric	2015	2025	Percentage increase
Number of Optometrists	4915	7340	49%[6]
Australian Population	23.9M	27.7M	15.9%

At the same time, significant unmet eye health need remains across the community — including uncorrected refractive error, long public ophthalmology waiting lists, and high out-of-pocket costs for private ophthalmologist care.

Modelling by the University of Queensland's Centre for the Business and Economics of Health, commissioned by Optometry Australia illustrates how differently the workforce question can be answered depending on how “need” is defined:

Basis for estimate	Optometrists required (2025)
Population-needs model (if everyone who needed care received it)	≈ 9,010
Projected workforce supply	≈ 7,234
Current utilisation model (based on who actually attends today)	≈ 4,125[7]

In 2024, there were approximately 28.5 full-time equivalent (FTE) optometrists per 100,000 population in metropolitan areas, compared with 19.1 FTE per 100,000 in regional, rural and remote communities.[8]

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[6] Optometry Board of Australia, Registrant data and statistics, https://www.optometryboard.gov.au/about/statistics.aspx; Australian Bureau of Statistics, National, state and territory population, https://www.abs.gov.au/statistics/people/population/population-clock-pyramid.

[7] Centre for the Business and Economics of Health, The University of Queensland, in partnership with Optometry Australia. Optometry Workforce Projections (Final Report). https://www.optometry.org.au/wp-content/uploads/Policy/Advocacy/Final-Report-Optometry-Workforce-Projections.pdf

[8] National Health Workforce Dataset, Australian Government Department of Health, Disability and Ageing, https://hwd.health.gov.au/resources/dashboards/nhwds-dashboard.html,and Australian Institute of Health and Welfare (9 July 2026), Profile of Australia’s population (by remoteness area as at 30 June 2024). https://www.aihw.gov.au/reports/australias-health/profile-of-australias-population

Within ophthalmology, there were 1,004 employed ophthalmologists nationally in 2023, equivalent to 3.9 FTE per 100,000 population.[9] The majority (84%) of ophthalmologists work in metropolitan areas, with shortages evident in regional and rural Australia[10].

This illustrates the potential for more non-complex eye care to be managed by optometrists in line with their experience and scope of practice.

A workforce that looks oversupplied against current utilisation can be substantially undersupplied against population need. The two things can be simultaneously true, and the difference between them is not a workforce number — it is a set of economic and access barriers that hinder people from accessing the eye care they need.

Have your say: Consultation Questions

Q7: How could the current and future optometrist workforce be better utilised?

Q8: Is the number of optometrists graduating from Australian Universities appropriate, and why?

Q9: What role should OA play in enabling this future?

Q10: What should be prioritised first?

1.2 Demand: an under-utilised workforce sitting next to a pressured health system

Alongside the supply question, Optometry Australia has increasingly focused on whether optometrists are being utilised to their full capability within the wider health system.

In 2023–24, there were 146,585 emergency department presentations nationally for eye conditions, of which only 9.1% required admission[11]; care that, with the right funding and referral pathways, could largely be managed by optometrists in primary care.

Collaborative care models in South Australia[12], New South Wales[13] and Victoria[14] have shown that a substantial proportion of low-risk and non-urgent ophthalmology referrals can

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[9] National Health Workforce Dataset, Australian Government Department of Health, Disability and Ageing, https://hwd.health.gov.au/resources/dashboards/nhwds-dashboard.html.

[10] Department of Health Disability and Ageing (2024). “Health Workforce Data”. Ophthalmologist clinical hours by Monash Medical Model 2023. Accessed 22 July 2026

[11] Australian Institute of Health and Welfare. Emergency department care: presentations by principal diagnosis. https://www.aihw.gov.au/hospitals/topics/emergency-departments/presentations

[12] Optometry Australia (2021), Working Together for Better Eye Care, including Australian collaborative-care case studies and evaluations. https://www.optometry.org.au/wp-content/uploads/Working-Together-for-Better-Health-Care-update-16Aug2021-update.pdf

[13] Wang H and Kalloniatis M (2021), Clinical outcomes of the Centre for Eye Health: an intra-professional optometry-led collaborative eye care clinic in Australia, Clinical and Experimental Optometry 104(7):795-804. https://doi.org/10.1080/08164622.2021.1878821

[14] Optometry Australia (2021), Working Together for Better Eye Care, including Australian collaborative-care case studies and evaluations. https://www.optometry.org.au/wp-content/uploads/Working-Together-for-Better-Health-Care-update-16Aug2021-update.pdf

be safely managed by optometrists. Estimates range from 40-60% of the non-urgent waitlist in a South Australian pilot to 57-68% of low-risk glaucoma and diabetic retinopathy referrals in New South Wales.

Optometry Australia also estimates approximately 3.5 million GP presentations each year relate to eye conditions, many of which would be better managed by optometrists as accessible primary eye care providers.[15]

Demand for eye care is also increasing, driven by an ageing population, rising chronic disease prevalence (particularly diabetes), growing rates of glaucoma and retinal disease, paediatric eye care and myopia management, and persistent unmet need in First Nations communities and rural and remote Australia.

Insight

Future workforce sustainability depends less on growing the number of optometrists and more on improving access, activating latent demand, strengthening referral and collaborative care pathways, and supporting optometrists to practise to their full scope in line with health system needs.

Have your say: Consultation Questions

Q11: How many optometrists are needed to serve demand for eye care?

Q12: Are there geographic or clinical areas of unmet need at present?

Q13: Are there emerging areas of demand that OA has not considered?

Q14: What should be prioritised first?

1.3 What Optometrists are saying about working conditions

The latest evidence on workforce conditions comes from the 2025–26 national workforce survey of employee optometrists (n=370 completed responses, 5% of AHPRA-registered

[15]Britt H, Miller GC, Henderson J, et al. *General practice activity in Australia 2015–16*. General practice series no. 40. Sydney: Sydney University Press, 2016 (BEACH program); Australian Institute of Health and Welfare, *Eye health: treatment and management*, https://www.aihw.gov.au/reports/eye-health/eye-health/contents/treatment-and-management; Morgan S et al. (2016). Australian general practice trainees' exposure to ophthalmic problems. *Journal of Primary Health Care* 8(4):295–302, https://doi.org/10.1071/HC16024; Australian Institute of Health and Welfare (2026), *Primary health care*: 167.2 million GP attendances in 2024–25, https://www.aihw.gov.au/reports/australias-health/primary-health-care. Estimate by Optometry Australia, applying BEACH rates to 2024–25 GP attendances.

See also Grattan Institute (2022), Special treatment: improving Australians' access to specialist care, https://grattan.edu.au/report/special-treatment-improving-australians-access-to-specialist-care/, for related analysis of specialist and ED access.

optometrists),[16] which used the organisational psychology Job Demands–Resources (JD-R) model.

The widely used JD-R workforce framework in which high job demands, and low job resources drive burnout and attrition, while adequate resources and manageable demands drive engagement and retention.[17]

The 2025-26 survey provided the following key findings:

Job resources — what is working

- 89% of optometrists get along well with their colleagues,
- 61% report satisfaction with their scope of practice,
- 68% are satisfied with the geographic location of their workplace.
- Over 75% agree they can provide high-quality, evidence-aligned patient care despite the pressures described below — optometrist's clinical commitment is not in question.[18]

Job demands — what is not working

- Only 22.5% of employee optometrists are satisfied with their career options and professional growth, and only 24.6% with their income.
- Only 43% are satisfied with their current scope of practice and level of autonomy.
- Nearly 40% do not feel they participate in decision-making in their practice, and only around 45% feel comfortable presenting new ideas
- 63% of optometrists have no formally allocated administrative time; median follow-up appointment time is 20 minutes, with some optometrists allocated none at all; and difficulty accommodating emergency patients is one of the strongest predictors of lower satisfaction across every outcome measured.

[16] Anstice, N., Trinh, M., Cheung, R., Dowdall, R., & Lim, V. (2025). Working conditions of employed optometrists: A workforce survey — plain-language summary of preliminary results, 14 February 2025; Cheung, R., Trinh, M., Lim, V., Dowdall, R., & Anstice, N. (2026). Working Conditions of Employee Optometrists in Australia. Ophthalmic and Physiological Optics, 46, 285–295. https://doi.org/10.1007/s44402-026-00050-2 (open access, CC BY 4.0).

[17] Divakar, R., Bentley, S. A., Wong, T., et al. (2026). Workforce retention and attrition trends among optometrists in Australia: key factors and reasons. Clinical and Experimental Optometry, 109, 170–181. https://doi.org/10.1080/08164622.2025.2550737

[18] See note 12 (Anstice et al., 2025; Cheung et al., 2026).

- Optometrists working mainly in corporate/franchise settings, or as locums, report significantly lower satisfaction with career growth and scope of practice than those in independent, academic or ophthalmology-linked settings — though experiences within each setting vary considerably.[19]
- the lowest-scoring items in the survey relate to involvement in workplace decision-making, not clinical confidence.

Qualitative comments from the survey raised many issues which were causing moral distress.

While most optometrists continue to make clinically appropriate decisions, many report that workplace pressures, including KPI expectations, rostering demands and commercial constraints, can make delivering care more challenging or limit how that care is provided[20].

In order to address these reported challenges Optometry Australia's 2025 Position Statement called for protected Clinical Support and Administrative Time (CSAT, a minimum guide of 10% of working hours), for KPIs to not impinge on clinical judgement, and for appointment scheduling that avoids routine double-booking and leaves room for urgent cases.[21]

The profession's consistently low AHPRA notification rates confirm we continue to be a safe profession, but optometrists should not have to rely on personal resilience to overcome conditions that undermine wellbeing, autonomy or could impact patient safety.

[19] See note 12 (Anstice et al., 2025; Cheung et al., 2026).

[20] See note 12 (Anstice et al., 2025; Cheung et al., 2026).

[21] See note 3 (Optometry Australia, 2025, Position Statement: Appropriate Workplace Conditions for Clinical Optometrists, February 2025).

[20] See note 12 (Anstice et al., 2025; Cheung et al., 2026).

Have your say: Consultation Questions

Q15: What has changed in workplace conditions for optometrists in recent years?

Q16: Are you subject to any workplace KPIs that impact your clinical autonomy?

Q17: Are there any other workplace conditions that impact your clinical autonomy?

Q18: Is there any further role OA can play in this area?

1.4 The economic case: why workforce conditions matter beyond individual wellbeing

The findings from the 2025 survey describe a reduction in the eye care system's effective capacity. Every optometrist who reduces their hours, avoids taking on complex or time-consuming patients, or exits the profession early represents workforce capacity that was trained at public and personal expense but is not being deployed for patient care.

The factors most strongly associated with job satisfaction in the survey were adequate patient follow-up times, capacity to see emergency patients, and job security. These are also the factors most directly linked to safe, efficient, lower-cost eye care (fewer preventable Emergency Department presentations, fewer missed follow-ups, less clinical rework)[20].

This reframes workforce policy.

In order for optometry to thrive, workforce conditions must be considered alongside funding and service delivery. Getting these conditions right is important to deliver benefits for patient care and for optometry to add value in new ways across the health system.

Workforce conditions also inter-relate with funding:

Medicare rebates have not kept pace with the clinical complexity, diagnostic capability and administrative burden of contemporary practice.

Most optometry practices rely on blended clinical and dispensing revenue models to remain viable.

The evidence from the survey indicates that current funding and many business models are not adequately supporting clinical autonomy, care coordination and time for increasingly complex chronic disease management, whilst acknowledging that practice models, and workforce experience within them vary considerably.

1.5 The Health Professionals and Support Services Award (HPSS)

Increasingly, Optometry is a postgraduate-entry profession whose clinical scope includes therapeutics, chronic disease management, collaborative care and advanced diagnostics. As noted in 1.3 above optometrists' report that remuneration and career progression have neither kept pace with extension in their clinical role, nor the rising cost of living.

This has intersected with an industrial relations question:

The Health Services Union has sought explicit recognition of optometrists within the Health Professionals and Support Services (HPSS) Award, alongside podiatrists and physiotherapists whereas currently optometrists are not explicitly covered, like medical doctors and dentists.

If **optometrists** were covered by the HPSS Award, it would establish a set of minimum entitlements and conditions for optometrists, helping ensure consistency and fairness including potential benefits such as:

- Minimum base pay rates with regular reviews, ordinary hours, overtime and penalty rates, allowances, breaks and formal dispute resolution
- Classification structures that recognise increasing experience, responsibility and expertise
- Potential workforce attraction and retention benefits, particularly for early-career optometrists seeking transparent remuneration and conditions.
- Greater consistency across workplaces, reducing variability in employment arrangements across the profession.

There may also be disadvantages from the inclusion of optometrists in the HPSS Award, such as:

- Reduced flexibility over remuneration structures, rostering and other workplace practices
- Administrative and compliance costs associated with transitioning to a new industrial relations framework
- Pressures on the viability of marginal practices, particularly small independent, rural and remote businesses, where added employment costs may not be recoverable through fees, potentially impacting access to care
- Some tasks could be delegated from optometrists to other practice staff or technology
- Possible reductions in hours or shifts, where higher penalty and overtime costs lead some practices to cut weekend or after hours trading that employees rely on.

Views differ on whether HPSS coverage would meaningfully improve professional recognition and minimum standards, particularly for early-career optometrists, or whether it is primarily an industrial mechanism that would not of itself resolve KPI pressure, workload or autonomy concerns.

Further information about the HPSS Award is available:
https://awards.fairwork.gov.au/MA000027.html#_Toc240883793

This paper seeks views and evidence from Members and stakeholders on the question of workforce conditions and the HPSS Award. Optometry Australia will use the feedback from this consultation to inform a decision by our Board. This paper does not pre-empt an answer to that question but treats it as a live and important part of the workforce sustainability conversation.

Insight

The Health Professional and Support Services (HPSS) Award covers:

- employers in the health industry and their employees who are in a classification in the award
- employers engaging a health professional employee.

The health industry includes the delivery of:

- health care
- medical services
- pathology services
- dental services.

Examples of health professional employees covered by the HPSS Award include:

- audiologists and speech pathologists
- chiropractors and physiotherapists
- occupational therapists (unless their employer is covered by the Educational Services (Schools) General Staff Award 2020)
- counsellors and psychologists
- dental hygienists
- dental therapists
- dieticians
- radiographers, sonographers and radiation therapists
- pharmacists (working in private hospitals only)
- podiatrists.

Who the HPSS Award does not cover
The following employers and employees are not covered by the Health Services Award:

- nurses who are covered by the Nurses Award
- community pharmacists who are covered by the Pharmacy Award
- paramedics who are covered by the Ambulance Award
- medical professionals such as doctors, GPs and surgeons.

Have your say: Consultation Question

Q19: Do you think optometrists should be covered by the HPSS Award, and why?

Q20: Should optometrists be covered by their own Award, like nursing or community pharmacy?

Part 2 — Proposed Model for Optometrist Workforce

Part 1 shows that the optometry workforce challenge is not simply about numbers, but about sustainability, working to full scope of practice, responsiveness to community need, clinically and culturally safe and appropriately positioned to contribute to an evolving health system.

Importantly, this consultation does not start from a predetermined view that optometry should either move towards a highly specialised clinical model or remain as it is today.

Instead, Optometry Australia is seeking member feedback on a proposed future workforce model that aims to balance the strengths of comprehensive generalist optometry, with emerging workforce opportunities and the evolving needs of the health care system.

This section outlines a proposed new future workforce model for optometry and seeks feedback from members and stakeholders.

2.1 A generalist foundation

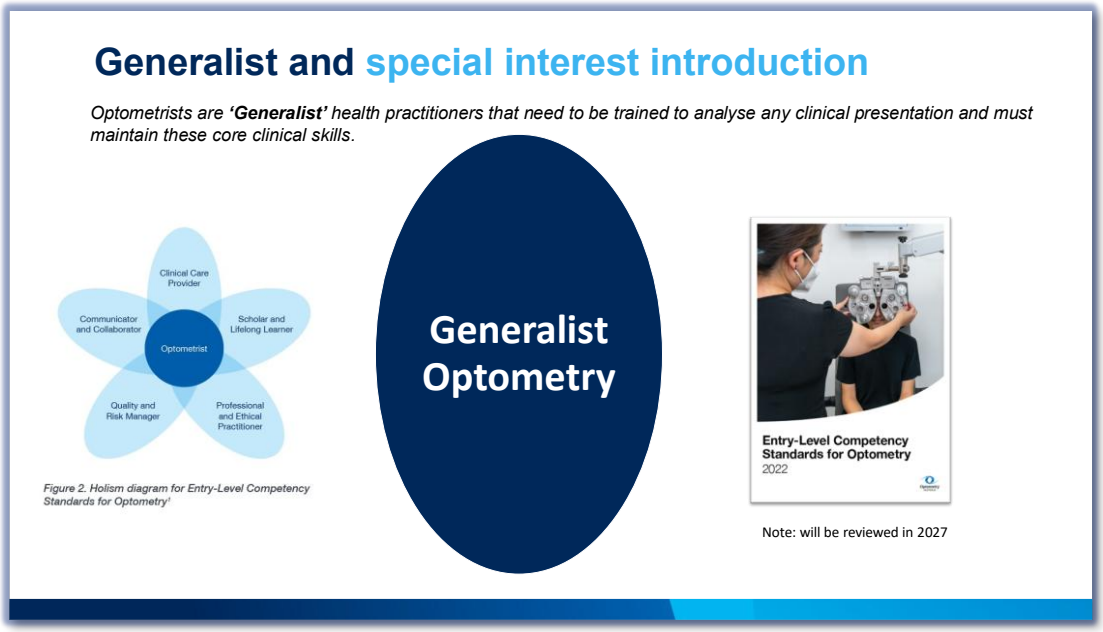
We know that Optometrists provide the majority of eye care in Australia and are usually the first point of contact for concerns about eye health and vision. Optometrists' broad clinical skills and knowledge underpin preventative eye care, correction of refractive error, early disease detection, therapeutic management, chronic disease monitoring, referral coordination, continuity of care, and equitable access across metropolitan, regional and remote communities.

These capabilities represent the accepted core professional identity and foundations of optometry (diagram 1).

Optometry Australia is proposing a workforce model that retains this core professional identity and clinical foundation of optometry as 'generalist practice', while also seeking to support the profession and individual optometrists in advancing their personal scope of practice.

Generalist practice is, and will remain, the essential foundation from which optometrists build their skills, knowledge and clinical practice across a range of services and roles.

Diagram1



Importantly, comprehensive generalist practice is not a fixed or static model of clinical practice.

As therapeutics continue to evolve, understanding of chronic disease deepens, technology and artificial intelligence become more integrated into clinical practice, and community needs change, the skills, knowledge and capabilities of generalist optometrists will also need to evolve.

Future generalist practice will require increasing expertise in areas such as evidence-based therapeutics, chronic disease management, digital health and AI-enabled care, paediatric eye care, culturally safe care, and meeting the needs of priority populations.

Building on this foundation, the proposed model aims to strengthen workforce capability and create opportunities for optometrists to:

- improve eye health outcomes across the community
- increase access to timely eye care services
- help reduce pressure on hospital and specialist waiting lists, and
- support sustainable and appropriate funded models of care.

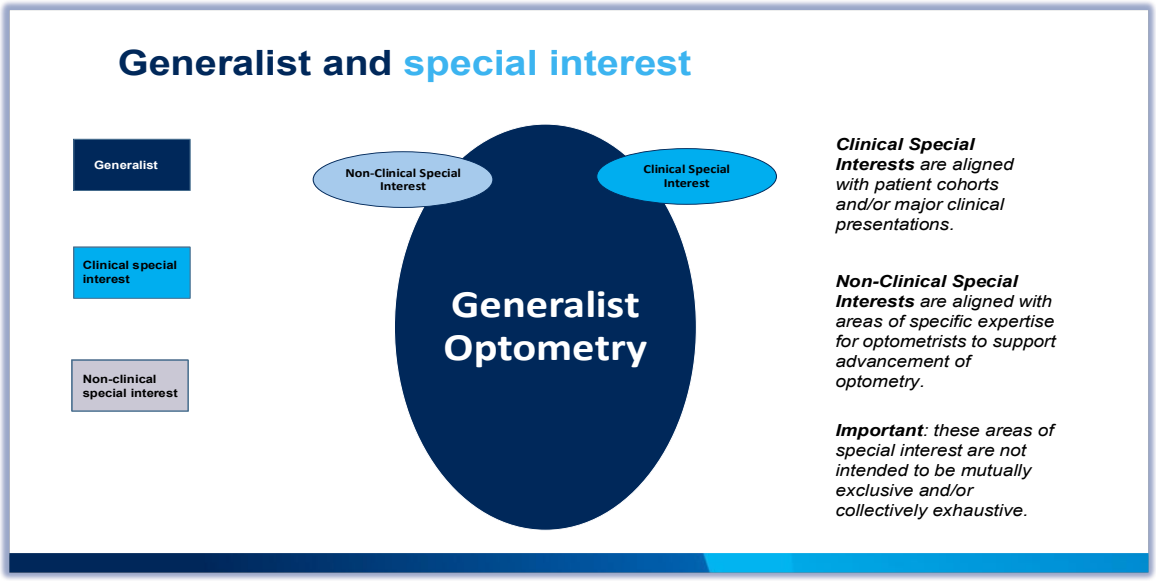
Additional areas of specialist interest or expertise would create opportunities for enhanced collaborative models of care, while also enabling practitioners to contribute to non-clinical domains such as leadership, education, research, policy and business ownership (diagram 2).

Special interests in optometry can help:

- create new opportunities for optometrists to add value in new ways across the health system
- empower practitioners to shape their own career development and professional interests
- build workforce capability in areas of growing community and health system need

- support advocacy for new funded services, models of care, and employment opportunities within hospitals and other healthcare settings.

Diagram 2



2.2 Structured special interest pathways

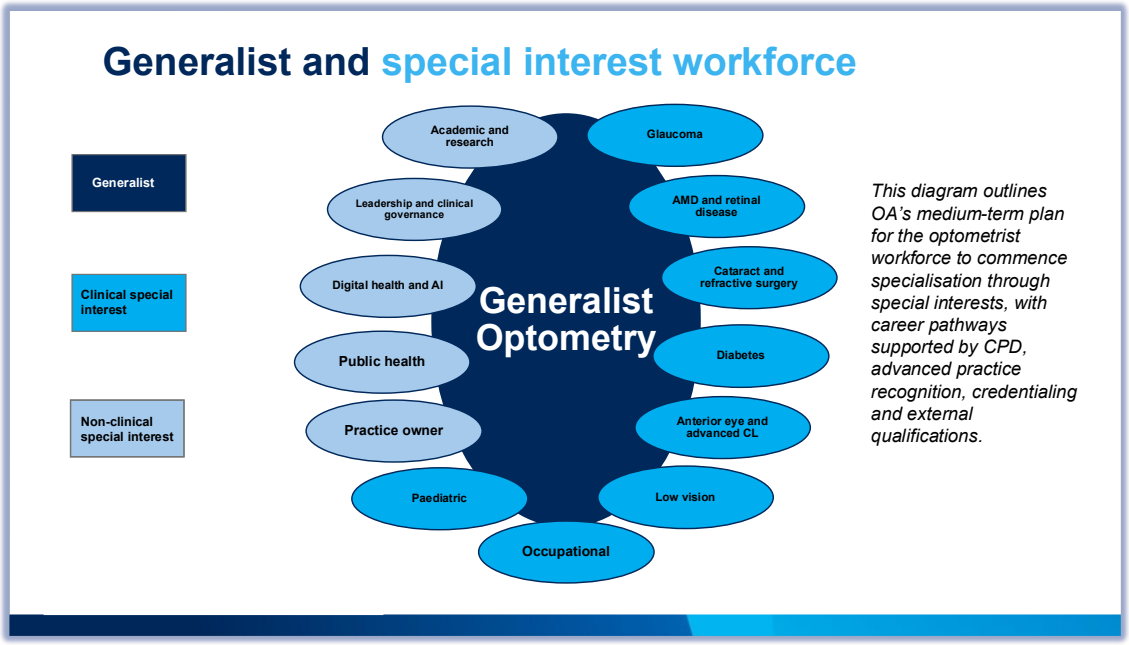
In some respects, special interests already exist in optometric practice. Many optometrists already have areas of clinical or non-clinical interest they have developed through CPD, workplace experience, mentoring, post graduate education and collaborative care arrangements.

Optometry Australia is proposing to make special interests more structured, visible, consistent and supported, without fragmenting the profession or replicating a sub-specialisation model (often seen in medicine).

As shown in diagram 3 below, several areas have emerged through previous workforce evaluations, member engagement and health system needs.

Structured pathways would sit alongside, not instead of, generalist practice, gained through additional education, competency assessment and credentialing.

Diagram 3



Optometry Australia is seeking feedback on the following working definition, of '*Special Interest'*.

Proposed definition

'Special Interest' is recognition of advanced skills and experience in a defined area of practice, over and above the level expected of a generalist optometrist. Optometrists with a Special Interest typically manage presentations of complex, severe or rare eye conditions, as clinically and culturally appropriate.

Clinical Special Interests are proposed to align with patient needs (or patient cohorts) and/or major clinical presentations.

Clinical special interest areas (proposed)

Area	Brief description
Glaucoma	Diagnosis, monitoring and formalised collaborative or independent management of routine, advanced and secondary glaucoma, including pre- and post-procedural care
AMD and Retinal Disease	Diagnosis and collaborative management of complex, atypical or rarer macular and retinal disease, including pre- and post-operative care.

Cataract and refractive surgery	Expert pre- and post-operative assessment and co-management, including complication detection and formalised surgical co-management protocols.
Diabetes	Diagnosis and management of complex diabetic eye disease, advanced retinal imaging, and coordinated care with GPs and multidisciplinary teams.
Anterior eye and advanced contact lenses	Advanced diagnosis and management of ocular surface disease (including complex dry eye) and specialty contact lens fitting (e.g. RGP, scleral, keratoconic, orthokeratology, prosthetics).
Low vision	Advanced rehabilitation skills and collaborative management for patients with significant, uncorrectable vision impairment.
Occupational optometry	Assessment against complex occupational / vocational visual standards (including CASA), workplace eye hazard and injury-prevention expertise.
Paediatrics	Advanced assessment and management of infant and paediatric vision conditions, particularly where diagnosis or treatment is complicated by neurodevelopmental, behavioural, family, or complex binocular vision factors.

Non-Clinical Special Interests are proposed to align with areas of specific expertise for optometrists to support advancement of optometry at the health system or service level.

Non-clinical special interest areas (proposed)

Area	Brief description
Academic and research	Sustained, active contribution to optometry or vision science research, typically evidenced by a substantial peer-reviewed publication record.
Leadership and governance	Health systems, clinical governance, workforce/team management and change management skills applied to leading eye care teams and services.
Digital health and AI	Health informatics, technology governance and change management applied to the adoption of digital tools and AI in eye care.

Public health	Ophthalmic epidemiology, health equity, program design and delivery, and culturally safe engagement with priority populations at a local, national or international level.
Practice ownership	Running a practice: clinical governance, workforce management, funding and financial governance, and community service delivery.

Importantly, these areas of clinical and non-clinical special interest are not intended to be mutually exclusive and/or collectively exhaustive, meaning that they can and will overlap, for example patients with diabetes may also develop retinal disease or have glaucoma.

Full proposed definitions for each area are set out at Appendix 1.

An optometrist may hold more than one special interest, and they are intended to build on — not replace — generalist capability.

Have your say: Consultation Questions

Q21: Are special interests the preferred direction for optometry?

Q22: If so, does the proposed definition of a “Special Interest” strike the right balance, and does it need refinement?

Q23: Are these the right clinical and non-clinical special interest areas?

Q24: Do the definitions accurately describe the scope and focus of each special interest Area? Please provide any suggested changes.

Q25: What special interest area, if anything, is missing, and why?

Q26: Are there any enhanced capabilities that the future generalist optometrist role should include?

Optometry Australia is not seeking to predetermine which special interest pathways emerge, or to force every clinical area or niche of practice into a national credential as that would be unsustainable.

Instead, this consultation is designed to test priority, readiness and the support optometrists would need to develop special interests.

2.3 Why formalise special interests now?

Insight

Three forces make special interests timely:

- Population need: rising rates of glaucoma, diabetes and retinal disease, an ageing population's demand for cataract and low vision care, and growing awareness of paediatric visual development and myopia management are all increasing demand for deeper expertise in specific areas.
- Health system pressure: ophthalmology waiting lists and ED presentations create a genuine opportunity for optometrists with deeper expertise to take on more collaborative-care capacity — but this requires credible, recognisable professional development that hospitals, ophthalmology and patients can trust.
- Workforce sustainability: Part 1 showed that career progression and professional growth are the lowest-scoring items in the national workforce survey. Structured special interest pathways are one of the workforce levers that could directly address this.

2.4 What “structured” should mean

For a special interest pathway to be more than an informal reputation, it will generally need a defined combination of additional education, assessed competency, and an endorsement process, together with an expectation of ongoing practice and CPD in that area (the appendix definitions propose specific thresholds, such as a minimum period of sustained research activity for the academic/research pathway).

If progressing with special interests, Optometry Australia’s CPD system would be upgraded to recognise agreed areas of special interest and enable members to capture data and evidence of their special interests through CPD, advanced practice, credentialing (where relevant e.g. CASA for pilots) and other external qualifications. Optometry Australia would seek to develop new training and CPD to support members in attaining a special interest. It is neither feasible nor desirable for Optometry Australia to provide all training in special interests, since there are already many quality education providers in optometry.

Have your say: Consultation Questions

Q27: What should be required for an optometrist to be formally recognised as having a special interest in terms of further professional development/education, assessed competency, a minimum caseload, or a combination?

Q28: What other entities should be able to provide training that supports individuals in attaining a special interest? For example, universities, health services, employers or other associations?

2.5 Prioritising which pathways to formalise first

Given the breadth of areas identified, Optometry Australia cannot formalise every pathway simultaneously. Three factors are proposed to shape sequencing:

- **Community and patient need —** pathways where demand and system pressure (e.g. glaucoma, diabetes, cataract co-management) are already greatest.
- **Workforce sustainability and fulfilment —** pathways that most directly respond to the career-progression and autonomy gaps identified in Part 1.
- **Health system readiness —** pathways with existing collaborative care pilots, funding pathways or policy alignment (e.g. state-based glaucoma or diabetic retinopathy co-management schemes) versus those needing longer-term reform.

Regional and rural workforce needs also warrant specific consideration: while some metropolitan areas report workforce concentration, rural and remote communities continue to experience reduced access, and special interest pathways could be designed to explicitly support rural capability and outreach rather than concentrating expertise further in metropolitan centres.

Have your say: Consultation Questions

Q29: Which special interest pathways should Optometry Australia prioritise for formal development first?

Q30: Why should these pathways be prioritised?

Q31: How can special interest pathways be designed to strengthen rather than reduce access to eye care in regional and rural Australia?

2.6 Supports needed for special interest pathways to succeed

- Recognised postgraduate education and CPD pathways mapped to each special interest area.
- Funding models (Medicare items, health service contracts, or private billing structures) that recognise the additional time and complexity special interest work involves.
- Formal collaborative-care agreements and referral pathways with ophthalmology, general practice and hospitals.
- Mentoring and supervised-practice arrangements for optometrists moving into a special interest area.
- A credible, transparent register or credentialing system that patients, employers and referrers can trust.

Have your say: Consultation Questions

Q32: Of the supports listed above, which should be prioritised?

Q33: Is there any other support that would help special interest pathways to succeed?

2.7 Consideration of priority populations

Generalist optometry will continue to serve all priority populations that present for care in community practices or hospitals by providing culturally safe care.

Priority populations in Australia are those deemed as having greater need, including:

- Aboriginal and Torres Strait Islander people
- People with a disability or special needs

- LGBTQIA+ people
- Older people with age-related diseases or impairments
- Australians living in rural or remote areas.

This consultation also seeks views from members and stakeholders on how (these or any other) priority populations should inter-relate with special interest areas, or whether advanced skills or recognition of additional training would be more appropriate to support priority populations.

Have your say: Consultation Questions

Q34: How should priority populations, including those identified above and any others, be considered in the development of special interest areas in optometry?

Q35: For these populations, would advanced skills, recognition of additional training, or another approach be the most appropriate way to support improved care?

Q36: Are there any other workforce reforms that could be considered to benefit priority populations?

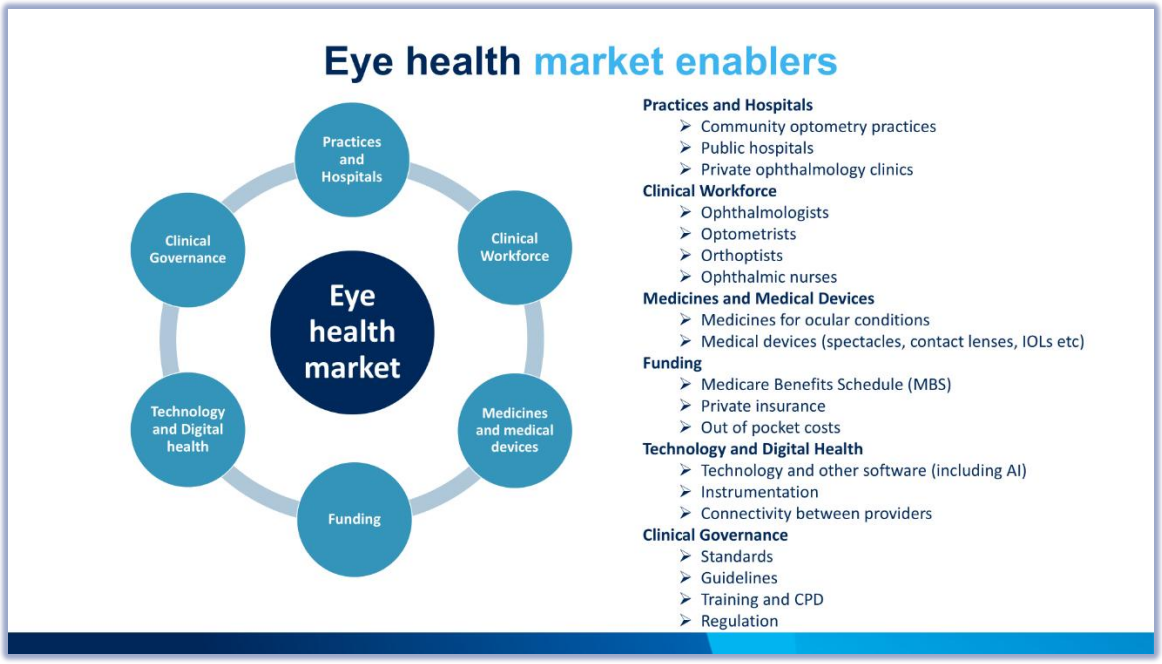
Part 3 — Strengthening workforce by building the Enablers

The optometry workforce is influenced by developments across the broader health system, including key enablers to deliver eye care, for example policy and funding settings.

Consideration of workforce must also take into account the underlying ‘enablers’ or supports that need to be in place to deliver eye care services nationally, including practices and hospitals; medicines and medical devices; service funding; technology and digital health; and clinical governance (diagram 4). These enablers are critical to serving the growing eye health needs of the Australian population, and to advancing optometry’s role in doing so.

These enablers are not new or unique to optometry they underpin service delivery in all healthcare markets. Optometry Australia's program of work already includes advocacy and projects across all of these areas, for example seeking additional Medicare or health insurance funding for optometric care, or for optometrists to prescribe oral medications for ocular conditions.

Diagram 4



The priority of seeking changes to these enablers of optometric care will differ across members and stakeholders.

For some the priority may be greater advocacy for:

- Medicare reform, or
- Private Health Insurance reform, or
- Removal of barriers to practising at full scope.

Importantly not all enablers are within the direct control of Optometry Australia. Some changes will require partnerships with stakeholders including government, universities, employers, regulators, educators, other peak bodies and broader parts of the health system. This broader collaboration will be essential to achieving sustainable reforms.

This consultation is seeking views from members and stakeholders on which of the following enablers should OA prioritise over the coming one to three years?

Practices and Hospitals

- Public Hospitals – optometrists integrated into hospital eye departments across Australia
- Private ophthalmology clinics – more optometrist roles in these settings
- Increase in collaborative care models between optometry practices and hospitals and/or private ophthalmology clinics
- Collaborative Care opportunities-ophthalmology, GP's, Aboriginal and Torres Strait Islander Community Health Organisations, other allied health professionals
- Community optometry practices – more optometry lead assessment and
- monitoring pathways e.g., for referral refinement or management of stable ocular disease

Medicines and Medical Devices

- Expedited implementation of oral prescribing of medicines for ocular conditions
- Arrange a pilot for optometrists to use lasers e.g. PI, SLT for ocular disease
- Arrange a pilot for optometrists to inject IVIs (under supervision)
- Focus on advances in care for other medical devices (including smart glasses, myopia control, light therapy for dry eye or other therapies)

Funding

- Seek greater funding and recognition in Medicare Benefits Schedule (MBS)
- Seek greater private health insurance funding for optometric care
- Seek funding from state governments for collaborative care between optometry practices and hospital eye departments
- Seek recognition for optometrists under the NDIS
- Seek other government grants or support, for example to improve access for Aboriginal and Torres Strait Islander populations

Technology and Digital Health Connectivity

- Increasing connecting optometry practices to national electronic prescribing service (ePrescribing)
- Building the capacity to share images and scans i.e., the ability for subsequent care providers to see previous imaging and support connected care

- Expansion of secure eReferral to include:
- Electronic referrals to other optometrists with specialist skills
- Electronic referrals to / from GPs
- Electronic referrals from public hospitals and emergency departments
- Sharing of electronic referrals from optometrists in My Health Record
- Expansion of telehealth for shared care arrangements with ophthalmology e.g. asynchronous telehealth
- Ethical and safe adoption of AI in optometry

Clinical Governance

- Practice standards for primary care optometry
- Collaborative care governance (between optometry practices and ophthalmology clinics and hospitals) and other resources such as model contracts
- New clinical guidelines aligned to identify priority special interests or other areas
- Support capacity building for clinical trials and pilots involving optometrists working to extended scope
- Removal of regulatory or other barriers to advancing optometry
- Do any regulations need to change to allow optometrists to practise to full scope?
- Are any new regulations needed to support an extended scope of practice for optometrists?

Clinical Workforce

New training and CPD pathways for optometrists in special interests will be developed by OA, aligned to the proposed special interests. The priorities submitted to Part 2 will inform those priority areas.

- Guidance on effective team-working between all health professions working in collaborative care arrangements
- Additional support for optometrists to practise in regional or rural settings, and if so, what should be considered?
- Is there greater potential for other health professions to collaborate with optometry?
- Are there other areas that optometrists could add value in other care settings, with additional training, if necessary, for example as diabetes educators or in delivery of NDIS supports for people with low vision?

Have your say: Consultation Questions

Q37: Which supports and/or enablers would most advance optometry and create new career opportunities for optometrists, and why?

Q38: What should Optometry Australia prioritise in Year 1, and why?

Q39: Is there anything important missing from the enablers listed above, and if so, what?

Q40: Do you have any other feedback on the enablers above?

Part 4 — Next Steps

From consultation to a workforce action plan

Feedback from this paper and its accompanying consultation will directly inform Optometry Australia's Workforce Plan and a first-year implementation roadmap, covering advocacy, policy, partnerships, workforce development, CPD and professional support.

Proposed Timeline

Stage	Activity	Timing
1	OA Member consultation open	2 November 2026
2	Stakeholder consultation open	9 November 2026
3	Consultation closes	18 December 2026
4	Analysis	March 2027
5	Workforce Plan and Year 1 roadmap published	April 2027

The consultation can be accessed at: https://www.optometry.org.au/advocacy/optometry-workforce-consultation/

Submissions close 18 December 2026.

We encourage all members and stakeholders to take part.

Appendix 1 — Proposed Special Interest Area- Full Definitions

These definitions are drafts for consultation (see questions 24-25). Each describes the additional knowledge and skills expected beyond generalist practice. Feedback is also welcome on the proposed wording of the definitions, please note the special interest area your feedback relates to, your proposed change to the wording and why.

Clinical special interest areas

Area	Sydney
Glaucoma	Encompasses developing focused knowledge, skills and experience in glaucoma care beyond that routinely applied in general optometric practice to provide timely, evidence-based, collaborative and patient-centred glaucoma care. Including diagnosis, management and formalised collaborative care when appropriate for routine, advanced and secondary glaucomas as well as pre-and post-operative procedural care and management. It may also include evolving areas of practice such as polygenic risk scores and other diagnostic and management advances. A practitioner would develop and maintain expert knowledge, evidence based and practical application of glaucoma: • pathophysiology, • detection, • diagnosis, • imaging interpretation, • risk assessment, • monitoring, • formalised collaborative, and independent management and indications for and pre and postoperative care of procedural management. They may also contribute to glaucoma research or education initiatives and writing for publication.
AMD and retinal disease	Encompasses developing focused knowledge, skills and experience in macular and other retinal disease diagnosis and management beyond that routinely applied in general optometric practice to provide timely, evidence-based, collaborative and patient-centred care. This would include diagnosis, management and formalised collaborative care when appropriate for advanced, atypical, complex and rarer presentations of retinal diseases and disorders as well as pre-and post-operative surgical care and management. Those with a Special interest in AMD and retinal disease would operate as an intermediate tier-care

	practitioner providing clinical management of suitable patients or work within, or for, an ophthalmology practice as a part of an integrated model of care. They may also undertake research or scholarship especially in clinical contexts and/or demonstrate a commitment to clinical audit or practice review.
Cataract and refractive surgery	Encompasses developing evidence-based skills and experience beyond that routinely applied in general optometric practice to provide timely, evidence-based, collaborative and patient-centred care. This would involve detailed knowledge and practical application regarding: Expert pre-operative assessment and management incorporating comorbidity screening and diagnosis, medication audit, and comprehensive ocular and visual function assessment. Comprehensive post-operative care that ensures the early detection and treatment of complications and side effects, including the development of formalised co-management protocols. Facilitation of complex, sensitive and high-stakes communication with patients, families and interprofessional teams. Clinical audit and practice review of surgical outcomes to inform continuous improvement of cataract and refractive surgical outcomes. Contribution to the improvement of health service delivery in teams, organisations and systems. Maintain and demonstrate this focus through ongoing specific education, clinical practice as well as mentoring of other optometrists. They must demonstrate clear knowledge and skill in identifying and acting appropriately where presentations are outside scope of practice (i.e. post-operative complications requiring tertiary care) specifically for patients who require urgent action
Diabetes	Encompasses evidence-based diagnosis and management of diabetic eye disease, including more complex retinal cases that can be monitored without ophthalmic intervention. Practitioners with a special interest in diabetes would practice within their defined scope and expertise, towards the full extent of the role that may have traditionally been performed by other health practitioners (e.g. ophthalmologists) with patients. They would recognise and manage anterior and posterior segment changes associated with diabetic eye disease in complex clinical scenarios where patient presentations are unclear or equivocal.

Anterior eye and advanced contact lenses	Encompasses advanced expertise in the evidence-based diagnosis and management of anterior eye disease, ocular surface disorders, and/or complex ocular presentations requiring specialised therapeutic and/or contact lens solutions; proficiency in anterior segment imaging and a comprehensive understanding of the factors influencing ocular surface health, comfort, visual performance, refraction, optics and higher-order aberrations to optimise clinical outcomes. This may involve detailed knowledge and practical application regarding: Advanced fitting of special purpose soft and RGP lenses e.g. scleral, keratoconic, orthokeratology, and prosthetics. Advanced dry eye management therapies Diagnosis and management of complex presentations of the lids and adnexa, lacrimal system, conjunctiva, cornea, and iris. They may also participate in teaching, or research associated with anterior eye disorders or advanced contact lens fitting.
Low vision	Encompasses developing evidence-based skills and experience beyond that routinely applied in general optometric practice to provide timely, evidence-based, collaborative and patient-centred care to patients with vision loss. This would include detailed knowledge of and/or the ability to perform or utilise: A detailed low vision history and quality of life assessment. Select and apply appropriate examination techniques to determine appropriate magnification requirements The full range of low vision optical magnification devices. Detailed knowledge of assistive technology options Demonstrate advanced capabilities in developing collaborative goals for patients with low vision that relate to the presenting condition and address the impact of the condition on the patient's ability to pursue life goals and purpose. Understanding, and the collaborative management, of orientation and mobility pathways to manage the social and mental health impacts of vision loss. A detailed understanding of stakeholders to ensure appropriate collaborative management.
Occupational optometry	Encompasses expertise in the assessment and management of vision as it relates to occupational, vocational, driving and recreational activities; evidence-based assessment of visual function (e.g. visual acuity, contrast sensitivity, binocularity, visual fields, colour vision) and ocular health,

	relevant to task performance and safety, to determine and management of visual performance, ocular health and fitness for occupational requirements to work, drive and/or undertake recreational activities. Expertise in prescribing tailored customised optical, visual, ergonomic, and environmental solutions to meet occupational or vocational demands and optimise visual performance in these settings, support workplace participation, and mitigate vision-related risks; in-depth knowledge of occupation- and recreation-specific vision standards, visual demands, and the effects of vision impairment on workplace safety; supporting individuals and employers to enhance visual outcomes, workplace safety and operational effectiveness. Ability to provide vision screening programs and surveillance programs, occupational and vision assessments across industries (e.g. transport, aviation, rail, emergency services, defence), visual solutions, and clear evidence-based reporting for employers and regulatory bodies specific workplace situations. Expertise in functional vision assessment and risk evaluation.
Paediatrics	Encompasses infant and paediatric vision assessment, including diagnostically challenging presentations, complex binocular vision and accommodative dysfunction and management, amblyopia and strabismus, rapid progressive or treatment resistant myopia, and assessment and referral of diagnostically challenging paediatric ocular and visual disorders, including formalised collaborative care when appropriate.

Non-clinical special interest areas

Area	Proposed definition
Academic and research	Encompasses contributing significantly to one or more areas of basic, clinical or translational research. Demonstrating the influence of their work on others, as well as the stimulation of new avenues of research, novel ideas or unexpected relationships that have resulted from their work. This would include: • Presenting scholarly work at seminars and conferences. • Informing and promoting communication to organisations and health providers regarding research findings • Engaging stakeholders in collaboration to enhance knowledge translation of research outcomes impacting professional practice. This would require a sustained period, typically at least five years, of active engagement in a specified area of research or scholarship. Evidence of this engagement would include applying research principles and scholarly inquiry to support scholarly investigation, contribute to the dissemination of

	research findings within the area of practice, and actively foster participation in research, service evaluation, and audit activities. Ongoing engagement in research would be expected including within areas of specialist knowledge, with a demonstrated commitment to continuing scholarly activity. Sustained and active involvement would generally be evidenced by a minimum of 10 research articles published in leading peer-reviewed optometry, vision science, or related journals, with authorship as first, last, or corresponding author. Such contributions should reflect a consistent record of advancing knowledge, disseminate research findings, and support evidence-based practice within the profession. An Optometry Educator would demonstrate a sustained commitment to the education and development of optometry students, early-career optometrists, and other health professionals. This may be through an academic appointment at a university and/or the provision of significant clinical supervision, mentoring, curriculum development, assessment, or educational leadership. While active involvement in research is not required, contributions should reflect a substantial and ongoing impact on optometric education and workforce capability.
Leadership and governance	Encompasses an in-depth understanding of leadership, management, and clinical governance, including the systems, processes, and accountability mechanisms that support safe, high-quality patient care. This would include detailed knowledge and/or the ability to apply principles of clinical governance, quality and safety, risk management, health system performance, workforce and team management, project and change management, funding arrangements and financial governance, team culture and development, and other evidence-informed approaches that support continuous improvement in patient outcomes and service delivery. This knowledge would be coupled with generalist optometry skills to lead teams and the delivery of eye care and other health services.
Digital health and AI	Encompasses in-depth understanding of digital technologies, their development, deployment and their implications for patient care. This would include detailed knowledge and/or the ability to perform or utilise: health informatics, information technology, project management and change management, application of technologies into health systems and services, governance and technical standards, legislation relating to digital technologies and other evidence-informed practice. This knowledge would be coupled with generalist optometry skills to support the adoption of digital technologies (including AI) in eye care and other health services.
Public health	Encompasses in-depth understanding of ophthalmic public health, epidemiology of ocular conditions and disease in the population, and programs to address ophthalmic public health issues that take account of

	the specific needs of priority populations at a local, national and international level. This would include detailed knowledge of: public health practices and evidence-based approaches, health systems and service delivery, program development and delivery, culturally safe consultation with consumers and priority populations, project management and change management, behavioural studies and research methods to inform public health approaches. This knowledge would be coupled with generalist optometry skills to advance public health, provide advice or deliver public health programs.
Practice ownership	Encompasses the significant responsibility for the operational management of optometric services, including legislative and regulatory compliance, human resource management, workforce obligations, workplace health and safety, risk management, and the implementation of policies and procedures required for the delivery of safe, compliant, and sustainable eye care services. Contributions should also demonstrate the application of best practice business governance, including effective financial management, strategic planning, quality assurance, and organisational oversight that supports high-quality patient care and long-term practice sustainability. This knowledge would be coupled with generalist optometry skills to lead a practice team and the delivery of community optometry services.

References and Source Evidence

This paper synthesises the following primary sources, alongside Optometry Australia's established workforce program of work (Optometry 2040, Working Together Better, Optometry 2040 Revisited and national workforce projections):

Anstice, N., Trinh, M., Cheung, R., Dowdall, R., & Lim, V. (2025). Working conditions of employed optometrists: A workforce survey — plain-language summary of preliminary results, 14 February 2025.

Cheung, R., Trinh, M., Lim, V., Dowdall, R., & Anstice, N. (2026). Working Conditions of Employee Optometrists in Australia. Ophthalmic and Physiological Optics, 46, 285–295. https://doi.org/10.1007/s44402-026-00050-2. (Open access, CC BY 4.0.)

Australian Bureau of Statistics. National, state and territory population. https://www.abs.gov.au/statistics/people/population/population-clock-pyramid

Grattan Institute (2022). Special treatment: improving Australians' access to specialist care. https://grattan.edu.au/report/special-treatment-improving-australians-access-to-specialist-care/

Optometry Australia. Jacqueline Warren: making significant strides in optometry and collaborative eye care. https://www.optometry.org.au/advocacy_government/jacqueline-warren-making-significant-strides-in-optometry-and-collaborative-eye-care/

Optometry Australia (2019). New MBS book for optometrists shows increased Medicare rebates. https://www.optometry.org.au/workplace/new-mbs-book-for-optometrists-shows-increased-medicare-rebates/

Full citations for the underlying statistics are available in the source documents listed above and their published reference lists.