VISION 2020
THE RIGHT TO SIGHT
AUSTRALIA

# Eye Health and Vision Care Sector Response

to the Department of Health and Ageing's
*Implementation Plan for National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss Sector Consultation Report*

October 2013

National body working in partnership to prevent avoidable blindness and improve vision care

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# 1 Introduction

## Background

In July 2004 the Australian Health Ministers' Conference agreed on the need to develop a National Eye Health Plan for Australia to promote eye health and reduce the incidence of avoidable blindness. This initiative represents Australia's response to World Health Assembly resolution WHA56.26 on the elimination of avoidable blindness in member countries.

The *National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss* (National Framework) document sets out the proposed strategy for the promotion of eye health and the prevention of avoidable blindness. It was essentially a blueprint for nationally coordinated action by governments, health professionals, non-government organisations, industry and individuals to work in partnership.

The second progress report on the National Framework to Health Ministers was endorsed in December 2012 and the former Minister for Health and Ageing, gave authorisation for the Department of Health and Ageing (DoHA) to develop an implementation plan to underpin the Australian Government's eye health and vision care priority activities over the next three years (2014-16). Vision 2020 Australia's role was to coordinate input from the eye health sector to contribute to the development of the implementation plan.

In March 2013, the DoHA held an eye health and vision care sector consultation for feedback and input into the development of the National Framework Implementation Plan (NFIP). Vision 2020 Australia assisted in the organisation of this sector consultation.

In advance of the sector consultation, participants were provided with documents developed by Vision 2020 Australia which identified the context and purpose of the NFIP within the global and local context. The sector consultation focused on identifying the priorities for the NFIP to ensure that there is continued progress towards the elimination of avoidable blindness and reduced impact of vision loss.

DoHA produced a report after the sector consultation, *Implementation Plan for the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss - Sector Consultation Report* (Sector Consultation Report), outlining areas where the sector had broad agreement.

## Sector engagement

The Sector Consultation Report was circulated among the eye health and vision care sector and feedback was sought through the Vision 2020 Australia Committees:

- Prevention and Early Intervention Committee
- Low Vision and Rehabilitation Committee
- Aboriginal and Torres Strait Islander Committee

This response to the Sector Consultation Report has incorporated feedback received following engagement with the Vision 2020 Australia member organisations through the Vision 2020 Australia Committee process.

## DoHA engagement

Since the March 2013 sector consultation, DoHA has advised that the former Minister for Health and Ageing approved the inclusion of national indicators as a key action within the NFIP. This is a positive outcome, as is the fact that the former Minister asked DoHA to utilise the Australian Health Ministers' Advisory Council (AHMAC) process in the development and endorsement of the plan.

Following the cancellation of the scheduled meeting of the Community Care and Population Health Principal Committee of the AHMAC (due to the 2013 federal election), Vision 2020 Australia was advised that the NFIP was being dealt with out of session.

While DoHA continues to liaise within the Commonwealth and with State/Territory governments, Vision 2020 Australia is undergoing consultations with the eye health and vision care sector in relation to the role the sector plays across the identified priorities, actions and roles.

This report will inform the second sector consultation that will take place later in 2013.

# 2 WHO Action Plan

In May 2013 World Health Organisation (WHO) members, including Australia, endorsed a new action plan the *Universal Access to Eye Health: A Global Action Plan: 2014-19* (Global Action Plan) following extensive consultation with Member States and international partners.

The Global Action Plan is an important document for WHO Member States, WHO Secretariat, and international partners (NGOs) to guide and align efforts to end avoidable blindness and address vision impairment, and to help achieve the goals of *VISION 2020*. Importantly, this Global Action Plan sets as a global target, the reduction in prevalence of avoidable vision impairment by 25 per cent, significantly reducing the global prevalence of avoidable vision impairment by 2019.

In early May 2013, the WHO Western Pacific Regional Office hosted a consultation workshop in Manila to begin to develop a *Regional Action Plan for the Prevention of Avoidable Blindness and Visual Impairment in the Western Pacific Region*. WHO regions are now starting to develop Regional Action Plans.

The Australian Government's commitment to the reduction of avoidable blindness in our region has established Australia as a global leader in this field.

The 2014-19 WHO Action Plan ensures eye health is on the international agenda and provides a platform and catalyst for the Commonwealth Government to support eye health in Australia. For the first time, specific reference to low vision is included in the WHO Action Plan, hence its focus throughout this document, particularly with respect to key policy asks. Critically, Member States are required to report on key national indicators, signalling greater emphasis on the evidence base and establishing national targets.

# 3 The National Framework Implementation Plan 2014-16

Vision 2020 Australia commends the Australian Government for developing the National Framework in 2005. There is an excellent opportunity to use the NFIP to strengthen Australia's efforts to improve eye health and vision care and contribute to achieving the goals outlined in the WHO Action Plan 2014-19.

Identifying priorities in the NFIP within a structured framework is a vital step towards achieving the goal: to prevent avoidable blindness and reduce the impact of vision loss in Australia.

*The points below, taken from the WHO Action Plan, including the objectives (and amended to reflect the requirements of the NFIP), are some initial thoughts that may be considered to align the NFIP with the WHO Action Plan.*

## Vision

The **vision** for the WHO Action Plan is *a world in which nobody needlessly has vision impairment, where those with unavoidable vision loss can achieve their full potential, and where there is universal access to comprehensive eye care services and rehabilitation.*

The NFIP is intended to align with this vision.

## Goal

The NFIP aims to sustain and expand Australian efforts to further improve eye health and vision care. The **goal** is *to reduce avoidable blindness and vision impairment and to secure access to rehabilitation services for people with vision impairment in Australia.*

## Purpose

The **purpose** of the NFIP is *to mobilise and support the efforts of the Commonwealth, State and Territory Governments, eye health practitioners, private sector organisations, non-Government organisations and consumers to ensure the development of comprehensive eye care services integrated in strong health systems throughout Australia*. Further details are provided in Appendix 2.

## Principles

Four **principles** and approaches underpin the NFIP: *universal access and equity, evidence-based practice, a life-stage approach, and empowerment of people with vision impairment*. Further details are provided in Appendix 3.

The following objectives propose actions for Australia to base activity, mirroring the WHO Action Plan 2014-19.

## Objectives

### Objective 1: Evidence generated and used to provide a base line for future planning and decision making, along with advocating for increased political and financial commitment of Commonwealth and State/Territory governments for eye health.

While the argument for focusing on eye health and vision care at the national level is evident, evidence and data is needed to continue to build a compelling case for all levels of government to continue to enhance policy and financial commitments to eye health and vision care for the benefit of the reduction in avoidable blindness and vision impairment in Australia.

#### National Eye Health Survey

To align with global commitments, the prevalence of blindness and vision impairment in Australia today must first be determined. A national eye health survey is required for Australia to provide a current baseline and track progress towards the reduction of avoidable blindness and vision impairment by 25 per cent by 2019 and to effectively report against indicators listed in the WHO Action Plan 2014-19.

**As there are not data for 2010, a baseline needs to be established from which a realistic target for the reduction of avoidable blindness can be set.**

#### Data Collection

Currently, the estimates of national prevalence are derived from limited data sources gathered from Medicare statistics and in the 1990s through the Melbourne Visual Impairment Project (1992-96) and the Blue Mountains Eye Study (1992-94). Current population demographics and ethnic variability limits the representativeness of the results generated from the samples that these studies included.

A nationally coordinated survey has been proposed to provide nationally representative and sufficiently disaggregated current data. The planning and approval process would commence in 2014 with field work being conducted over a 12 month period during 2015, and analysis and reporting in the first six months of 2016.

It is recommended that a follow up survey be conducted in 2019-20 to assess change from a baseline of 2014, provide evidence of achievement of outcomes and identify areas of need (and for the purpose of reporting for the 2014-19 WHA period).

Regular collection, analysis and public reporting of these data at a national level will help Australia to fulfil its global reporting commitments to the WHO.

It is also recommended that the Australian Bureau of Statistics (ABS) collect data that can support forward planning such as collection of population data on legal blindness.

## Objective 2: Nationally consistent eye health policies, plans and programs for eye health integrated into health care plans

Through the sector consultation process, four **key priority areas** have been identified in order to provide Australia with a strong position with which to work towards the World Health Assembly goals as set out in the WHO Action Plan 2014-19:

- Improving the evidence base
- Support for people with low vision
- Aboriginal and Torres Strait Islander eye health and vision care
- Awareness raising

As part of an integrated approach, key areas that have been identified as a focus over the coming three years, which account for the majority of either avoidable blindness or vision impairment, include:

- Age-related macular degeneration
- Cataract
- Diabetic retinopathy
- Glaucoma
- Refractive error
- Trachoma

### Education for Health Care Professionals

In order to strengthen Australia's response to avoidable blindness and vision impairment, eye health and vision care should be integrated into all Commonwealth, State and Territory health care programs to ensure all people in all communities have the chance for optimal vision throughout their life. The integration should be across a range of policy areas including health, aged care and disability.

**There needs to be nationally consistent eye health policies, plans and programs for eye health integrated into health care plans, including education for health professionals about eye health.**

### Workplace supply and skills

There are issues around access to eye health through professionals, including ophthalmologists, optometrists and GPs. Health practitioners who are well trained and sustainably remunerated are critical to the delivery of effective eye health and vision care. In Australia, culturally appropriate skills are vital, especially for health practitioners delivering comprehensive primary health care services to Aboriginal and Torres Strait Islander peoples and other diverse communities.

Consistency in access to eye care, and design of eye care services, varies across Australia with uneven distribution of personnel including ophthalmologists, optometrists, orthoptists, nurses and other primary health workers. Specific barriers to access also exist for some sections of the population, such as Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

As with many health care practitioners in Australia, the distribution of practitioners working in eye health and vision care could be improved in rural and regional Australia. Equal incentives such as those offered to General Practitioners would go some way in providing additional incentives for primary care practitioners to move from city to rural areas. Continuation of successful visiting practitioner programs should also be assured and strengthened.

### Continuum of Care

In order for more communities to gain access to comprehensive eye care and rehabilitation services, it is important for health care professionals at all levels to have a better understanding of their role in diagnosing, treating and referring people with eye conditions.

Comprehensive referral pathways are necessary to ensure that people with eye health needs are addressed effectively and there is a continuum of care. For example, better early detection and timely referrals to eye care practitioners may prevent vision loss, or referrals to rehabilitation providers would have a significant impact on those with vision loss. The development of 'best practice' guidelines for referral and management of eye care in hospitals, the primary care system and links between the various eye care and low vision service providers is essential.

Services for those Australians who live in remote locations where there are fewer personnel may be facilitated through better telemedicine processes. Telemedicine may allow specialist personnel to provide some services remotely, minimising delays due to travel by either the patient or the specialists.

## Objective 3: Sector engagement and effective partnerships for improved eye health.

In moving to a more integrated approach, increasing sector engagement and continuing to build effective partnerships for improved eye health is a key objective of the NFIP.

Appendix 4 sets out the WHO Action Plan indicators for prevention of avoidable blindness and vision impairment.

Appendix 5 sets out the proposed national indicators, as discussed during the sector consultation.

# 4 Role and responsibility of the sector

There are many stakeholders with diverse roles and responsibilities within the eye health and vision care sector. Also, while some within the sector operate nationally, there are many who operate within restricted jurisdictions.

Successful implementation of the NFIP will rest upon the development of partnerships across and between all levels of government, health professions, including the specialist eye health workforce and the generalist medical and allied health workforce, training institutions, industry bodies and non-government organisations, researchers and communities.

Some initial considerations drawn mainly from the existing National Framework include:

## Governments and policy makers

In 2005, the Australian Health Ministers' Conference charged DoHA and the Victorian Department of Human Services with developing the *National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss* in consultation with the sector. The Office for an Ageing Australia had responsibility within DoHA for the coordination of the development of the Plan.

**The Australian Government's responsibilities under the NFIP may include:**

- the provision of national leadership on eye health policy development and implementation;
- the coordination of collaborative actions across governments to further nationally agreed eye health objectives;
- the establishment of formal linkages to related national public health strategies and initiatives and the development and fostering of strategic partnerships;
- taking on an 'Oversight Function' for both Aboriginal and Torres Strait Islander peoples and the rest of Australia, which accesses the expertise of the sector;
- identifying and utilising opportunities to promote eye health issues in relevant national health planning initiatives and programs, including through the Medicare Local reporting frameworks and indigenous health indicators;
- responding to identified areas of need by commissioning, promoting and sponsoring work that is best done at the national level;
- the coordination of Australian health workforce policy and planning;
- the promotion of eye health awareness within existing services, including general practice and aged care facilities;
- the identification and promotion of good practice approaches nationally across all key action areas in the Framework;
- the continued funding through Medicare of optometric, ophthalmological, orthoptic and general practice services related to eye health and vision care;
- funding through the Pharmaceutical Benefits Scheme of ophthalmic therapeutic agents prescribed to eligible patients;
- the development and funding of a range of initiatives to improve access to specialist eye health services for people living in rural and remote Australia;
- contributing to the development of nationally agreed research priorities for eye health research and funding of eye health research;

- providing advice on the policy related aspects of Australia's international obligations, including supporting the representation of Australia on a WHO taskforce to monitor the elimination of avoidable blindness globally;
- analysing and monitoring eye health data and outcomes and reporting on performance against the indicators at the national level.

**The state and territory governments' responsibilities under the NFIP may include:**

- developing and implementing state based eye health action plans consistent with the nationally agreed framework based on local priorities;
- designing, developing and implementing public health information and education programs aimed at raising public awareness of eye health and vision care and complementary to any national awareness programs;
- providing public sector eye health services or funding community-based organisations to provide programs to prevent, detect and treat eye conditions;
- ensuring that eye health and vision care services are provided in a manner consistent with the principles and intent of the National Framework;
- analysing and monitoring trends in eye health, service utilisation and health outcomes at the jurisdictional level;
- contributing to cross-jurisdictional and national surveys, data collection systems and research.

The state and territory governments are responsible for providing leadership in regard to eye health policy within their respective jurisdictions and according to local needs and priorities.

## Vision 2020 Australia

Vision 2020 Australia is the peak national advocacy body for eye health and vision care and works in partnership with stakeholders to eliminate the causes and remove the barriers to prevention of blindness and vision impairment in Australia and our region, focusing on core principles of collaboration, coordination, accessibility and equity.

Vision 2020 Australia convenes three member-based committees which provide specific forums for specialised policy areas and programs. These are the Prevention and Early Intervention Committee, the Low Vision and Rehabilitation Committee and the Aboriginal and Torres Strait Islander Committee. Committee meetings bring together members that work across a range of settings to share knowledge and expertise.

Vision 2020 Australia is responsible for engagement with members to exchange views, share information, collaborate and develop policies, strategies and submissions to improve eye health and vision care for all Australians.

## Professional associations

Professional associations can contribute to the elimination of avoidable blindness and vision impairment in Australia, through providing the infrastructure for education and training, developing referral pathways, developing and disseminating guidelines for good practice, supporting members to adopt or introduce changes in practice that may be sought and maintaining other professional support activities and networks.

Professional associations can advise on what changes in the policy context may be necessary to achieve particular outcomes and on the impact of policy changes on professional practice and related outcomes. They also provide education and training, may support eye care initiatives for disadvantaged communities(for example, ACO clinic, VOS work, MSOAP, USOAP, other visiting

services or volunteer services), provide community information and resources, support or conduct research, may support or develop innovative service models and assist in the co-ordination of scarce resources to maximise effectiveness and productivity.

## Community (Not-for-profit) organisations

In Australia, a large number of community (not-for-profit) organisations, deliver eye health programs through education and awareness activities and fill the much needed gap in services that are often not provided by Government. They provide information to the public and to health care and other professionals about specific eye diseases, eye disorders and available interventions, as well as offering support to people with vision loss by delivering national, state and local programs. They are the voice of their respective communities. This sector has grown rapidly over the past decade, and now makes up just over 4 per cent of GDP (just under $43 billion), with nearly 5 million volunteers contributing an additional $14.6 billion in unpaid work (Productivity Commission Report, *Contribution of not-for-profit sector*, January 2010).

## Business and industry

Employers and employees are responsible for occupational health and safety in the workplace, including the development of policies to reduce the risk of eye injury occurring in the workplace and to ensure good eye health practices among staff. Many businesses support the eye health community by providing sponsorship or philanthropic support for community organisations, as most receive little government funding. In addition, there are businesses which supply eye health and vision products.

# 5 Vision 2020 Australia Committee Feedback

## Prevention and Early Intervention Committee

The Prevention and Early Intervention Committee (PEIC) meeting was held on 8 August 2013. Committee members determined that there were three broad categories – policy; best practice; and awareness raising (including prevention, early intervention and rehabilitation) that needed addressing.

The following is a framework for consideration of various identified major conditions.

| Condition | Good Policy (Objectives) | Current Data (Issues identified) | Good Practice (Benchmarking) | Outcome (Action) | Impact (Change) |
|---|---|---|---|---|---|
| *Age-Related Macular Degeneration* | · Elimination of blindness and severe vision loss from AMD | · Data on number of people affected (now available) | · High awareness levels of the disease and early detection | · Australians are aware of the AMD and the early detection and prevention messages | · Reduction by x% in the social, economic and physical impact of AMD |
| *Cataract* | · Better access to cataract surgery across Australia | · Data on cataract surgery numbers and the funding of such surgery | · Accessibility and affordability of cataract surgery | · Advocate for governments to develop a sustainable policy for public access to cataract surgery across Australia | · Reduction by x% of those on cataract waiting list |
| *Diabetic retinopathy* | · Elimination of blindness and severe vision loss from diabetic retinopathy<br>· Medicare reimbursement for retinal photography | · Data on number of people affected<br>· Application being processed | · High awareness levels of the disease and early detection<br>· Screening as part of general diabetic management | · Australians are aware of diabetic retinopathy and the early detection and prevention messages<br>· Greater access for early detection | · Reduction by x% in the social, economic and physical impact of diabetic retinopathy |
| *Glaucoma* | · Elimination of blindness and severe vision loss from glaucoma<br>· Better access to accurate diagnosis and effective treatment | · Data on number of people affected | · High awareness levels of the disease and early detection | · Australians are aware of glaucoma and the early detection and prevention messages<br>· Improved quality of care | · Reduction by x% in the social, economic and physical impact of glaucoma |
| *Uncorrected Refractive Error* | · Accessible spectacle scheme so that cost is not a barrier to good vision | · Number of people without spectacles due to affordability and access issues | · Support for national consistency in subsidised spectacle schemes based on sound principles | · Advocate for the support of an agreed policy | · Reduction by x% of those affected by affordability and access issues |

## Low Vision and Rehabilitation Committee

A special meeting of the Low Vision and Rehabilitation Committee was convened on 27 August 2013 to seek further feedback on the Sector Consultation Report.

There is recognition and understanding from Committee members that while there was support for those with low vision in the 2005 National Framework, it was not clearly stated as a priority, but rather a theme that occurred across the National Framework. Low vision is now a recognised priority at a global level (refer to *Universal Access to Eye Health: A Global Action Plan: 2014-19*) and it is imperative that low vision is also recognised as a priority in Australia in the NFIP. Therefore, the Committee emphasised the importance of maximising the opportunity of the development of the NFIP to ensure that the inclusion of low vision and rehabilitation needs are appropriately addressed.

The reasons for this are:

- the need for services will be further compounded by the ageing population, which has a flow on impact to individual quality of life, independent ageing and productivity
- there is an inequity of access to services for people aged over 65 years who fall outside of the NDIS
- it is estimated that only 20 per cent of people in Australia who are vision impaired access low vision and rehabilitation services. This is largely due to lack of awareness by the public and health care providers, limited availability of services, lack of government funding for services and lack of understanding of the need for services
- there is an unequal distribution of rehabilitation services which are mostly centred around metropolitan populations and the inconsistent link between eye health providers and low vision service providers
- effective coordination and consistency in approach between the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the DoHA will ensure eye health issues are holistically addressed in Australia.

The Committee's priorities for addressing low vision and rehabilitation needs are summarised in following table.

| Priority | Activities |
|---|---|
| 1. *Enhance access and affordability of low vision aids and equipment* | a. Advocacy for fairness and equity within the NDIS, DoHA and FaHCSIA<br>b. Audit of geographic needs for services<br>c. Referral pathway enhancement for early referral for people who are blind or who have low vision to service providers |
| 2. *Support the development and implementation of standards and guidelines for quality outcomes* | a. Audit of existing practices of low vision service providers and eye health providers<br>b. Establishment of guidelines, standards to ensure efficiency and effectiveness (to result in the delivery of quality outcomes)<br>c. Ongoing monitoring in a changing landscape with NDIS and Aged Care reforms<br>d. (For example, if private providers enter the market, pre-determined service standards will have to be met) |
| 3. *Enhance the capacity of organisations to deliver timely quality services* | a. Accessing funding<br>b. Governance, reporting, measuring outcomes<br>c. Staffing<br>d. Qualifications, training |

## Aboriginal and Torres Strait Islander Committee

The eye health of Aboriginal and Torres Strait Islander people is clearly a priority for both the Government and the eye health and vision care sector. Blindness rates among Aboriginal and Torres Strait Islander people being six times those of non-Indigenous Australians and vision loss being the equal third leading cause of 'the gap' after heart disease, diabetes and trauma, with stroke and alcoholism.

The sector has endorsed the Roadmap to Close the Gap for Vision (the Roadmap) as a focus for improving Aboriginal and Torres Strait Islander eye health.

While a number of recommendations from the Roadmap were discussed in the March sector consultation and included in DoHA's Sector Consultation Report, the Committee agreed at its meeting on 19 August 2013 that implementation of **all** recommendations in the Roadmap should be addressed through the final NFIP.

The Roadmap progress table can be viewed at Appendix 1.

The table describes the current progress in implementing the recommendations of the Roadmap. It reflects sector wide activity from multiple organisations and governments. The report helps to identify what has been achieved but also identifies all the areas where further work is required.

The sector also agreed it was important to:

a) identify linkages between the National Framework and the Roadmap

b) incorporate them into the NFIP

c) ensure eye health is integrated into the Closing the Gap strategy.

# 6 Next steps

The table below outlines the steps required to achieve our goal, the implementation of the NFIP.

Given the recent change of Government, it is difficult to determine exact dates after the final report has been submitted to DoHA. The dates below are indicative only and are subject to change.

| Date | Activity |
|---|---|
| *20 Sep 2013* | Deadline for feedback on the Draft Sector Response (this report) to DoHA's Sector Consultation Report |
| *27 Sep 2013* | Final report circulated to members for approval |
| *7 Oct 2013* | Final report submitted to DoHA |
| *Late 2013* | Second Sector Consultation with DoHA of the NFIP |
| *Early 2014* | NFIP on the AHMAC Agenda |
| *Early 2014* | NFIP endorsed by AHMAC |
| *Mid 2014* | Implementation of the NFIP by all Government jurisdictions and the sector, 2014-2017 |

# Appendix 1: Roadmap progress table

(updated April 2013)

| Domain | Recommendation | Outcome | Current Action | | |
|---|---|---|---|---|---|
| **1 Primary Eye Care as part of Comprehensive Primary Health Care** | 1.1 Enhancing eye health capacity in primary health services | Education programs developed and implemented for practitioners and health workers | Two RHEF programs and DVD | NACCHO/RACGP preventative health guidelines | Web-based module to be developed |
| | 1.2 Health assessment items include eye health | Medicare and computer software includes eye health assessment | Included in NACCHO/RACGP and CARPA/CRANA guidelines | Adult/Older Person Health Checks include mandatory vision assessment | Computer software to support eye health – software roundtable to be organised |
| | 1.3 Diabetic Retinopathy detection | Medicare item for retinal photography | More demonstration projects underway | MSAC application currently being processed | |
| | 1.4 Eye health inclusion in clinical software | Computer software includes eye health | Patient and audit software being developed | Software roundtable arranged for late April 2013 | |
| **2 Indigenous access to eye health services** | 2.1 Aboriginal Health Services and eye health | Specialist eye care delivered through AHS | FHF/Oxfam DVD 2012 | Pilot project suggested for optometry | |
| | 2.2 Cultural safety in mainstream services | Clinics and hospitals considered culturally safe | Programs available in most states | Cultural competency training required within MSOAP, VOS and with Medicare Locals | Implementation being progressed |
| | 2.3 Low cost spectacles | Nationally consistent scheme for Indigenous Australians | VCRC/OAA national review. NT program re-contracted | Nationally consistent subsidized spectacle scheme criteria developed and sector agreed | VIC good review – 2013 funding uncertain. NSW funding temporarily stopped in 2012 |
| | 2.4 Hospital surgery prioritization | Indigeneity prioritized for cataract surgery | Surgical blitzes used to reduce back logs | Sustainable solutions being discussed | |
| **3 Co-ordination – case management** | 3.1 Local Eye Care Co-ordination | Regional coordination arranged through Medicare Locals | Indigenous eye health used as a case study for the DoHA Medicare Local Collaborative Framework | NSW planning in Western Region, VIC, NT in 3 regions | |
| | 3.2 Clear pathways of care | Local referral pathways and service directories established | DoHA Medicare Local Collaborative Framework project | DoHA is considering processes that could be used to improve co-ordination | |
| | 3.3 Workforce identification and roles | Local personnel identified to support patient journey | Initial steps to assess NSW, NT, VIC | | |
| | 3.4 Eye care support workforce | Sufficient personnel engaged in eye care needs | NT community workers trial | | |
| | 3.5 Case co-ordination | Case management for patients with diabetes or requiring surgery | DoHA assessing role of Chronic Disease co-ordinators | | |
| | 3.6 Partnership and agreements | Local and regional agreements established | Some partnership agreements established in NT, NSW, VIC regions | | |
| **4 Eye health workforce** | 4.1 Provide eye health workforce to meet population needs | Population-based needs determine eye health workforce across Australia | Estimations for selected regions | | |
| | 4.2 Improve contracting and management of visiting services | VOS and MSOAP work effectively and properly coordinated | MSOAP and VOS review released | Linkage between MSOAP and VOS with ML and LHN | Medicare Local Collaborative Framework project evidences Indigenous eye health |
| | 4.3 Appropriate resources for eye care in rural and remote areas | Services are adequate to meet eye care needs | Eye care skills and regional planning being developed | | |
| | 4.4 Increase utilization of services in urban areas | VOS supports AHS eye care in both regional and urban areas | USOAP includes some allied health | | |
| | 4.5 Billing for visiting MSOAP supported services | MSOAP services are bulk-billed | DoHA considering appropriate strategy | | |
| | 4.6 Rural education and training of eye health workforce | Training opportunities are included and funded for optometry and ophthalmology | NSW western region trial | VOS to include optometry training support | |
| **5 Elimination of Trachoma** | 5.1 Definition of areas of risk | Areas with trachoma are defined across Australia | NT, WA and SA completed mapping | QLD and NSW partially resolved | |
| | 5.2 Effective interventions | SAFE strategy is implemented | Good progress in NT, WA and SA | QLD and NSW pending | National guidelines being revised |
| | 5.3 Surveillance and evaluation | Ensure continuance of NTSRU | NTSRU report 2010 published | NTSRU report 2011 prepared | |
| | 5.4 Certification of elimination | Australia eliminates trachoma | Australian Government commitment made to eliminate trachoma | | |
| **6 Monitoring and Evaluation** | 6.1 Managing local eye service performance | Performance is assessed against need-based targets | Regional and local benchmarks and service targets being developed | | |
| | 6.2 State and National performances | State and national data are analysed and reported | Indicators endorsed by eye sector stakeholders | Inclusion of regional data in NHPA reports | Indicators included in National Framework Implementation Plan |
| | 6.3 Collating existing eye data sources | Existing data sources are used to review service needs and performance | Discussions with DoHA and AIHW | | |
| | 6.4 National benchmarks | National benchmarks and guidelines are established and used | Eye Health Measure in Aboriginal and Torres Strait Islander Health Performance Framework 2012 | Indicators endorsed by stakeholders | Include eye health in NHPA and other frameworks |
| | 6.5 Quality assurance | High quality service is achieved | CQI tool being developed | | |
| | 6.6 Primary health service self audit in eye health | Services can easily determine needs and performance | Audit tool being developed | | |
| | 6.7 Program evaluation | Implementation of Roadmap is evaluated | Annual progress report 2012 published | Annual progress report and Roadmap updated | |
| **7 Governance** | 7.1 Community engagement | Local communities use and champion eye care services | Multiple local services encouraging eye care | | |
| | 7.2 Local Hospital Networks and Medicare Locals | Indigenous eye health is coordinated at the regional level | Roadmap available as resource | DoHA Medicare Local Collaborative Framework project | |
| | 7.3 State/ Territory management | State/territory Indigenous eye health committees operate effectively | VIC VACKH committee operating with state purview, developed Strategy for 2013 -2014 | NT plans for 3 regions developed | |
| | 7.4 National oversight | National Indigenous eye health oversight body reports to AHMAC | Informal national group formed, NACCHO, OAA, RANZCO, Vision 2020 Australia, Uni. Melbourne | Advocacy to Government to establish national oversight body | |
| | 7.5 Program interdependence | Roadmap is effectively delivered across Australia | Vision 2020 Australia advocating for full implementation of the Roadmap | | |
| **8 Health promotion and awareness** | 8.1 Eye health promotion | Community and staff recognize the need for eye care | FHF/Oxfam/NACCHO/VACCHO digital stories | Material developed by AHS and NGO | |
| | 8.2 Social marketing eye care services | Community and staff know about local services | Trachoma social marketing | DoHA considering integration of health messaging | |
| **9 Health financing** | 9.1 Current spending on Indigenous eye health | Current services are maintained | No cuts to current spending | | |
| | 9.2 Current spending on trachoma | Funding continues until trachoma is eliminated | It is likely that funding will continue beyond the current commitment to 2012/2013 | | |
| | 9.3 Full additional annual capped funding required | Adequate capped funding provided (est. $19.5m pa) | Vision 2020 Australia and OAA funding bids for 2013/2014 | | |
| | 9.4 Cost to Close the Gap for Vision funded for 5 years | Additional funding continues until the gap for vision is closed | | | |

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# Appendix 2: WHO Action Plan - Vision, goal and purpose

| **VISION**<br>A world in which nobody is needlessly visually impaired, where those with unavoidable vision loss can achieve their full potential, and where there is universal access to comprehensive eye care services | | | |
|---|---|---|---|
| **Goal** | **Measurable indicators**[1] | **Means of verification** | **Important assumptions** |
| To reduce avoidable visual impairment as a global public health problem and secure access to rehabilitation services for the visually impaired[2] | Prevalence and causes of visual impairment<br>*Global target: reduction in prevalence of avoidable visual impairment by 25% by 2019 from the baseline of 2010* | Collection of epidemiological data at national and subnational levels and development of regional and global estimates | Human rights conventions implemented, equity across all policies achieved, and people with visual impairment fully empowered<br>Sustained investment achieved |
| **Purpose** | | | |
| To improve access to comprehensive eye care services that are integrated into health systems | Number of eye care personnel per million population<br>Cataract surgical rate | Reports summarizing national data provided by Member States | Services accessed fully and equitably by all populations |

[1] See also Appendix 4

# Appendix 3: Cross-cutting principles and approaches

| **Universal access and equity** | **Evidence-based practice** | **Life-course approach** | **Empowerment of people with blindness and vision impairment** |
|---|---|---|---|
| All people should have equitable access to health care and opportunities to achieve or recover the highest attainable standard of health, regardless of age, gender, or social position. | Strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and good practice. | Eye health, vision care and related policies, plans and programs need to take account of health and social needs for all stages of life. | People who are blind or who are vision impaired or have low vision can participate fully in the social, economic, political and cultural aspects of life. |

# Appendix 4: WHO Action Plan indicators for prevention of avoidable blindness and vision impairment

**1. Prevalence and causes of vision impairment**

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|---|---|
| Purpose/rationale | To measure the magnitude of visual impairment including blindness and monitor progress in eliminating avoidable blindness and in controlling avoidable visual impairment |
| Definition | Prevalence of visual impairment, including blindness, and its causes, preferably disaggregated by age and gender |
| Preferred methods of data collection | Methodologically sound and representative surveys of prevalence provide the most reliable method. Additionally, the Rapid Assessment of Avoidable Blindness and the Rapid Assessment of Cataract Surgical Services are two standard methodologies for obtaining results for people in the age group with the highest prevalence of visual impairment, that is, those over 50 years of age |
| Unit of measurement | Prevalence of visual impairment determined from population surveys |
| Frequency of data collection | At national level at least every five years |
| Source of data | Health ministry or national prevention of blindness/eye health coordinator/committee |
| Dissemination of data | The Secretariat periodically updates the global estimates on the prevalence and causes of visual impairment |

**2.1 Number of eye care personnel by cadre: ophthalmologists**

| | |
|---|---|
| Purpose/rationale | To assess availability of the eye health workforce in order to formulate a capacity-development response for strengthening national health systems. Ophthalmologists are the primary cadre that deliver medical and surgical eye care interventions |
| Definition | Number of medical doctors certified as ophthalmologists by national institutions based on government-approved certification criteria. Ophthalmologists are medical doctors who have been trained in ophthalmic medicine and/or surgery and who evaluate and treat diseases of the eye |
| Preferred methods of data collection | Registers of national professional and regulatory bodies |
| Unit of measurement | Number of ophthalmologists per one million population |
| Frequency of data collection | Annually |

| | |
|---|---|
| Limitations | The number does not reflect the proportion of ophthalmologists who are not surgically active; clinical output (e.g. subspecialists); performance; and quality of interventions. Unless disaggregated, the data do not reflect geographical distribution |
| Source of information | Health ministry or national prevention of blindness/eye health coordinator/committee |
| Dissemination of data | The Secretariat annually issues a global update based on the national data provided by Member States |

### 2.2 Number of eye care personnel by cadre: optometrists

| | |
|---|---|
| Purpose/rationale | To assess availability of the eye health workforce in order to formulate a capacity-development response for strengthening national health systems. In an increasing number of countries, optometrists are often the first point of contact for persons with eye diseases |
| Definition | Number of optometrists certified by national institutions based on government-approved certification criteria |
| Preferred methods of data collection | Registers of national professional and regulatory bodies |
| Unit of measurement | Number of optometrists per one million population |
| Frequency of data collection | Annually |
| Limitations | The number does not denote performance, especially the quality of interventions to reduce avoidable blindness. There is a wide variability in knowledge and skill of optometrists from one nation to another because curricula are not standardized<br><br>Numbers do not reflect the proportion of ophthalmic clinical officers, refractionists and other such groups who in some countries perform the role of optometrists where this cadre is short-staffed or does not exist |
| Source of information | Health ministry or national prevention of blindness/eye health coordinator/committee |
| Dissemination of data | The Secretariat annually issues a global update based on the national data provided by Member States |

### 2.3 Number of eye care personnel by cadre: allied ophthalmic personnel

| | |
|---|---|
| Purpose/rationale | To assess availability of the eye health workforce in order to formulate a capacity-development response for strengthening national health systems. Allied ophthalmic personnel may be characterized by different educational requirements, legislation and practice regulations, skills and scope of practice between countries and even within a given country. Typically, allied ophthalmic personnel comprise opticians, ophthalmic nurses, orthoptists, ophthalmic and optometric assistants, ophthalmic and optometric technicians, vision therapists, ocularists, ophthalmic photographer/imagers, and ophthalmic administrators |
| Definition | Numbers of allied ophthalmic personnel comprising professional categories, which need to be specified by a reporting Member State |
| Preferred methods of data collection | Compilation of national data from subnational (district) data from government, nongovernmental and private eye care service providers |
| Unit of measurement | Number of allied ophthalmic personnel per one million population |
| Frequency of data collection | Annually |
| Limitations | The numbers do not denote performance, especially the quality of interventions to reduce avoidable blindness. There is a wide variability in knowledge and skill. These data are useful for monitoring of progress in countries over time but because of variation in nomenclature they cannot be reliably used for intercountry comparison |
| Source of information | Health ministry or national prevention of blindness/eye health coordinator/committee |
| Dissemination of data | The Secretariat annually issues a global update based on the national data provided by Member States |

### 3.1 Cataract surgical rate

| | |
|---|---|
| Purpose/rationale | Globally, cataract remains the leading cause of blindness. Visual impairment and blindness from cataracts are avoidable because an effective means of treatment (cataract extraction with implantation of an intraocular lens) is both safe and efficacious to restore sight. The cataract surgical rate is a quantifiable measure of cataract surgical service delivery. The rate can be used to set targets within countries rather than for intercountry comparisons. It is also often used as a proxy indicator for general eye care service delivery |
| Definition | The number of cataract operations performed per year per one million population |
| Preferred methods of data collection | Government health information records, surveys |
| Unit of measurement | Number of cataract operations performed per one million population |

| | |
|---|---|
| Frequency of data collection | Annually at national level. In larger countries it is desirable to collate data at subnational level |
| Limitations | This indicator is meaningful only when it includes all cataract surgeries performed in a country, that is, those performed within the government and nongovernmental sectors |
| Comments | For calculations, use official sources of population data (United Nations) |
| Source of information | Health ministry or national prevention of blindness/eye health coordinator/committee |
| Dissemination of data | The Secretariat annually issues a global update based on the national data provided by Member States |

### 3.2 Cataract surgical coverage

| | |
|---|---|
| Purpose/rationale | To assess the degree to which cataract surgical services are meeting the need |
| Definition | Proportion of people with bilateral cataract eligible for cataract surgery who have received cataract surgery in one or both eyes (at 3/60 and 6/18 level) |
| Preferred methods of data collection | Calculation using data from methodologically sound and representative prevalence surveys. Additionally, calculation using data from the Rapid Assessment of Avoidable Blindness and the Rapid Assessment of Cataract Surgical Services, which are two standard methodologies to obtain results for people in the age group with the highest prevalence of blindness and visual impairment due to cataract, that is, those over 50 years of age |
| Unit of measurement | Proportion |
| Frequency of data collection | Determined by the frequency of performing a national/district study on the prevalence of blindness and visual impairment and their causes |
| Limitations | Requires population-based studies, which may be of limited generalization |
| Comments | Preferably data are disaggregated by gender, age, and urban/rural location or district |
| Source of information | Health ministry or national prevention of blindness/eye health coordinator/committee |
| Dissemination of data | The Secretariat periodically issues updates |

# Appendix 5: Proposed national indicators for prevention of avoidable blindness and vision impairment

**Coverage rates for cataract, diabetic retinopathy, glaucoma, uncorrected refractive error and macular degeneration for all of population and by Aboriginal and Torres Strait Islander sub-population**

(WHO Action Plan 2014-19 headline indicators are shaded in pale blue)

| Indicator | Purpose | Source | Status |
|---|---|---|---|
| **Prevalence and causes of vision impairment** | To measure the magnitude of vision impairment including blindness and monitor progress in eliminating avoidable blindness and in controlling avoidable vision impairment | Population surveys | No population surveys currently |
| | Measures detection and treatment coverage rates for:<br>– Cataract<br>– Diabetic retinopathy<br>– Glaucoma<br>– Macular degeneration<br>– Refractive error | | |
| | Measures utilisation rates of rehabilitation services for those who are vision impaired:<br>– Low vision clinical services<br>– Follow up OT rehabilitation<br>– Orientation and mobility support | | |
| **Cataract surgery rate** | To measure cataract surgical service delivery | State health data<br>Medicare data | |

| | | | |
|---|---|---|---|
| **Cataract surgery coverage** | To assess the degree to which the cataract surgical services are meeting the need | State health data<br>Medicare data | |
| **Cataract**<br>Number of patients on waiting list for surgery | To measure availability of services | State health data | Reported by AIHW |
| **Cataract**<br>Number of patients on waiting list for surgery for more than 90 days | To measure availability of services | State health data | Reported by AIHW |
| **Refractive error**<br>Number of people and percentage of population aged over 40 years who have had an eye examination (in last two years for non-Indigenous Australians) | To assess availability of and usage of eye care assessment services | Medicare data (comparison to whole population) | |
| **Refractive error**<br>Number of low cost/subsidised spectacles provided | To assess provision of refractive error correction | State health data | |
| **Diabetes**<br>Number and percentage of people with diabetes who have had a retinal examination within the past 12 months (in last two years for non-Indigenous Australians) | To asses access and usage of diabetic retinopathy treatment | State health data<br>Medicare data | |
| **Diabetes**<br>Number of patients who received diabetic retinopathy laser treatment | To assess level of access and ensure sufficient availability | State health data | |

### Workforce by cadre

| Indicator | Purpose | Source | Status |
|---|---|---|---|
| Number of eye care personnel by cadre: ophthalmologists | To assess availability of the eye health workforce | RANZCO, AHPRA | Accessible |
| Number of eye care personnel by cadre: optometrists | To assess availability of the eye health workforce | OAA, AHPRA | Accessible |
| Number of eye care personnel by cadre: allied ophthalmic personnel | To assess availability of the eye health workforce | | |
| Number of eye care personnel by cadre: rehabilitation personnel<br><br>Categories of personnel and level of disaggregation to be discussed further – orthoptists, O& M trainers, occupational therapists etc | | | |

### Trachoma – by Aboriginal and Torres Strait Islander sub-population

| Indicator | Purpose | Source | Status |
|---|---|---|---|
| **Trachoma**<br><br>Number of communities with endemic levels of trachoma in children aged 5-9 years | To monitor progress in eliminating blinding trachoma | State reported data | Reported by NTSRU |
| **Trachoma**<br><br>Number of people treated with Azithromycin | To monitor extent of SAFE intervention | State reported data | Reported by NTSRU |

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National body working in partnership to prevent avoidable blindness and improve vision care