PRIMARY eyecare

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Save Our Sight 2017 is now underway!

This year the New Zealand Association of Optometrists is again warning people with suspected eye disease to be careful they do not get 'blindsided'!

Our usual message to the public is about being sure that people have any change in vision investigated, so that any potentially blinding condition can be treated or managed early.
The intent is to increase the probability of them achieving a better outcome.

While the Save our Sight message remains the same, our concerns are highest for people with blinding conditions who have been referred into hospital eye departments but are not being followed up in a timely fashion.

A recent NZ Herald article reported that at the end of last year more than 20,000 New Zealanders were overdue for hospital eye appointments with almost 70 people who were already losing their vision finding their conditions worsening because of delays in getting treatment.

One unfortunate person referred to the Waikato DHB with neovascular glaucoma went from being able to see a couple of metres to only seeing hand movements because they waited six months for a follow-up appointment.

This news will come as no surprise to the many GPs and optometrists around the country who have patients languishing on waiting lists for DHB eye department appointments and follow-ups. But the scale of the problem is overwhelming.

A league table published by the Herald last month made shocking reading:

League Table of Patients Over-due for Recall	
Counties Manukau	5649
Auckland and Waitemata	4807
Southern	3709
Canterbury	2773
Waikato	1720
Nelson Marlborough	839
Hutt Valley	398
MidCentral	239
Northland	209

A spokeswoman for the Royal Australian and New Zealand College of Ophthalmologists told the Herald there was concern about any patient having to wait too long for eye care appointments.

> " more than 20,000 New Zealanders were overdue for hospital eye appointments "

Save Our Sight Brochure

Association of Salaried Medical Specialists Executive Director Ian Powell was reported as saying it was a huge concern so many patients were overdue for appointments.

The New Zealand Association of Optometrists is concerned as well. The problem of delays is said to be due to a national shortage of ophthalmologists which makes it difficult for DHBs to keep up with the growing demand.

The same problem was highlighted back in 2010 when the Ministry of Health released a report on the national Eye Service Review.

One of the key workforce issues identified by the review group is that community optometrists could be better utilised in the assessment, treatment and management of eye health care within the wider eye health team particularly with the shortage of ophthalmologists.

Then as now there is an urgent need to change the way that eye health services are delivered and this means primary care practitioners (Optometrists and GP's) must be supported to manage eye health care in the community.

There is a need to reduce reliance on the specialist workforce to provide all eye services; there is a need to avoid duplication of services that are readily available in the community. Optometrists and GPs could be utilised better together to ensure that DHBs fund primary care at a realistic level so capacity to reduce the burden on hospital outpatient care is ensured.

But is this safe you might think? Surely referral to ophthalmology is better for the patient? Maybe, but if the referred patient is not seen in a timely way, and if their condition worsens unnecessarily due to delays in the hospital system then perhaps not.

Let's look at the facts:

In New Zealand optometrists complete 5 years of ophthalmic education at the University of Auckland. The School of Optometry is part of the Faculty of Medicine and Health Sciences. Optometry students complete their first year in the common health program with peers who apply to enter dentistry, pharmacy, medicine, or optometry (and other health related programs). Traditionally optometrist students have had to get a minimum GPA of xxx to be considered for entry to the optometry course.

Since 2006 optometrists have graduated with the right to prescribe medicines for treatment of eye disease. Since 2014 optometrists are included within the Medicines Act definition of 'Authorised Prescriber' along with medical practitioners and nurse practitioners. Optometrist authorised prescribers can also issue standing orders, just like medical practioners and, like all authorised prescribers, prescribe within their scope of practice. The Optometrists and Dispensing Opticians Board reports that at 31 March 2017 there were 486 optometrist authorised prescribers registered and practising in New Zealand.

What is the optometrist scope of practice?

An optometrist registered in the optometrist scope of practice provides evidence-based comprehensive eye health and vision care in a professional and ethical manner, in accordance with the HPCA Act.
The "practice of optometry" includes:

- Prescribing any ophthalmic appliance, optical appliance, or ophthalmic medical device intended for remedial or cosmetic purposes or for the correction of a defect of sight;
- **Assessing, diagnosing, treating and managing conditions affecting the eye and its appendages;**
- **Prescribing medicines whose sale and supply is restricted by law to prescription by authorised prescribers;**
- Reporting or giving advice in an ophthalmic capacity, using the knowledge, skills, attitudes and competence initially attained for the primary optometry qualification and built upon in postgraduate and continuing clinical education, wherever there could be an issue of patient health or wellbeing;
- Signing any certificate required for statutory purposes, such as driver licensing eyesight certificates; and
- Holding out to the public or representing in any manner that one is authorised to practise optometry in New Zealand.

The practice of optometry goes wider than clinical optometry, and includes teaching, research, optometric or eye health management, in hospitals, clinics, general optometric practices and community and institutional contexts, whether paid or voluntary.

Additionally, clinical practice is defined as any work undertaken by an optometrist that relates to the care of an individual patient. Non-clinical practice is defined as any work undertaken by an

optometrist that does not relate to the care of an individual patient.

But referral to the hospital means free services for the patient so isn't that better than referring to an optometrist?

Well for a few patients over the past year hospital care has been a free ticket to blindness. For others it has left them with low vision.

The truth is that some people have paid a high price for referral to a 'free' service.

Currently, 98% of optometrists are community-based, provide primary care that reduces the burden on secondary care, and in practical terms must be part of the workforce solution for public eye health services. In general, optometry practices are early adopters of technology and penetration of OCTs and other advanced imaging/ diagnostic technologies is advancing rapidly. This means that the ability to diagnose and manage eye patients in the community for longer before referral to secondary services will continue to increase and patients will be able to be discharged back to the community avoiding the risk of missed follow-up appointments.

As fellow community based health providers, who do charge patients a fee, general practitioners will appreciate that for some patients the need to pay is not an issue.

In any case, there is a cost to the DHB for providing eye health services in the hospital and perhaps there needs to be more thought given to that.

Imagine how much more efficient and cost-effective eye services could be if DHBs paid for patients to see an optometrist if referred by their GP.

No lengthy wait for an eye condition to have a first assessment; referral priority could be established before the patient is seen at the hospital; some patients could be treated without the need for a hospital appointment.

Why is the hospital eye department the only funded option for people with eye conditions?

Why is funding only available to the most costly option for providing services?

These choices do mean that the most clinically advanced conditions are afforded specialist care – that is a good thing – but what about the other people. Must they wait until they get so bad that their condition becomes urgent?

Surely we can do better than that.

Some eye health numbers to think about

Total number in the eye health workforce

Optometrist authorised prescribers 486
Ophthalmic nurse specialist 2 of 145 nurse practitioners
Ophthalmologists approximately 146

Distribution outside of Auckland

Optometrists authorised prescribers 271 of 486
Ophthalmic nurse specialist none of 1
Ophthalmologists approximately 100 of 146

Age

Optometrists 29% aged 50 or over
Nurses 45% aged 50 or over
Doctors 45% aged 50 or over

Overseas trained

Optometrists 13.5% (March 2017)
Nurses 26%
Doctors 43.6%

Primary care is a Ministry of Health strategic priority

* Face to face consultation time for patient with community optometrist typically 30-45 minutes
* Role of primary care in prevention or reversal of health loss caused by long-term conditions such as diabetes.
* The top four blinding conditions are diabetes, glaucoma, AMD, and cataract. Early diagnosis and intervention at an appropriate time are crucial to preventing blindness.

The HWNZ eye health workforce review report published in 2011 https://www.health.govt.nz/system/files/documents/pages/eye-health-review-may-2011.pdf included a recommendation for

"Better utilisation of optometrists in the assessment, treatment and management of patients with eye health care issues."

Most people have a high level of confidence in their GP to assist them with their healthcare issues, including eye care. General Practice is the health care home for most people.

It is where doctors manage systemic diseases that impact eye health and most doctors encourage patients to undergo periodic evaluation by an optometrist. For specific eye health issues. Because, while general practice serves as the access point into the healthcare system for many patients with eye problems, to investigate these problems sufficiently for a diagnosis needs optometry or ophthalmology training, resources, and time to perform all of the elements of the comprehensive eye examination.

In order for the goals of Save our Sight to be achieved it will be necessary for general practice and optometry to work together for our shared patients with sight threatening eye disease.

This year for Save our Sight we are asking doctors to think about their patients with diabetes—are they getting their annual screening on time and are you, their doctor, getting reports on the results; patients who might be at risk for age-related macular degeneration - are there any early signs that would suggest targeted use of AREDS supplementation; patients at risk of glaucoma - if over 45 are they having an eye examination as recommended by Glaucoma NZ?

There are many ways that your local optometrist can provide supportive eye care to your own patients and reports on eye health and vision can be requested easily by email or letter.

Please support Save our Sight this year by making sure your Mediboard has a good supply of Save our Sight brochures and if you don't subscribe to Mediboard please order a supply of free Save our Sight brochures from our National Office.

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