

Unleashing the Potential of our Health Workforce Review (Scope of Practice Review)

Feedback on the Terms of Reference Paper

from Optometry Australia

About Optometry

Optometry Australia is the national peak body representing Australia's 6,700 registered optometrists. Optometrists have access to Medicare and undertake more than 10 million eye examinations annually, as well as being integrally involved in the diagnosis and management of chronic eye health conditions such as glaucoma, cataract, macular degeneration, and diabetic retinopathy.

As the first port for 80% of people in relation to ocular health and often identifying eye disease in asymptomatic patients, optometrists are an integral part of Australia's primary health care system. Optometrists work closely with other health professionals, particularly general practitioners and ophthalmologists. Patient referrals and diagnostic results are key elements of optometry practice, which occurs in the community, hospitals and specialist clinics, residential aged care, and remote First Nations communities.

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Optometry and the Scope of Practice Review

Optometry Australia strongly supports the Scope of Practice Review, which is of vital interest to the optometrist profession.

The scope of practice of optometrists in Australia is more limited than in comparable countries like New Zealand, the United Kingdom, the United States and Canada. Differences in scope between Australia and New Zealand, including in relation to oral prescribing¹, are noteworthy as they mean that Australian optometrists with equivalent qualifications that are duly recognised in New Zealand are unable to practise in Australia to the same scope as their counterparts across the Tasman.

Optometrists face various funding, regulatory, technological, cultural, and inter-professional 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.

¹ In 2014, the New Zealand Medicines Act was amended giving optometrist the status of authorised prescribers. Registered optometrists with therapeutic accreditation were able to prescribe any medication within the scope of practice of optometry as defined by the Optometrists and Dispensing Opticians Board. In Australia, optometrists are currently not able to prescribe oral medications.

Despite these hurdles, optometrists have demonstrated their willingness to embrace enhancements to their scope of practice² and an ability to develop innovative models of collaborative care³ to address unmet eye health needs, including in disadvantaged rural and remote communities.

- More than two-thirds of registered optometrists are therapeutically endorsed to prescribe topical scheduled medicines for the treatment of eye conditions.
- A significant proportion of optometry practices make use of advanced 3D imaging technologies like optical coherence tomography, and increasingly share imaging results digitally with other health professionals.
- During the COVID pandemic, optometrists embraced telehealth which is becoming more integrated into collaborative eye care, particularly in rural and remote communities, as well as electronic prescribing.
- Optometry is embracing artificial intelligence, with AI around diagnostic imaging used to help detect eye conditions such as diabetic retinopathy and age-related macular degeneration.
- Around Australia, optometrists are working with ophthalmologists and other health professionals developing and implementing collaborative models of care to treat and manage patients with a range of chronic eye health conditions, including glaucoma, cataract, age-related macular degeneration, diabetic retinopathy, and pediatric eye conditions. These collaborative care models are successfully operating in the community, in public and private hospital settings, and in some of the most remote and disadvantaged communities with the assistance of telehealth.⁴

Structural and systemic impediments

One of the challenges for optometrists and their professional organisations (such as Optometry Australia and State Optometry bodies) is being able to scale successful collaborative care initiatives in the mainstream health system. Despite clear evidence that traditional models of eye care are not meeting patient demand and that collaborative approaches are more effective for patients and health care providers, efforts to diffuse these collaborative approaches more broadly in the health system are frequently stymied by funding, regulatory and decision-making barriers. As a result, the opportunity for optometrists to practise to their full scope as qualified eye health professionals in multidisciplinary teams managing patients with a range of chronic eye health conditions remains confined to a relatively small number of geographic locations and care settings.

Optometry Australia believes it is vital that the Scope of Practice Review recommends meaningful changes which will have an ongoing beneficial impact on patient outcomes and the overall productivity of the health system. To do this effectively, Optometry Australia encourages the Review to focus on the structural and systemic impediments that are holding back the broader rollout of innovative models of multidisciplinary care where health professionals practise to their full scope.

These structural and systemic impediments include:

- Incompatibilities between the Federal and State/Territory health systems (and between the public and private systems) in terms of funding and remuneration, regulatory requirements, clinical and organisational obligations, and access to and sharing of patient data.

² See Appendix One – Examples of Optometry Scope of Practice Enhancement.

³ See Appendix Two – Examples of Optometry’s Involvement in Collaborative Care.

⁴ Working Together for Better Eye Care provides a summary of a number of these collaborative care initiatives.

<https://www.optometry.org.au/wp-content/uploads/Working-Together-for-Better-Health-Care-update-16Aug2021-update.pdf>

- Discrepancies in the ability of various health professions to access MBS items even when they are performing the same clinical tasks.
- Traditional patient gatekeeper arrangements and referral pathways that engrain treatment siloes and prevent patients from having access to timely care.
- Disincentives to utilise the most affordable, cost-effective, and accessible care options.
- A failure to put the necessary policy, regulatory and funding enablers in place in a timely manner so health professionals can practice to their full scope, and successful models of multidisciplinary care can be implemented at scale in the health system.
- The lack of incentives to encourage health professionals to fully utilise available technologies to enhance patient access and enable multidisciplinary care.
- A longstanding aversion to change by policy makers, funders, service providers and clinicians, which is, in part, the result of an overstretched and underfunded system that is not able to provide the time or financial resources to develop new approaches.

The Final Report of the Strengthening Medicare Taskforce focussed on a number of these matters and pointed to the benefits for patients and the health system of health professionals being able to practice to their full scope. To a not insignificant extent, these benefits will come from unleashing the relatively untapped skills and expertise of allied health professionals and other non-medical health professionals. By way of example, optometrists practising to their full scope in multidisciplinary teams allows ophthalmologists to focus on utilising their highly specialised skills to the maximum benefit of patients whilst reducing hospital outpatient wait times and enabling treatment to occur in more cost-effective community settings. This example points to the benefits of the Review taking a broad approach to full scope of practice, which is not confined to general practice or primary care.

Specific Feedback

Optometry Australia believes the paper does a good job outlining the objectives, principles, focus areas, phases of work, deliverables, and anticipated timeframes. We wish to make a number of specific comments that might assist the reviewers in considering their approach to the Review:

1. There would be value in undertaking a detailed comparison of the current scope of practice of individual health professions in Australia and in other countries with similar health systems, identifying possible scope enhancements from other countries that could benefit patients and the overall productivity of Australia's health system.
2. It is important that the Review not only considers how to enable general practitioners and allied health professional to practice to their full scope. It is equally important that medical specialists are practising to their full scope, rather than undertaking tasks that can and should be undertaken by non-specialists. The starting point should be that all health professionals are practising to full scope for the benefit of patients and the health system.
3. While having health professionals practising to their full scope will benefit the primary care system, there are also significant benefits for hospitals, both in terms of the more efficient allocation of finite hospital resources and a greater diversion of hospital-based patient care into less resource intensive community settings. These benefits should be considered by the Review.

4. Optometry Australia supports the Review's strong focus on multidisciplinary team-based care but it is also important that all health professionals are able to practise to their full scope as individual providers of health care to their patients.
5. The paper refers to the Review examining specific examples where key funding mechanisms support or inhibit working to full scope of practice. These specific examples should include the incompatibilities between Federal (Medicare) and State and Territory (hospital) funding arrangements, which can inhibit community-based health professionals from practising to their full scope, providing care to patients with hospital referrals. In a similar vein, funding incentives in the private health system can discourage minor medical procedures from being undertaken in a non-hospital setting. Devolution of hospital funding approaches to the local health area level can also inhibit the scaling of innovative models of care. All these funding mechanisms are potential impediments to full scope of practice and should be considered by the Review.
6. Optometry Australia supports the establishment of an expert advisory committee to support the Review. It is important that the membership of the expert advisory committee is representative of the breadth of health professionals, including allied health professionals and non-medical primary health care professionals, whose scope of practice is being considered by the Review.
7. In terms of lessons learned and areas of future opportunity, the paper states that the Review will consider innovative practices in rural and remote contexts. Optometry Australia strongly supports this element of the Review. In eye health, some of the most innovative approaches are in rural and remote locations, including the Pilbara in Western Australia, where optometrists and ophthalmologists have development co-management models of care that are making a marked difference to the eye health of First Nations Peoples through a combination of practising to full scope and utilising digital technologies to enhance patient access and interprofessional collaboration.
8. The paper refers to preventative health and Optometry Australia supports the Review considering the undervalued preventative health role of health professionals as part of their scope of practice. This includes counselling patients about taking responsibility for their health care, encouraging check-ups, and screening, and disseminating public health messages. A practical example is general practitioners encouraging diabetes patients to have their eyes checked for diabetic eye disease by an optometrist on a regular basis.
9. The paper rightly identifies a range of funding, regulatory, educational, professional, and cultural impediments to full scope of practice. It is vital that the Review includes a thorough and objective analysis of these structural and systemic barriers and identifies effective ways to address them. The paper also refers to enablers and incentives, albeit with less detail, but it is no less important for the Review to identify the key enablers of full scope of practice and to recommend ways in which health professionals can be encouraged and rewarded for delivering improved health outcomes by practising at full scope in multidisciplinary teams.
10. The role of technology in the health system is rapidly evolving and it is important that the link between scope of practice and technology is an integral part of the Review. Advances in

data analytics and data sharing, remote health monitoring, advanced digital imaging, telehealth, and education and collaboration tools can enable health professionals to practise to full scope and may enhance scope. On the flip side, a lack of access to digital and other critical technologies will increasingly be seen as a barrier to the full participation of health professionals in the health system. Technologies like artificial intelligence, machine learning, robotics and genetic testing have the potential to fundamentally re-define scope of practice and to blur the lines between health professions. At the same time, advances in precision medicine are leading to greater levels of specialisation, with flow-on implications for the roles of health professionals more broadly. These issues should be considered by the Review.

Appendix One

EXAMPLES OF OPTOMETRY SCOPE OF PRACTICE ENHANCEMENT

Scope of Practice - Oral Therapeutic Prescribing

In all states and territories, endorsed optometrists can prescribe topical scheduled medicines for the treatment of eye conditions and diseases. About two-thirds of registered optometrists are endorsed, including all current and recent graduates. However, optometrists in Australia are not able to prescribe oral medications in stark contrast to similar countries where optometrists have been prescribing oral medication for many years: United Kingdom (since 2008), New Zealand (since 2014) and the United States (in 45 of 50 states).

In New Zealand (NZ), therapeutically endorsed optometrists can prescribe oral medications for eye conditions such as bacterial and viral infections, inflammatory conditions, and ocular allergies. Notably, optometrists trained in Australia in the use of topical medicines can gain registration in NZ automatically and prescribe oral medicines. Since 2014, the NZ Optometrists and Dispensing Opticians Board has found no evidence of optometrists over-prescribing or any adverse incidents.

It makes sense to allow therapeutically endorsed optometrists to prescribe oral medications for the purpose of the practice of optometry. Currently, optometry patients needing oral medications must be referred to a GP or ophthalmologist. The need to visit a second health practitioner for a simple prescription can mean additional patient cost as well as a loss of convenience. In some cases, patients will not access the oral medication, potentially putting their eye-health at risk. These issues are more pronounced for rural and remote patients where there are fewer GPs, longer wait times, a lack of after-hours services and challenges accessing specialist ophthalmology services.

Scope of Practice – Intravitreal Injections

Intravitreal injections have revolutionised the management of retinal disease, becoming the standard of care for neovascular age-related macular degeneration (AMD) and diabetic macular oedema (DMO). With an ageing population and the increasing prevalence of chronic eye disease, the number of patients requiring treatment via intravitreal injections is expected to continue increasing.

There are significant barriers to care, including geographic access, especially outside the metropolitan centres, and substantial out-of-pocket patient costs as most intravitreal injections are administered in the private system, with low rates of bulk-billing. As a result, the necessary numbers of injections that are required for effective treatment are not always administered.

In countries like the United Kingdom, the United States and New Zealand, non-ophthalmologists are played an enhanced role in enabling access to intravitreal injections, with high levels of patient satisfaction and increased throughput in retinal clinics. The Federal Government's MBS Taskforce Review has recommended a similar approach in Australia.

Enabling appropriately trained optometrists to have an enhanced role in treating patients requiring intravitreal injections would deliver real benefits to patients. This would particularly be the case in outer metropolitan areas and regional, rural and remote communities. Collaborative care models that build upon existing local inter-professional relationships – including between ophthalmologists and optometrists – should be developed, piloted, evaluated and rolled out more broadly. For example, there is a ready opportunity for optometrist to be more effectively utilised in treatment planning and implementation.

Appendix Two

EXAMPLES OF OPTOMETRY'S INVOLVEMENT IN COLLABORATIVE CARE

Case Study 1: Centre for Eye Health – Intermediate tier care model in NSW

Centre for Eye Health (CFEH) is a joint initiative between Guide Dogs NSW/ACT and the University of New South Wales (UNSW) with the goal of reducing preventable vision loss in the community. CFEH operates two physical clinics (UNSW and Parramatta) incorporating several models of care. All clinical services are provided at no charge to patients with consultations bulk billed if appropriate.

Intermediate Tier Care is the CFEH's primary care model. Optometrists refer patients to the Centre for assessment with the referred condition either managed within the Centre or a report detailing a recommended management plan is returned to the referring optometrist. In both scenarios, all other aspects of the eye care remain with the referring optometrist. Diagnostic and management reports are reviewed electronically by POWH consultant ophthalmologists as required.

CFEH operates a glaucoma management clinic as a branch of the POWH, with a glaucoma specialist consultant ophthalmologist on site once a fortnight. Glaucoma is diagnosed and managed for patients referred directly by community optometrists, internally by the CFEH, or from POWH. CFEH also provides public hospital triage and collaborative care from its Parramatta clinic which operates as one of the sites for the Community-Eye-Care program, while the UNSW Clinic operates a similar model of care whereby stable patients are transferred to CFEH for ongoing care.

An independent evaluation has showed that between 2017 and 2024, CFEH's model of care will have potentially saved 10,300 disability-adjusted life years (DALYs), the equivalent of 17,200 years of living with blindness. This equates to \$131m in social benefits and \$131m savings to the NSW Government.

Case Study 2: Queensland Children's Hospital Paediatric Optometry Alignment Program

The Paediatric Optometry Alignment Program provides community optometrists with the knowledge, skills, communications strategies, continuing education and resources to enable them to examine and treat children's eyes confidently. Optometrists who have completed the education program and meet other criteria are invited to align with the Qld Children's Hospital, enabling them to care for stable, discharged patients. They are supported by a direct line of communication with the hospital ophthalmology department, as well as events and newsletters to keep them updated on paediatric treatment and the program itself. The collaboration with aligned community optometrists helps manage the workload of the ophthalmology department ensuring only patients needing specialist ophthalmic care are required to attend the hospital.

Case Study 3: Lions Eye Institute, Lions Outback Vision in remote Western Australia

The Lions Outback Vision is part of the Lions Eye Institute in Western Australia and has been providing teleophthalmology services to rural and remote communities since 2011. The teleophthalmology services work with outreach ophthalmologist and optometrist clinics as well as local optometry practices. They connect patients in real time with optometrists and ophthalmologists, increasingly utilising eye imaging technologies such as Optical Coherence Tomography (OCT) to fast-track diagnoses and place patients on surgery waiting lists on a timely basis.

Three audits found that the Lions Outback Vision significantly increased the number of patient consultations performed with an increasing focus on chronic eye disease and significantly improved management of patients requiring surgery. Patient attendance rates increased markedly with no reduction in the accuracy of diagnoses.

To enhance the program, the North-West Hub has been funded by the WA Government to enable delivery of ophthalmology and optometry services through a hub based in Broome with telehealth enabled outreach into multiple regional nodes. The Lions Outback Vision is supported by two teleophthalmology MBS items, with the potential for further enhancements through the addition of new MBS items for short optometry consultations and the transfer of ophthalmologist reports to patients through participating optometrists.