Position Statement on Prescribing of Medicines by Optometrists

Endorsed May 2024

Purpose and Scope

This position statement has been developed by Optometry Australia (OA) to outline OA's position on the prescribing of medicines by optometrists.

OA is dedicated to the continuous evolution of the profession of optometry, improved community eyecare, and a sustainable healthcare system. Acknowledging international evidence, OA advocates for a change to the current medicine prescribing regulations for optometrists to enable prescription of any medication that is for the purpose of practising optometry and is in the best interests of the patient.

Optometry Australia's Position

OA believes that:

- To ensure the eyecare needs of the population are met safely and efficiently in a strained health care system, the clinical scope of optometrists in Australia must expand.
- Optometrists should be able to prescribe medicines for the purpose of practising optometry.
- Oral prescribing by optometrists would significantly benefit patients and the community.
- International evidence clearly indicates that expanded prescribing by optometrists is effective and safe.
- Oral and topical prescribing are within the current level of training and knowledge of therapeutically qualified Australian optometrists, in alignment with their New Zealand colleagues.
- National, state and territory laws and regulations should support contemporary practice. Importantly, relevant regulations should allow therapeutically endorsed optometrists to prescribe medications for the purpose of practising optometry, rather than listing specific medications considered to be in scope. This would significantly reduce unnecessary delays and barriers in allowing therapeutically endorsed optometrists to prescribe the most effective, up-to-date medications for the purpose of the practice of optometry.

Context:

Australia's approximately 7,000 optometrists provide around eleven million eye exams per year [1, 2]. Around 76% of the profession are endorsed to prescribe scheduled medicines. It has been found that a higher scope of practice in optometry is correlated with lower levels of vision impairment and blindness [3].

OA's *Optometry 2040* report highlighted that the profession in Australia must change and adapt to provide broad, timely access to quality, efficient eye care [4]. Evolution in optometrists' scope of practice was recognised as a key enabler of positive eye care outcomes for Australians in a changing health landscape. Accordingly, OA has requested that the Optometry Board of Australia review and contemporise the Guidelines for the Use of Scheduled Medicines, to enable therapeutically endorsed optometrists to prescribe medications for the purpose of practising optometry.

The Federal Government's Scope of Practice Review- *Unleashing the Potential of our Health Workforce* has acknowledged that there is "strong evidence of improved consumer access to care, consumer experience of care and health outcomes when health professionals are enabled to work to full scope of practice" [5]In its submission to this review, OA has emphasised the need for greater

consistency in the Drugs and Poisons legislation of the states and territories [6]. Differing legislation means that Australian optometrists are unable to provide the same level of care across the country, despite having equivalent qualifications. It is imperative that all optometrists across Australia can prescribe medicines within their scope of expertise regardless of their state or territory of practice. This will ensure consistency within the profession and equality in access to care for patients.

Oral Prescribing by Optometrists in Comparative Countries

Optometrists in Australia currently face significantly more limitations to their scope of practice than their counterparts with similar training in other countries. In contrast to Australian optometrists, overseas colleagues with similar training and expertise have been prescribing oral medication for many years: this includes the United Kingdom (UK) (since 2008), New Zealand (since 2014) and the United States (US) (in all 50 states, the first of which commenced oral prescribing in 1977) [7-9].

Restrictions on prescribing by optometrists in Australia are especially incongruous with New Zealand, despite a long-standing acknowledgement of the alignment in training, expertise and knowledge in the profession across these two countries. *The Trans-Tasman Mutual Recognition Act 1997* ensures that Australian registered optometrists are recognised and can apply for registration in New Zealand, and vice versa [10]. As 'authorised prescribers', alongside midwives, nurse practitioners, and medical practitioners, optometrists in New Zealand have been able to prescribe oral medications since 2014, with regulatory freedom to prescribe within the scope of practice of optometry, as defined by the Optometrists and Dispensing Opticians Board (ODOB) of New Zealand [11]. As of 31 March 2023, there were 1050 registered optometrists in New Zealand, of which 910 were practising, with 788 (78% of practising optometrists) endorsed to prescribe medications (including oral medications) [12]. In fact, the paradigm in New Zealand has shifted to therapeutic optometrists being seen as the norm, and those who are not therapeutically qualified having a restriction noted on their registration. Apart from this decade-long discrepancy in therapeutic scope, all other aspects of the scope of practice of optometrists in New Zealand are comparable with Australia.

Between 2014-2019, oral medications represented 3% (n = 4,314) of all prescriptions by optometrists in New Zealand; however, this percentage has been increasing consistently, reaching 4.4% between 2022 and 2024 [8]. Of New Zealand's authorised optometry prescribers, 53% had prescribed at least one oral medication in 2019, with a mean number of oral medication prescriptions per therapeutically endorsed optometrist of 12.4 [8]. Over the past few years, the breadth of prescribing in New Zealand has widened significantly. An increase in documented medicines prescribed by optometrists from 24 to 100 reflects growing confidence since the expansion of therapeutic scope [12].

Provided that the condition is within the optometrist's scope of practice and expertise, appropriately trained 'independent prescribing optometrists' in the UK have been able to prescribe any drug listed in the British National Formulary for any condition of the eye and adnexa, be it topical or oral, since legislation was enacted in 2008 [13, 14]. With reliance on clinical guidelines and competencies, and trusting that optometrists know their limitations, the General Optical Council (GOC) scope of practice definition is broad. There were over 1344 independent prescriber optometrists in the UK in 2022, representing about a 60% increase since 2018 [15].

Optometrists in many states of the US have a scope of practice that extends far beyond ours in Australia. Notably, optometrists can prescribe oral therapeutics in all 50 states, with significant variation existing between state lines with regards to breadth of allowed medicines [16]. It is estimated that around 99% of qualified US optometrists can prescribe oral therapeutics, with only a minority of those practitioners who completed their training many years ago not embracing this scope. The most commonly prescribed oral medicines include antibiotic and antiviral medicines, with oral steroids and acetazolamide being prescribed judiciously and sparingly. Oral prescribing, along with other scope expansion in the US, has been acknowledged as a key to meeting increased need for medical eye care [17]. There have been no patient complaints regarding oral prescribing by optometrists in the US.

Evidence Base for the Safety of Optometrists Prescribing Oral Medications

There is strong evidence that optometrists in other jurisdictions across the world prescribe oral medications within their scope and without adverse events. Instances of malpractice litigation are often utilised to assess the safety of a profession in the provision of specific care. Incidences of reported negligence have not increased in overseas countries with expanded scope of therapeutic practice in optometry, nor has oral prescribing resulted in increased indemnity premiums. In the UK, major providers of professional indemnity cover make no distinction in risk for qualified independent prescriber optometrists, while in the US, already infrequent malpractice rates have not increased in states with expanded scope over a two-decade period compared to their counterparts in other states with restricted scope of practice [17, 18]. With just 42 malpractice payments per year between 2000 and 2020, and the US Bureau of Labor Statistics indicating there are 43,400 practicing optometrists, the estimated annual risk of a malpractice payment per optometrist has been found to be consistently less than 0.1% [19, 20]. This is the case even though optometrists in the US have the most expansive scope of practice in the world and have done so for the longest period.

Australian and New Zealand optometrists have similar levels of reported professional notifications. Such notifications remain very low compared with other registered health care professions. As of 30 June 2023, 0.8% of Australian registered optometrists were the subject of a notification, with the optometry profession accounting for less than 0.3% of all health practitioner notifications [21]. Similarly, less than 1% of New Zealand practising optometrists were the subject of a notification as of 31 March 2023 [12]. There have been **no complaints, notifications, or evidence of harm related to prescribing in New Zealand** since changes in legislation which allowed for prescribing within scope, including oral therapeutics [8, 12, 22]. This is also true of prescribing by optometrists **in the UK, where no incidences of adverse effects or complaints have been made in relation to oral prescribing** [13, 23].

In New Zealand, the latest prescribing figures demonstrate that optometrists primarily use oral medicines to treat chronic ocular surface disease, herpes simplex keratitis, lid swelling, ocular allergy and inflammation, and angle closure glaucoma, where appropriate and indicated. This is clearly exemplified by the fact that antibiotics (60%), antihistamines (8.3%) and antivirals (7.4%) were the most prescribed oral medications by optometrists in New Zealand from 2014- 2019, and that acetazolamide accounted for a small minority of prescriptions only [8].

The indications for, and clinical approach to, common ocular conditions requiring oral medications are clearly outlined in the comprehensive and well researched ODOB Oral Medicine Guidelines [24]. Of note is the New Zealand recommendation that optometrists prescribe oral acetazolamide for angle closure “at initial presentation, if it is going to take more than 1 to 2 hours for the patient to receive ophthalmological care’ [25]. The ODOB closely monitor each medicine prescribed by optometrists in New Zealand, to ensure alignment with scope and clinical evidence. All cases of oral prescribing by New Zealand optometrists were found to be accurate in such ongoing data analysis, exemplifying that optometrists prescribe confidently and appropriately within scope [12].

Broader Implications

Access to Care

Numerous reports over the past decade have highlighted the need to improve access to eye health care services, systems and standards of care [26, 27]. Despite this, studies continue to indicate that there is still significant improvement to be made, especially for First Nations and remote populations [28, 29]. Coping with the eye care demands of an aging population in Australia, as well as challenges in rural and remote care provision requires a multidisciplinary approach to health care, and this approach is strongly favoured by the Australian Government [30]. The authority for optometrists to prescribe oral medications would contribute to meeting these targeted areas of action.

For Australian patients, treatment of common ocular conditions requiring oral medicines currently requires care from a second practitioner (GP or ophthalmologist). This need to consult a second practitioner can result in delays to treatment and an increased cost to the patient and health system.

This can be particularly problematic when urgent ocular care is needed in a rural or remote setting or where lengthy waits to see GPs or ophthalmologists limit or disincentivise access to care [31, 32].

Quality of Care

Overseas models of eye health care have demonstrated that enhanced patient care and improved outcomes are achieved through optometrists practising to their full scope, including the use of oral therapeutics [33, 34]. Patient perception is a crucial consideration in non-medical practitioner prescribing. Generally, patients perceive non-medical practitioner prescribing in a positive light, with regard to knowledge, safety, accessibility, timeliness, and convenience [33, 35]. Allied health practitioners have been found to prescribe with accuracy, while delivering comparable patient compliance, satisfaction and quality of life to medical practitioners [36].

Advancement of optometrist scope overseas has encouraged progressive post-graduate clinical education, increased public awareness of optometrists' abilities, and optimised utility of the workforce [33]. Following changes to optometry legislation in other countries, expanded scope has become accepted as an imperative part of primary care [22, 34, 37].

Legislation

The process of allowing optometrists to prescribe medications for the purpose of practising optometry begins with an assessment by the Optometry Board of Australia. OA supports the timely progression of this assessment and the provision of advice to the Federal and State and Territory Health Ministers.

State and territory alignment with changes to the Guidelines in relation to the prescribing of scheduled medicines by optometrists is imperative. Incongruous changes to prescribing legislation, both within Australia and overseas, have resulted in inconsistencies within the profession, and inequitable access to eye care for patients [27, 29]. OA is committed to working with the States and Territories to ensure there is a streamlined and consistent approach across the jurisdictions.

Conclusion

Optometrists in Australia, unlike many of their overseas colleagues, face various regulatory barriers to maximising the utilisation of their professional skills and qualifications. These barriers can prevent optometrists from providing comprehensive treatment and support to their patients and make it more difficult to work collaboratively with other health professionals managing chronic eye health conditions.

Advances in scope would benefit the health and safety of patients, bring improvements in efficiency and access to eyecare services, and ensure that the increasing supply in optometrists can be best utilised to meet healthcare needs. OA welcomes therapeutically endorsed optometrists being able to prescribe medicines for the purpose of practising optometry.

Contact details:

Skye Cappuccio
Chief Executive Officer
Optometry Australia
s.cappuccio@optometry.org.au

Nicola Mountford
Optometry Advancement Advisor
Optometry Australia
n.mountford@optometry.org.a

Revised February 2025.

References

1. AHPRA. *Optometry Board. Registration Data Table- 31 December 2023*. 2023 [cited 2024 May]; Available from: https://www.optometryboard.gov.au/About/Statistics.aspx.
2. Australian Government. *Services Australia - Medicare Item Reports*. MBS Item Statistic Reports; Available from: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp.
3. Shneor, E., Isaacson, M. and A. Gordon-Shaag 2021., *The number of optometrists is inversely correlated with blindness in OECD countries.* Ophthalmic Physiological Optics, 2021. **41**(1): p. 198-201.
4. *Optometry Australia. Optometry 2040, Taking control of our future*. 2018; Available from: https://www.optometry.org.au/wp-content/uploads/optometry_2040_-_key_findings__priority_commitments.pdf.
5. *Scope of Practice Review. Unleashing the Potential of our Health Workforce.* . Available from: https://www.health.gov.au/sites/default/files/2024-01/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-issues-paper-1.pdf.
6. *Unleashing the Potential of our Health Workforce Review (Scope of Practice Review). Feedback on the Terms of Reference Paper from Optometry Australia*. 2023 May 2024]; Available from: https://www.optometry.org.au/wp-content/uploads/Policy/Submissions/20231016_Sub_Scope-of-Practice-Review_FINAL.pdf.
7. Needle, J.J., R. Petchey, and J.G. Lawrenson, *A survey of the scope of therapeutic practice by UK optometrists and their attitudes to an extended prescribing role.* Ophthalmic Physiol Opt, 2008. **28**(3): p. 193-203.
8. Turnbull, P.R. and J.P. Craig, *Oral medication prescribing by optometrists in New Zealand.* Clin Exp Optom, 2021. **104**(3): p. 425-427.
9. Cooper, S.L., *1971 - 2011: Forty year history of scope expansion into medical eye care.* Optometry, 2012. **83**(2): p. 64-73.
10. Office of Parliamentary Counsel, C. *Trans-Tasman Mutual Recognition Act No. 190, 1997. Compilation No.23*. 1997; Available from: https://www.legislation.gov.au/C2004A05284/2020-09-18/text.
11. Black, J.M., et al., *The changing scope of Optometry in New Zealand: historical perspectives, current practice and research advances.* Journal of the Royal Society of New Zealand, 2019. **49**(2): p. 188-204.
12. *Optometrists and Dispensing Opticians Board. Annual Report.* 2023 May 2024]; Available from: https://odob.health.nz/document/8128/ODOB%20Annual%20Report%202023%20(Final%20Online).pdf.
13. Rumney, N., *Optometry and independent prescribing.* Journal of Prescribing Practice, 2019. **1**: p. 87-92.
14. Lawrenson, J., *Legislation and the optometrists.* Optician, 2012. **26**.
15. *General Optical Council. Registrant Workforce and Perceptions Survey 2023. Research Report.* . July 2023 May 2024]; Available from: https://optical.org/media/5mbhq4tf/goc-registrant-workforce-and-perceptions-survey-2023-research-report.pdf.
16. Spiegle, L., *Optometric Scope: Breaking Down Barriers.* Review of Optometry, 2024(March).
17. Spiegle, L., *How Scope Expansion is Shaping Optometry's Future.* Review of Optometry, 2025.
18. Association of Optometrists. *Insurance*. Available from: https://www.aop.org.uk/advice-and-support/legal/insurance.
19. Duszak, R.S. and R. Duszak, *Malpractice payments by optometrists: An analysis of the national practitioner databank over 18 years.* Optometry - Journal of the American Optometric Association, 2011. **82**(1): p. 32-37.
20. Palmer, W., *Why Optometrists Get Sued and How to Reduce Your Risk of a Claim.* Berxi, 2024.
21. AHPRA. *Optometry Board. 2018/2019 Annual Summary*. 2023 [cited 2024 May]; Available from: https://www.optometryboard.gov.au/News/Annual-report/2018-19-annual-summary.aspx.
22. Turnbull, P., *Therapeutic prescriptions and optometry: Trends in New Zealand.* Optometry Connection, 2021(November).

23. *Optical Consumer Complaints Service. Forging the Future. Annual Report 2021-2022*. May 2024]; Available from: https://www.opticalcomplaints.co.uk/app/uploads/sites/2/2022/07/2021-22-Report-Forging-the-Future-.pdf.
24. *Optometrists and Dispensing Opticians Board (ODOB) New Zealand. Standards and Guidelines.* . 2017 May 2024]; Available from: https://www.odob.health.nz/site/standards-guidelines.
25. Optometrists and Dispensing Opticians Board, *Oral Medication Guidelines – Acute angle closure*. 2022.
26. *Optometry Australia submission to the Federal Budget 2021 – 2022. Better access to critical eye care.* . May 2024]; Available from: https://www.optometry.org.au/wp-content/uploads/OA-Federal-Budget-Submission-2021-2022_design_v2.pdf.
27. *Optometry Australia submission to the Federal Budget 2024-2025. Enhancing Patient Outcomes: A Collaborative Approach to Eye Care.* .
28. AIHW, *Australia Institute of Health and Welfare. 1.16 Eye Health. Indigenous HPF.* .
29. *Vision 2020 Australia. 2022-2023 Annual Report. Strategy in Action.* May 2024]; Available from: https://www.vision2020australia.org.au/wp-content/uploads/2023/11/V2020A-2022-23-Annual-Report-FINAL-compressed.pdf.
30. Poulos, R.G., et al., *Preparing for an aging Australia: The development of multidisciplinary core competencies for the Australian health and aged care workforce.* Gerontol Geriatr Educ, 2021. **42**(3): p. 399-422.
31. *Australian Medical Association (AMA). AMA plan for improving access to rural general practice.* . 2023 May 2025]; Available from: https://www.ama.com.au/sites/default/files/2023-09/ama-plan-for-improving-access-to-rural-general-practice.pdf.
32. Gardiner, F., et al., *Equitable Patient Access To Primary Healthcare In Australia*. 2020.
33. *Optometry's Essential and Expanding Role in Health Care: Assured Quality and Greater Access for Healthier Communities. Avalon Health Economics, commissioned by American Optometric Association*. 2019 May 2024]; Available from: https://www.aoa.org/AOA/Documents/Advocacy/state/Optometry's%20Essential%20and%20Expanding%20Role%20in%20Health%20Care-Final%20Report%20(002).pdf.
34. Konstantakopoulou, E., et al., *Clinical safety of a minor eye conditions scheme in England delivered by community optometrists.* BMJ Open Ophthalmology, 2018. **3**(1): p. e000125.
35. Creedon, R., et al., *The impact of nurse prescribing on the clinical setting.* British Journal of Nursing, 2015. **24**: p. 878-885.
36. Weeks, G., et al., *Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care.* Cochrane Database Syst Rev, 2016. **11**(11): p. Cd011227.
37. Gunn, P.J.G., et al., *Scope of practice of optometrists working in the UK Hospital Eye Service: Second national survey.* Ophthalmic & Physiological Optics, 2022 Feb 12. **42**(3).