



Australian Government
Department of Health and Ageing

Australian Government Response

to the Review of the Implementation of the
National Aboriginal and Torres Strait Islander
Eye Health Program

AUSTRALIAN GOVERNMENT RESPONSE

to the Review of the Implementation of the
National Aboriginal and Torres Strait Islander
Eye Health Program

May 2004

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ISBN: 0 642 82452 5

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Publication approval number: 3445/JN8336

FOREWORD

Eye health has been a key issue in Aboriginal and Torres Strait Islander health. From the days of the late Professor Fred Hollows, a number of ophthalmologists and optometrists have demonstrated a strong personal commitment to this area and many Indigenous Australians have benefited. However, the Review is a timely reminder that much remains to be done.

In 1996, the Commonwealth Government established a national approach to Aboriginal and Torres Strait Islander health based on:

- improving access to primary health care for Aboriginal and Torres Strait Islander peoples;
- improving the responsiveness of the mainstream health system; and
- providing complementary Indigenous specific health programs, such as the National Aboriginal and Torres Strait Islander Eye Health Program.

Since that time, the Commonwealth Government has nearly doubled Indigenous health funding through the Office for Aboriginal and Torres Strait Islander Health. As well, new measures have improved Indigenous access to the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme. For example, I recently announced a new MBS item for a two yearly adult health check for Aboriginal and Torres Strait Islander peoples. This will make a significant contribution to addressing the burden of chronic disease.

The Commonwealth Government has a strong commitment to collaboration between Indigenous communities, mainstream health providers and Aboriginal community controlled health services to achieve better health outcomes which, in part, come from access to appropriate and timely health care.

This partnership approach is embedded in the Agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements), that are now in place in all States and Territories between the Commonwealth, State and Territory Governments and Aboriginal and Torres Strait Islander organisations.

I thank those individuals and services that contributed to the Review, especially the Centre for Remote Health in Alice Springs, and look forward to continuing to work with these individuals and organisations in the development of Government policies.

A handwritten signature in black ink, appearing to read 'Tony Abbott'.

Tony Abbott MHR
Minister for Health and Ageing

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INTRODUCTION

HISTORY OF THE NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER EYE HEALTH PROGRAM

The development of the National Aboriginal and Torres Strait Islander Eye Health Program (the Program) was informed by recommendations arising from a review of Aboriginal and Torres Strait Islander eye health, titled *Eye Health in Aboriginal and Torres Strait Islander Communities*¹ undertaken by Professor Hugh Taylor in 1997. The report identified that in some regions the incidence and/or prevalence of eye conditions and diseases, such as diabetic retinopathy and trachoma, were unacceptably higher than those reported for the general population. Exposure to certain risk factors associated with living in rural and/or remote communities (including social, environmental and political factors) was identified as contributing to poor eye health, along with the lack of a systematic approach to eye health service provision.

Implementation of the Program commenced in 1998 and is administered by the Department of Health and Ageing (the Department) through the Office for Aboriginal and Torres Strait Islander Health (OATSIH). The aim of the Program is to improve the eye health of the Aboriginal and Torres Strait Islander population. The Program seeks to achieve this primarily through the provision of a skilled workforce and appropriate infrastructure, thereby increasing the regional access of Aboriginal and Torres Strait Islander peoples to quality eye health services. The Program focuses particularly, but not exclusively, on the provision of eye health services in rural and remote areas.

Major components of the Program have emphasised improving primary eye health care through a regional model, including the following:

- the establishment of 29 eye health coordinator regions with 34 positions nationally to facilitate access to optometry and ophthalmology services in the Aboriginal and Torres Strait Islander primary health care setting;
- the provision of ophthalmic and optometric equipment in identified Aboriginal community controlled health services (ACCHSs) across the country, to reduce barriers in service delivery for specialists visiting regional areas; and
- the provision of eye health training for regional eye health coordinators and Aboriginal Health Workers.

In addition to these core elements of the Program:

- Specialist Eye Health Guidelines were developed and distributed in September 2001.
- In 1998 azithromycin was listed on the Pharmaceutical Benefits Schedule for the treatment of trachoma. Azithromycin has been made available to remote ACCHSs under the provisions of section 100 of the *National Health Act 1953*, which allows remote Aboriginal and Torres Strait Islander communities to access treatment (free of charge) through their local ACCHS at the point of consultation. Remote services that are operated by State and Territory governments are also able to participate, following a commitment to maintain current outlays directed towards health care services for Aboriginal and Torres Strait Islander peoples.

The following Australian Government Response covers the scope of the Review and its key findings, then comments on specific elements of the Review clustered under the five key areas of:

- strengthening the integration of eye health into primary health care services and the role of the eye health coordinator;
- better utilisation of mainstream specialist services;
- data and information systems;
- infrastructure support; and
- trachoma.

Consistent with the Review Report, this document uses the term 'specialist' to refer to both ophthalmologists and optometrists as specialist eye health service providers.

THE REVIEW

In September 2002 the OATSIH engaged the Centre for Remote Health, located in Alice Springs, to undertake the review of the implementation of the Program. The Review was undertaken and completed in 2002–03 and a final Review Report was received in October 2003.ⁱⁱ

The Review focused on the implementation of the Program to date and its context, as well as its relationship to broader mainstream health programs. Importantly it was intended to provide a basis on which to refine the Program over the next phase, particularly in regard to strengthening its integration into primary health care services for Aboriginal and Torres Strait Islander peoples.

The Review Report outlined 24 recommendations spanning State, Territory and Australian Government responsibilities and areas of the health system including primary health care professionals, public health units, hospitals, specialist and other eye health service providers and their professional organisations.

While acknowledging the substantial successes of the Program, the Review process identified a key tension in the existing program. It found the disparate service responses required to address eye health do not easily form a cohesive program or function for a single staff position in the Aboriginal and Torres Strait Islander primary health care context.

The Review confirmed the individual importance of various health issues covered by the 'eye' umbrella (diabetic retinopathy, cataract, refractive error, and trachoma) and it also identified that the interventions required cut across the health system, from population health through to eye surgery.

These key categories of intervention could be described as:

- systems for primary health care liaison and referral to specialists and hospitals;
- support for the coordinated quality management of diabetes in the primary health care setting, including checks for diabetic retinopathy as part of routine complication screening, and the effective use of information systems to organise care;
- continuing population screening for, and treatment of, trachoma in endemic regions; and
- access to optometric services and spectacles.

The Review focus was largely, but not exclusively, on rural and remote areas. It found that there is poor access to mainstream health programs (such as access to specialists and hospitals) to support eye health activity in the Aboriginal and Torres Strait Islander primary health care setting. It is clear that there is a role for

mainstream Australian Government and State and Territory government programs, but the extent to which this responsibility has been taken up in delivering eye health services to Aboriginal and Torres Strait Islander peoples is highly variable.

The Review outlined the variable implementation of the Program across regions and the diverse roles of the eye health coordinators across Australia. This variability limits the availability of nationally consistent data and information.

The Review identified that the Program is not sustainable without integration into the primary health care system. In many regions the Program runs as a relatively isolated service with systems (e.g. appointments, patient databases, eye checks) that are highly dependent upon individual staff and not embedded into routine primary health care clinic practices. The Review recommends integration of the Program into primary health care services as a priority, with a future emphasis on integration with services required to manage chronic diseases, particularly diabetes, in the primary health care setting. There is a high burden of chronic disease among Aboriginal and Torres Strait Islander peoples, and their prevention, early detection and management are a priority.

The Australian Government supports the majority of the Review recommendations and acknowledges the need for strengthening integration of the Program into primary health care while ensuring that mainstream services make an appropriate contribution to improving eye health for Aboriginal and Torres Strait Islander peoples.

A number of existing mainstream programs and services can support the delivery of eye health care, the major ones identified by the Review being:

- spectacle schemes administered through the States and Territories;
- ophthalmologists and optometrists (public and private);
- public hospital services;
- State and Territory public health units;
- specialist outreach programs and training support schemes under the Regional Health Strategy - *More Doctors, Better Services* (2000–01 Federal Budget); and
- the Visiting Optometrists Scheme (VOS).

This move to strengthen integration into primary health care does not mean that the importance of eye health is diminished, but reflects the need for the Program to continue to evolve while ensuring that existing capacity in eye health is preserved.

STRENGTHENING INTEGRATION OF EYE HEALTH INTO PRIMARY HEALTH CARE SERVICES AND THE ROLE OF THE EYE HEALTH COORDINATOR

The Review suggested that the Program should shift in emphasis away from a vertical program of eye health specialist support, towards building the capacity at the primary health care level, in order to continue to support specialist services and to move towards closer integration with chronic disease care, where the burden of disease currently lies. The existing Program will be refined through incorporating key functions into core primary health care activities where possible and, within this, strengthening a focus on chronic disease, while retaining the service capacity and gains that have been achieved in eye health.

The Review recommended that in those areas where there are well-established specialist services, it is timely and appropriate that the Program should reorient itself towards integration within chronic disease programs. This is already the case in some areas. Whereas in others, where specialist access is not yet well established, there will be a need to examine regional options for improving access and integrating the eye health coordinator's work into the primary health care setting. The Australian Government supports the further evolution of the Program in this manner.

Eye health coordinators have been important in facilitating access to optometry and ophthalmology services. The Australian Government acknowledges the difficulties that regional eye health coordinators have encountered in the absence of regional support, and supports the general thrust of the recommendation that the eye health coordinator role will evolve over time. The role may develop into a broader specialist coordinator or it may become integrated into the chronic disease programs of the service/region. The diversity of the existing roles of eye health coordinators means that decisions will be required at a regional level about the direction and pace of this transition. The generic duty statements included in the Review Report may be used as a tool to inform discussions.

The provision of eye health equipment under the Program, such as retinal cameras, was an area of specific comment and concern in the Review Report. The Review identified that some regions already have successful models whereby eye health coordinators have undertaken retinal camera programs where access to eye specialist services is difficult. It also articulated the evidence to support this model and recommended that remuneration for ophthalmologists who read retinal photographs could be in the form of a Medicare item. The Australian Government is referring the question of the effectiveness of retinal photography in the detection of diabetic retinopathy in remote locations to the Health Policy Advisory Committee on Technology (HealthPACT) as a matter of priority.

The future direction of the Program will be supported by the implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (the National Strategic Framework). The National Strategic Framework is a 10-year overarching framework of action by all levels of government to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

The National Strategic Framework has a number of key result areas with objectives and action areas that inform future directions for eye health, in particular:

- Key Result Area One: Community controlled primary health care services;
- Key Result Area Two: Health systems delivery framework;
- Key Result Area Three: A competent health workforce;
- Key Result Area Five: Environmental health; and
- Key Result Area Seven: Data, research and evidence.

Each jurisdiction is required to develop an implementation plan for the National Strategic Framework. Mechanisms to address Aboriginal and Torres Strait Islander eye health at every level in the health system are best integrated into these plans in the areas of:

- primary health care chronic diseases programs;
- access to hospital services;
- access to specialists;
- public health programs including trachoma control in endemic regions; and
- environmental health.

Regional planning forums, where they are in existence, play a key role in guiding future developments. The OATSIH will be engaging with State and Territory Aboriginal and Torres Strait Islander Health Planning Forums in this transition phase. Regular national meetings of coordinators will be considered within this context.

BETTER UTILISATION OF MAINSTREAM SPECIALIST SERVICES

The Review found that, through their work in a number of rural and remote communities, optometrists and ophthalmologists had achieved improvements in access for Aboriginal and Torres Strait Islander peoples, but there is still further work to be done and sustainability is a critical issue.

The Australian Government acknowledges that the capacity for mainstream services to appropriately meet the needs of Aboriginal and Torres Strait Islander peoples is influenced by a number of issues, some of which include geographical isolation and access to specialist and hospital services, as well as the need for appropriate training and support for those providing services.

The Australian Government acknowledges the importance of encouraging optometrists to work in rural and remote areas, and recognises that the Optometrists Association Australia and training institutions can have a role in this regard. However, it is not clear how these bodies can oversee the recruitment and monitoring of optometrists as recommended by the Review.

Optometrists who provide a service in isolated areas, including Aboriginal and Torres Strait Islander primary health clinics, have been utilising mainstream program funds to finance their practice, such as Medicare and the Visiting Optometrists Scheme (VOS). The VOS commenced in the mid-1970s to promote access to optometrical services in rural and remote areas and is administered by the Department. Concerns about the VOS were raised in the Review Report and these concerns have been noted by the Australian Government and will be addressed in a review of the VOS to be undertaken by the Department in 2004. The view expressed in the Review Report that the VOS should be better targeted towards areas of community need rather than driven by provider availability or preference is accepted, and will be considered by the Department in its review.

Access to specialist services, particularly in rural and remote areas, is the primary responsibility of State and Territory governments, complemented by specific initiatives under the Australian Government's Regional Health Strategy and Medicare. The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) has a complementary role in the accreditation of ophthalmology training posts. Provision of specialist services requires mainstream health programs and professional bodies to work in partnership with Aboriginal and Torres Strait Islander communities and health services to improve access to services.

Access to specialists relies on the availability of a suitably trained workforce and removal of financial and other barriers to working in rural and remote settings. These are issues that have been raised by the Review. The Medical Specialist Outreach Assistance Program (MSOAP) is one component of the Regional Health Strategy. MSOAP reimburses participating medical specialists for travel time; travel and accommodation costs; ongoing communication with local practitioners; and for training and up-skilling of local medical practitioners. The Support Scheme for Rural Specialists (SSRS) is an initiative which provides continuing professional development opportunities for specialists practising in rural and remote areas.

The Regional Health Strategy also funds:

- the Rural Advanced Specialist Training Scheme (RASTS), under which funds are available to selected specialist colleges to provide training support for advanced trainees in rural and remote areas; and
- the Advanced Specialists Training Posts in Rural Areas (ASTPRA) program, which provides matched funding with States and Territories for trainees in specialties such as ophthalmology in rural areas.

The extent to which these programs have been accessed by ophthalmologists and the RANZCO varies. These programs are currently under review as part of the evaluation of the Regional Health Strategy. The Australian Government acknowledges that these programs need to realise their potential to improve access to specialist services for Aboriginal and Torres Strait Islander peoples. The need for better coordination of these outreach programs with Aboriginal and Torres Strait Islander primary health care services is recognised and the Australian Government intends to actively work towards this objective.

The Australian Government is working with the States and Territories, through the Australian Health Ministers Advisory Council National Rural Health Policy Subcommittee, to identify models of specialist outreach; review existing barriers to access; and identify new options for rural and remote areas.

The Review Report outlined several recommendations regarding the remuneration of specialists, for eye health services. In response, consideration of any special provisions of the type recommended within the Review Report would require funding agreements separate to the general Medicare arrangements. Such arrangements can and have been reached at a regional level and supported by other mainstream programs such as the MSOAP.

Regarding the recommendation that a Medicare rebate be made available for the reading of retinal photographs, this matter must await the HealthPACT priority review of the evidence in relation to the effectiveness of retinal photography.

DATA AND INFORMATION SYSTEMS

The Review Report described how the measurement of the impact of the Program on eye health is hampered by the lack of standard elements in data collections and the wide variation and capacity of health services to collect and use health information.

The development of a minimum data-set as recommended in the Review Report conflates service, and regional and national level data requirements. The Australian Government agrees that it is not reasonable nor realistic to expect Aboriginal and Torres Strait Islander primary health care services to be accountable for or report against measures of activity beyond their sphere of influence. The Department is working to improve Aboriginal and Torres Strait Islander identification in mainstream health data-sets including those relating to eye health, while at the same time taking a strategic approach to integrating eye health measures within the developing health performance framework for Aboriginal and Torres Strait Islander health. Therefore the OATSIH does not intend to develop a minimum eye health data-set in isolation from the development of a performance framework.

It is acknowledged that the sustained and enhanced use of service-level information systems requires substantial support and the ongoing commitment of services. The OATSIH is developing strategies to marshal and provide that support. For example, services can now request recurrent funds under the 'Service Activity Reporting enhancement funding' process to meet the ongoing costs of the staff and training needed to fully implement these information systems.

The Australian Government notes and acknowledges that networking of electronic data systems within local areas or regions is of potential benefit. Recognising this, the OATSIH has already funded some primary health care services to develop or maintain networked electronic clinical information systems over a number of locations. The networking of data systems between service providers requires cooperation and financial support. Through its *HealthConnect* trials, the Department is testing mechanisms that allow the electronic exchange of data between service providers to derive the maximum health benefit from health information and provide an improved service to mobile populations. This certainly has the potential to address some of the concerns raised in the Review Report.

INFRASTRUCTURE SUPPORT

Equipment

The Review reported that, as a result of the Program, the availability of regional eye health equipment in the primary health care setting has made a material difference to eye health care for Aboriginal and Torres Strait Islander peoples. In terms of existing specialist equipment for use in the primary health care setting, this was an important one-off funding measure to overcome barriers to the delivery of specialist eye health in primary health care. This equipment was purchased by the coordinating ACCHS for the region, in line with regional plans and individual specialist input. It is recognised that circumstances may have changed in some regions and steps are already being taken to redistribute and relocate specialist equipment where appropriate. Also, where appropriate, the OATSIH will consult with the relevant community controlled health services and their representative bodies to determine the best possible approach to assessing utilisation and location of existing equipment.

Future equipment purchases for eye health and for other clinical activities will be guided by a broader primary health care equipment policy, which will be developed by the OATSIH in 2004.

Evidence-based practice

The Australian Government supports evidence-based approaches to eye health in the primary health care setting and the comprehensive review of the evidence in the Review Report makes an important contribution in this regard.

To strengthen the use of evidence-based approaches to eye health care, two sets of clinical guidelines have been developed.

The OATSIH commissioned the Central Australian Rural Practitioners Association (CARPA), under the auspices of the Centre for Remote Health, Flinders University, to develop primary eye care guidelines in 2000, as part of a review of the 4th edition of the *CARPA Standard Treatment Manual*. This review was completed in 2003.

In September 2001 the *Specialist Eye Health Guidelines for Use in Aboriginal and Torres Strait Islander Populations* were published and distributed by the OATSIH. These guidelines were developed by the Centre for Eye Research Australia in collaboration with the National Aboriginal Community Controlled Health Organisation and have been well received. The RANZCO currently distributes these guidelines.

The Australian Government notes the lack of evidence to support school vision screening programs as identified in the Review Report, and supports the recommendation that visual acuity screening for school-aged children currently in place be evaluated, with no further expansion of school screening until this occurs. The OATSIH will consult with the International Centre for Eyecare Education and relevant stakeholders prior to commissioning an evaluation in this area.

Training

The Australian Government acknowledges that a competent health care workforce is an important mechanism for improving Aboriginal and Torres Strait Islander health. This is a key result area of the National Strategic Framework.

Training under the Program has been developed independently in each jurisdiction. The Review expressed the need for ongoing training for the regional eye health coordinators with a broader emphasis on the skills and principles required for the successful integration of the Program into primary health care services.

Training for eye health workers will be an important mechanism to assist with the evolution of eye health initiatives within the comprehensive primary health care setting. The development of National Competency Standards for Aboriginal Health Workers is currently underway and will take account of eye health competencies for each level of training and qualification. It is anticipated that these competencies will be in place by 2005.

As these competencies become embedded in the training and education curricula, the OATSIH will continue to support ongoing training for eye health coordinators with an enhanced emphasis on:

- the place of a systems approach and the application of population health principles and strategies in primary health care;
- promoting evidence-based primary health care interventions in eye health;
- quality assurance and data;
- integrating eye health into primary health care, particularly chronic disease care; and
- where appropriate, trachoma control and retinal camera programs.

TRACHOMA

The Review Report recommended that trachoma control should be the primary responsibility of State and Territory public health units and should be organised on a regional basis where population mobility is high. The Australian Government supports this recommendation and recognises that trachoma remains a problem in some locations, particularly the desert regions of Australia. There is scope for a more coordinated approach between jurisdictions to address trachoma and its sequelae.

At a national level, bodies such as the Communicable Diseases Network Australia have a key role in developing a nationally consistent approach to collection and reporting of prevalence data, and control measures for trachoma. While the leadership required for an effective regional approach to trachoma control is the responsibility of State and Territory public health units, primary health care services have a role in supporting control activities through making staff available to participate in routine screening and treatment programs. Trachoma and its sequelae should also be integrated into well baby and well adult health checks in endemic regions.

The prevalence of trachoma is strongly associated with sub-optimal housing and living environments. Therefore, in addition to a health system response, sustained and sufficient environmental improvements across the geographical regions affected are required. Environmental health is a key result area of the National Strategic Framework, which emphasises the collaboration needed across sectors and at all levels of government.

SUMMARY

Optimal eye health service provision for Aboriginal and Torres Strait Islander peoples requires an improved response to needs across the health system. This is best viewed at a systems level and with a strategic approach that will benefit not only eye health but the broader health needs of Aboriginal and Torres Strait Islander peoples in their interaction with all levels of the health system.

Therefore the following principles will guide future discussions with regard to the further evolution of the eye health program:

- Eye health must be addressed as a component part of comprehensive primary health care.
- Mainstream programs and services, including specialist services, have the same responsibility to address the health needs of Indigenous Australians as other Australians and at all levels of the health system.
- Regional approaches to eye health will, over time, place more emphasis on strengthening the capacity of local primary health care services in an organised approach to chronic disease detection and management.
- Trachoma control in endemic regions requires a public health response with the involvement of public health units, primary health care services, and housing and essential services.
- Existing capacity in eye health in the Aboriginal and Torres Strait Islander primary health care setting must be preserved.
- Program development and implementation should be based on the best available evidence.

ENDNOTES

- i *Hugh R Taylor, Eye Health in Aboriginal and Torres Strait Islander Communities, 1997.*
- ii *Centre for Remote Health, Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program, 2003.*

