RANZCO The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

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RANZCO submission to Western Australian Sustainable Health Review

The Western Australian (WA) Branch of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to provide this submission as part of the public consultation on the Sustainable Health Review to prioritise the delivery of patient-centred, high quality and financially sustainable healthcare across the State.

Adequate timely provision of ophthalmic care is heavily dependent on appropriately equipped and resourced out-patient based consulting and diagnostic services. Ophthalmology services within the public sector fall within, and are subjugated by, hospital general surgical services and so are not considered independently. As a result, overall competition for capital and recurrent funding has constrained ophthalmic service capacity. Along with the regional based compartmentalization of health services in WA (eg Health Service Areas, Country Medical Service etc), a lack of a coordinated independent ophthalmic service has resulted in considerable variance in the current ophthalmic capacity across the WA public sector. That variance produces inequitable service provision for public patients in WA, and this is almost entirely dependent on the location of the patient's interaction with WA Health.

Despite the availability of well-trained, willing, and enthusiastic Western Australian ophthalmologists, there is now a small but significant workforce shortage within the public sector. Mostly this is due to lack of capacity overall, but exacerbated by maldistribution of existing capacity across, and within, the various public facilities in the State. This has the knock on effect, as those facilities are also required for training purposes, so in time this will amplify present workforce problems.

So competing interests across the health service, along with fragmented administrative structures divert attention and resources away from the eye care needs of the WA population. This inequality has the biggest impact on the indigenous, poor and needy as they have little alternative than to seek care within the public sector, which is felt most acutely by the remote and regional folk in the State.

An appropriately structured, independent administrative service within Health specifically for Ophthalmology, co-ordinating the provision of care across all the eye care services in the State, will go a long way towards addressing the currently fragmented capacity issues and constraints in our Public Sector.

With a comprehensive Ophthalmic Services structure, optimal resources can be better directed (or redirected) to pockets of need, provide for equitable provision for current requirements, and allow for planning of future resources. Specifically we believe a significant up-grade to services for the North West is now required.

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Executive summary

1. There is significant variability of ophthalmology services across the state and even within the metro area, which underlines the need for a coordinated approach to eye health service planning provided by a single State–wide ophthalmology administrative service. Hospital and region-specific issues and unmet needs are further detailed in the report.
2. Existing public sector capacity (equipment, space, and staff) can be optimised with an appropriate, independent administrative service specifically for ophthalmology within Health to coordinate the provision of eye care services across the State.
3. Despite being the first surgical 'sub-specialty', the bulk of ophthalmic services are predominantly medical, and now predominantly outpatient based. Compared with other medical services there is little utilisation of radiology, pathology, ancillary medical services such as intensive care, or even many ancillary general hospital services such as physiotherapy. Instead ophthalmology relies on self-contained specialty outpatient based diagnostic and therapeutic capability. Newer ophthalmic technologies such as Optical Coherence Tomography (OCT - a scanning laser imaging system) are now standard of care, but the public sector provision of such essential capacity is patchy and generally under-resourced.
4. RANZCO identifies a small but significant workforce shortage within the public sector, mostly due to lack of capacity, and exacerbated by maldistribution and fragmented administrative structures.
5. Capacity constraints in the public sector have a more significant impact on the indigenous, poor and needy as they have little alternative than to seek public care within and rely on the public system to a much larger degree than the general population.
6. RANZCO data analysis suggests that ophthalmology patients in Western Australia face longer waiting times compared to the rest of the country, in both public and private facilities, with the more significant gaps in public hospitals.
7. Despite independent initiatives such as the Lions Outback Vision Van, remote care remains inadequate, especially in the North, and is mostly reliant on expensive transfer to southern centres. Establishment of an ophthalmology service based in Broome, and permanent out-reach clinics in the remaining Kimberly and Pilbara would address a significant area of need and provide much needed rural ophthalmic training opportunities.
8. Eye health service planning requires a high degree of collaboration between ophthalmologists and allied eye health workers (including optometrists, ophthalmic nurses, and orthoptists), working in close collaboration following the best models of care. RANZCO is leading the development of shared referral pathways, which are key to ensure optimised utilisation eye care services.
9. When planning Western Australia's future health systems, RANZCO supports a collaborative approach which ensures that patients receive access to the best possible standard of care, from the best-trained professionals, working and communicating effectively to ensure optimal care. RANZCO's principles of collaborative care are detailed in the report.
10. The Lions Outback Vision Van is an example of a new project that has proven valuable in servicing rural and remote areas. Such projects require long-term support, and can be used as a model for innovative approaches to healthcare delivery.
11. The challenge in managing a number of medical ophthalmic problems, in particular diabetic eye disease, is expected to worsen in the near to medium-term future, and requires ongoing collaboration across different health sectors as well as across the health system (public and private).

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Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition

Maldistribution of ophthalmic capability across, and within, the various public facilities in the State creates *inequity in the provision public eye care services*. And that is before any comparison with the capacity of private care.

Despite the availability of Australian trained ophthalmologists locally, there is now a small but significant workforce shortage within the public sector. Mostly this is due to lack of capacity overall, but exacerbated by the variance in capacity. This has the knock-on effect, as these facilities are also required for training purposes and this in time will amplify present workforce problems.

Lost within the current overall WA Health structure, the fragmented nature of ophthalmology services has to compete with conflicting local interests across the service. Along with the lack of a coordinated ophthalmology administrative structure, this diverts attention and resources away from the eye care needs of the WA population.

Such inequitable and poorly co-ordinated public care has the biggest impact on the Indigenous, poor and needy as they have little alternative than to seek care within the public sector. And this is felt most acutely by the remote and regional folk in the State.

An appropriately structured, independent administrative service within Health specifically for Ophthalmology, coordinating the provision of care across all the eye care services in the State, will address the currently fragmented capacity issues in our Public Sector.

With a comprehensive Ophthalmic Services structure, resources can be better directed (or redirected) to pockets of need, and planning of current requirements and for future resources will be optimised.

For example the public visiting medical practitioner scheme (VMP) based at district hospitals such as Bentley Hospital only provide for limited surgical services such as cataract surgery and do not provide for any ophthalmic training. Those funds would be better directed to Royal Perth outpatient services (which is the bulk of ophthalmic care) and the theatre time provided to the public clinics under an incentivised sessional scheme that also allows for ophthalmic training (as trialled by Osborne Park Hospital and Sir Charles Gairdner Hospital eye clinic).

Another example is the idle equipment currently based in a vastly inadequate clinic space without any appropriate staff to use it at the Fiona Stanley Hospital. Although the FSH equipment is the newest in the State, lack of capacity otherwise leaves it unused. The funding model to provide that equipment is part of the new FSH outsourcing arrangement, which unfortunately prevents the re-deployment of the idle equipment to other public clinics in need.

Better patient centred care for those in the Kimberly and Pilbara would be served by establishing an ophthalmic service in the North West. Funds would be saved from the expensive need to expatriate many currently requiring ophthalmic services to southern centres. A full time regional presence would at the same time enhance much needed rural ophthalmic training opportunities.

There also currently a need for adequate equipment such as OCT scanners in smaller local centres that will allow for easy patient access to increasingly demanding recurrent treatments

such as that required for neo-vascular macular degeneration. But this requires evaluation as to whether it is better to support multiple small centres with adequate staff and basic equipment or to consolidate most of ophthalmology into a few larger but more efficient centres with up-to-date equipment.

Appropriate co-ordinated planning such as would be provided for by a comprehensive Ophthalmic Service would avoid capital and recurrent expenditure missteps. Appropriate strategic resourcing would help provide for adequate support staff and equipment and dramatic improvements in clinic efficiency at major clinics such as the Royal Perth Eye Clinic.

Like most developed countries the aging population presents more challenges in treating eye diseases. Generally, the prevalence of cataract blindness in WA is low, being well catered for in most of the state. There are some areas that are still significantly underserviced (for example, Esperance, and the North West). The bulk of the serious ophthalmic work is with the big 3 chronic diseases that cause blindness: Glaucoma (damage to the optic nerve); Age Related Macular Disease (degraded macular function); and Diabetes (causing a retinopathy affecting the macula). Together they present in around 10% of the population. Although well serviced in the private sector, and increasing optometric 'shared care' is enabling wider ongoing care, there still is an increasing need for public outpatient services.

Private care is unable to adequately provide for the specialised care of a number of blinding (and for example in the case of tumours, life threatening) eye diseases such as trauma; severe corneal and other eye infections; and tumours around, within, and on the eye. Currently, a number of basic diagnostics (eg OCT scans) and simple treatments (eg punctum plugs) have no Commonwealth Medicare Rebate, thus requiring an out of pocket expense for patients and so are often out of the reach of the poor and needy. Public facilities are definitely necessary to meet that gap.

The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public

Although nominally a 'surgical' specialty, ophthalmology actually provides more physician-like care for 80+% of all eye patient interactions, with most occurring in the outpatients setting. It is in this setting that all the diagnostic workups (OCT scans, angiography, physiology function tests) and many treatments (lasers, injections etc) occur. Ophthalmic eye care only requires a small input from external medical providers, as the demand for radiology and pathology services is not intensive in our specialty.

Ophthalmology's generally autonomous capability however, still necessitates outpatient hospital based services and requires specialty equipment, run by technical staff, with administrative support services, in an adequate space (ie sufficient capacity).

Ophthalmic surgical care is now highly developed and is generally performed as day cases. It also requires specialty equipment to provide the superior outcomes expected of modern ophthalmology. Again, this requires appropriately trained technical and nursing staff for appropriate use. Ideally modern ophthalmic surgical care is best co-located close to outpatient services to enable sharing of nursing and technical expertise.

Royal Perth Hospital (RPH) – RPH has the largest ophthalmology department, and cares for more patients per full time equivalent than any other Department in the country. It has the oldest clinic equipment in the State, and apart from being hampered by lack of appropriate upgrading of equipment, there is an inadequate amount of basic equipment to meet clinical need efficiently. Access to theatre time is currently also limited. Most of the private ophthalmologists operating at Bentley do not otherwise contribute to the RPH eye clinic, nor provide teaching or training opportunities for registrars. Redirecting their fee for service VMP payments to the RPH Department of Ophthalmology would go a long way towards addressing the funding needs gap, improve the ongoing services of the clinic, and enhance training opportunities for the registrars who require more theatre time. Funding for more consultants needed to meet demand at RPH would also be helped by the redirected VMP payments.
Without a major upgrade in equipment, the clinic will continue to run inefficiently and below an acceptable level of care for a major tertiary and teaching centre. Additional trained ophthalmic assistants should be utilised to increase capacity and improve clinic efficiency.

Fremantle Hospital – has a new outpatient clinic space and good theatre access. The main problems in that service are access of patients to outpatient appointments (seemingly due to administrative processes), poor inpatient capability, and no after-hours services available to deal with emergencies.

After hours' access is the major red flag for South Metro ophthalmology. Currently this is being provided by RPH using a combined consultant on call service. However, given the burden of after hours' cases on RPH and the excellent access to theatres at FH, there is certainly the scope to extend access at FH. FH operating theatres remain relatively underutilized and are easily able to cope with five cataract cases while teaching during a list. Administrative barriers have limited simple transfer of waitlist patients from RPH to FH. A free flow of surgical cases between the two sites would aid ophthalmology's ability to provide better care to patients, and achieve better training. Despite numerous discussions regarding a combined service, no real action has ever been taken.

Sir Charles Gairdner Hospital (SCGH) –The Ophthalmology Department at SCGH offers tertiary level eye care to the North Metropolitan Health Service. Additional theatre lists at Osborne Park Hospital on an incentivised session model has allowed consultants at SCGH to better meet both training and service commitments. As a result, by restructuring the existing Full Time Equivalent (FTE) consultant allocation, the Ophthalmology department at SCGH has been able to appoint more consultants. As a result of this, there has been an increase in the service provision and training registrar posts at SCGH. SCGH is currently accredited by RANZCO for two training registrar posts. It has also allowed a recent upgrade in the eye clinic's equipment.

Fiona Stanley Hospital (FSH) – FSH has the newest equipment but this mostly lies idle. The clinic is woefully inadequate and not fit for purpose as it is all squeezed into one room including all the equipment. As there are no consultants and no theatre availability, there is no possibility of establishing a training program. A registrar rotates through the hospital to see and triage consults, so does not usually use the eye room and the equipment. Walk-ins to ED with eye issues will be referred on to Fremantle Hospital during working hours. Although there is after-hours emergency service – eye patients are triaged and sent on to RPH for appropriate care. We are most concerned that inpatients with inter-current eye problems who are not able to be sent on to RPH for ophthalmic care (eg intensive care and burns patients) are at risk of poor or adverse outcomes. Although RPH and Fremantle are covering this situation at present this arrangement is not at all suitable long term. Some clear plan for developing proper outpatient facilities and theatre access is desperately required.

Princess Margaret/Children's Hospital – there is an undersupply of paediatric ophthalmologists through-out Australia. It is imperative that training is enhanced in this area. In WA, this is the only facility to provide such training. There is currently an excessively long waiting time for patient appointments as there are patients waiting for over 2 years to be seen. The loss of access for paediatric surgery at Osborne Park and Rockingham Hospital, and all paediatric services at Fremantle Hospital have significantly degraded paediatric ophthalmic public eye care services. The Princess Margaret Hospital for children is now the only tertiary public facility seeing paediatric ophthalmic cases. The added demand for service has not been matched with increase in FTE nor facility. The pressure may be relieved to some extent by the larger eye clinic at the new Perth Children's Hospital when it opens eventually. There is however need for support for the new hospital to purchase more service for the Children's Ophthalmology Department in the form of increased FTE, which will in turn help to increase the through-put and reduce waiting time.

Rockingham & Mandurah – have good regular private services but the loss of surgical services at Rockingham has degraded the local public service capacity. Fremantle Hospital, however, has been able to meet some of that demand, except for paediatric cases.

South West Eye Services – the recent increase in specialists in the region has improved capability, and the training post has been successful over the recent years.

Great Southern Services - a full-time ophthalmologist supported by visiting ophthalmologists provide good care. However, Albany lacks private surgical facilities.

Gold Fields Services – some regular visiting ophthalmology services provide basic care. Like Albany the lack of private surgical facilities limits the care available locally. Remote communities are significantly underserviced. Esperance, in particular, requires much more capacity as it was the significantly low outlier for cataract services in the recent Atlas of Surgical Variation.

Wheatbelt Services - some regular visiting ophthalmology services provide basic care, Northam has the best visiting service and offers regular surgery, and tends to be a hub for the rest of the area.

Mid-West (& Gascoyne) Eye Services – the recent establishment of a service registrar post has improved capacity and paths the way for potentially up-grading it to a training post in the near future. A visiting service to Carnarvon is provided out of Geraldton.

North West Services – there are no fulltime ophthalmologists in this region which presents many challenges in adequate delivery of ophthalmic eye care. There is an eye care 'access gap' compared with urban areas, coupled with higher prevalence of many ocular conditions among these communities. Currently the Lion's Outback Vision mobile eye health service visits the Kimberley and Pilbara areas, providing five days of services, four times per year, to each. It should be noted that the consultant ophthalmologists involved in this service are volunteers who cover their own transport and accommodation costs as well as the costs of leaving their own private practices unattended. They receive only a token payment through the small amount of costs recovered from Medicare rebates for consultations. It remains to be seen how long this will be sustainable, as the rising costs associated with maintaining a private practice in this increasingly high-tech specialty, will make it increasingly difficult for people to volunteer, While this does provide a much-needed service in these areas, there is an unmet need for regular treatment and monitoring – for example, injections to treat age-related macular

degeneration or regular monitoring of diabetic retinopathy patients. At present a high number of patient transfers to major eye clinics is still required to meet patient need.

The model is both expensive to facilitate and insufficient to meet long term demand. In addition, there is great pressure and stress placed on local communities when all the eye work is saved for an intensive week, with the eye clinic tending to overwhelm clinics/theatres with the number of eye patients compared to other visitors.

A more effective and sustainable model is therefore required. We suggest a new North West public eye health service with Broome providing 'hub' with a weekly theatre list, registrar base and weekly clinics. This hub would then share services and coordinate with four major 'spokes' in Karratha, Hedland, Derby and Kununurra. They would receive monthly outreach trips providing day clinics, and a week of routine surgical sessions twice a year.

This service would then be augmented by the Vision Van, a fully equipped mobile eye clinic that would provide outreach, including optometry and ophthalmology services with high-tech telehealth and a resident medical officer, to smaller remote communities to provide onsite eye clinic and eye surgery services.

A real challenge is providing the best levels of care for retinal conditions needing anti-VEGF therapy. The traditional model of 2-3 visits a year has to be reconfigured into more frequent but shorter trips. For Indigenous patients whether in the city or the rural areas, these barriers are also present for accessing specialist care. Fortunately, there are culturally appropriate settings often provided in regional towns and in the city, particularly, the Aboriginal Medical Services (AMS). AMS can be accessed more easily and it is worth considering eye health services being connected into these health services. In Western Australia, nearly all of the services have a connection with an eye health service including in the city. The encouraging news is that there are inroads being made for Indigenous eye health. Results from the National Eye Health Survey has demonstrated improvements since 2008, with a halving in the prevalence of blindness though there is still much work to be done while the gap still exists.

As illustrated above, there is significant variability across the state and even within the metro area in how service is provided and there is a need for a coordinated approach ensuring a balance between service commitments, 'incentivisation' schemes and teaching commitments.

Optometric Care – after a 5-year undergraduate degree, optometrists are trained to prescribe and dispense optical appliances (glasses). Modern optometrists also have training in the use of diagnostic ophthalmic equipment and some limited understanding of ocular therapeutics. In general, the provision of refraction and optical appliances by optometrists is a low risk and convenient service for the adult population. Their ocular examinations may provide a useful triage and referral service for patients as well. The Royal Australian and New Zealand College of Ophthalmologists has developed shared care guidelines for the management of a number of chronic eye diseases such as glaucoma with the SpecSavers group which employs around 60% of the country's optometrists). In time, appropriate guidelines should provide a safe 'shared care' pathway for patients wanting routine optometric care. The care of children by optometry is problematic, as inappropriate application of optical appliances and unproven alternative therapies (eg behavioural optometry) may disadvantage a child for the remainder of life.

Need for increased public hospital consultant positions

The 2017 RANZCO Workforce Survey data analysis suggests that ophthalmology patients in Western Australia face longer waiting times compared to the rest of the country, in both public and private facilities.

When comparing waiting times reported for WA vs whole of Australia, in both public and private, Western Australia performed worse than Australia in general. For emergency referrals, more than a quarter (27%) of WA ophthalmologists working in public reported that patients need to wait beyond the following day, which is more than double the Australia-wide rate for public (13%). The difference in private for patients waiting more than a day for emergency referrals is 14.1% (WA) vs 9.2% (Australia).

For non-emergency referral, the rate of ophthalmologists working in public hospitals reported a waiting period of under 2 weeks Australia wide (10.2%) almost double the rate for WA alone (5.4%). Again, there is a gap in private as well, but not as significant (42.9% for Australia-wide, 38.5% for WA).

These figures suggest that WA is already slightly lagging behind the rest of Australia in terms of service availability, and the more significant gaps appear to be in public hospitals.

Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance

Ophthalmology has led the way in the innovative use of modern technology. Most of these advances have resulted in not only improved patient outcomes (well validated by trial data), but more efficient and cheaper delivery of those outcomes.

WA has particular expertise in the data linkage of health records. This capability has been applied to ophthalmology, in particular cataract surgery which has produces a database that extends over 35 years covering the transition of surgery through 3 techniques to today's modern small incision phacoemulsification cataract extraction. We have shown clearly that in WA the outcomes have steadily have improved over this time, to the extent that this, the most common operation performed in the state, is also among the safest and effective of all capital operations. Data Linkage is a useful tool for continuous performance monitoring, but there is no current or ongoing funding to do so. As the cataract complication rate is so small, administrative data alone is not adequate to identify processes for improvement in cataract surgery. Better data 'granularity' about the surgery would be obtained with a detailed digital operative record. Such a system is available and well developed as a result of collaboration between the College, UWA and the Department of Health. The eCats operative record now requires funding to fully implement the system and maintain it ongoing. Such a measure would provide a state of the art comprehensive surgical audit system.

Registries have an important part to play in the monitoring the quality of outcomes of newly introduced treatments and technologies. WA has considerable expertise in participating in the management of the Fight Retinal Blindness registry which monitors the recently introduced use of anti-VEGF treatments for macular disease. The analysis of outcomes has provided considerable input internationally about optimum use. Generally manual input registries may be too cumbersome for high volume commonly performed procedures such as cataract surgery as the burden of data input negates their usefulness. Digital medical records with automated data

scraping may provide a solution, but there is considerable development to make the process integrated in clinical practice and seamless in operation in the public sector. The IRIS program of the American Academy of Ophthalmology is a hugely successful example of such a process.

New models of service provision have originated in WA, such as the Lions Outback Vision Van. It has completed two full circuits of Western Australia in 16 regional communities this year since March treating 1600 patients. The Van is a unique new service model that delivers ophthalmology clinic-based care for all major eye conditions close to where people live. This service is provided in addition to the usual outreach so has assisted patients by preventing city transfer for many conditions where more specialised equipment is required.

The Van travels greats distances to service the sixteen towns, but there are places that the van cannot access. An additional 30 locations are supported by the Federally funded Visiting Optometry Scheme (VOS). The optometrists provide much of the diabetic screening while helping the patients with immediate vision impairment with glasses. In addition, they facilitate telehealth with the patients to help consent directly for surgery. This saves unnecessary travel and waiting times just to meet the specialist in clinic and enables the patient to attend for the surgery directly. During the consultation, an optometrist ran through the findings and the patients were booked for surgery without having to attend at clinic until the surgery date. Sharing the same electronic medical records as the optometrists more recently has been an improvement.

Telehealth can happen at any time and ophthalmologists can conduct telehealth consultations from anywhere. Telehealth has worked well with optometry as access to OCT equipment in addition to other eye-specific equipment has really increased this scope for its clinical application. For telehealth to work however, there needs to be an opportunity to provide specialist outreach as well to provide surgery or face-to-face clinic visits.

The current barriers between different records and different computer software companies has meant it has been very difficult to integrate care. Many piece-meal systems have been developed to manage patient records whereby, out of necessity, services have ended up creating their own medical records because there is no integrated patient record management system across Western Australia for example. However the IRIS program provides an example of how different systems can be integrated into one registry.

Regarding technology in outreach, OCT has become a standard part of comprehensive ophthalmic practice. Centres providing outreach ophthalmology require this device to monitor and treat common conditions. Machines are often integrated with the retinal photograph they are a useful part of outreach visits, aside from being very easy to use as automation enable health workers in the clinics to be involved in patient pre-assessment.

Having an ability to collate data from a number of different diagnostic machines used within a clinic automatically into the medical record would greatly improve clinical efficiency and safety. Improved access to integrating software in the clinics and development programs are required before this becomes standard practice.

Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care

We believe that the fragmentation, variance, and inequities in the delivery of ophthalmic care would be better addressed by and independent overarching co-ordinated Ophthalmic Service within Health in WA.

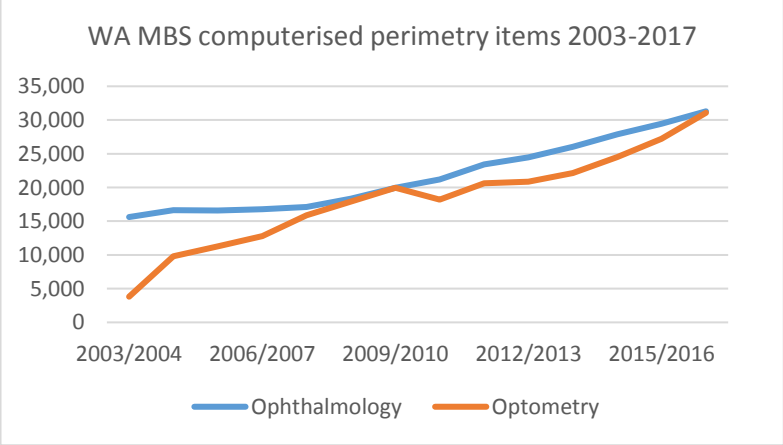
RANZCO is also a strong proponent of effective partnerships, both within the eye health sector, and across different health sectors. When planning Western Australia's future health systems, RANZCO supports a collaborative approach which ensures that patients receive access to the best possible standard of care, from the best-trained professionals, working and communicating effectively to ensure optimal care.

RANZCO's support for a collaborative care approach rests on RANZCO's principles of collaborative care, as detailed in the RANZCO guideline document Principles for Collaborative Care of Glaucoma Patients. According to the document, the aims of collaborative care should be:

- Patient-focused treatment;
- Evidence-based health care;
- Access to the most appropriate health-care provider in a timely fashion;
- Clearly defined roles for health-care providers and effective communication;
- To reduce unnecessary duplication of tests;
- To reduce unnecessary health-care provider visits;
- To avoid unnecessary treatment or overtreatment of patients; and:
- To ensure patients at risk of progression to visual loss are not undertreated and have access to the full range of treatment alternatives of which they should be made fully aware.

In recent years, RANZCO has increased its emphasis on collaborative partnerships with other health professionals as well as other sectors in the spirit of the principles quoted above. One such collaborative care project was the formulation of three Collaborative Care Pathways in cooperation with Specsavers, to ensure that optometrists have the tools to properly refer patients to ophthalmologists in a timely manner. These pathways are for glaucoma, age-related macular degeneration (AMD), and diabetic retinopathy.

Analysis of MBS items from Western Australia shows that in the last decade optometrists have been performing computerised perimetry assessments at a rate almost identical to ophthalmologists:



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Diabetic eye disease

The nature of some of the most common eye conditions requires a high level of collaborative care to ensure patients are diagnosed and treated on time. One of the most rapidly rising causes of loss of vision in Australia is diabetic retinopathy. There are presently over a million Australians with diabetes, a number which is expected to double by 2025. Almost all patients with type 1 diabetes, as well as over 60% of patients with type 2 diabetes, may develop diabetic-related eye disease within 20 years of diagnosis.[1]

To ensure that Western Australia responds appropriately to the growing challenge of diabetic eye disease, a high level of collaboration is required between ophthalmologists, endocrinologists, general practitioners, and optometrists, as well as appropriate collaboration between the Department of Health, Primary Health Networks, hospitals, and both the private and public health sector.

A key aspect of addressing the challenge of diabetic eye disease is to ensure regular screenings to the rate recommended by NHMRC (once every 2 years, or once a year for Aboriginal and Torres Strait Islander patients)[2], as well as to ensure appropriate referral pathways once a patient has been screened. Experiences from overseas show that a well-coordinated public screening program can ensure very high screening rates and compliance, for example the Diabetic Eye Screening Programme in the UK.

The challenge of diabetes in general, and diabetic eye disease in particular, offers a unique opportunity to drive partnerships across sectors and all levels of government. This challenge is similar to challenges offered by other chronic conditions, and provides a good case study to a wider need to improve collaboration between providers and institutions to combat the multi-faceted nature of chronic conditions, and the need for effective ongoing multi-dimensional support for patients, carers, and families.

An effective collaboration will ensure optimal screening rates and follow-ups, while also likely to reduce duplication and ensure the delivery of integrated and coordinated care, in line with international best-practice.

Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies

Registries and Data Linkage will provide insights into the effectiveness and safety of interventions in ophthalmology but for effective feedback we require an ongoing infrastructure for not only data collection, but also for analysis. With appropriate resources that capacity will be met easily as there is considerable expertise within the ophthalmic community in WA.

Understanding current practice better will optimise outcomes and clinical efficiency, providing better value as the resources are not deflected into remediation of preventable problems. Finding new effective and efficient practices requires a culture of innovation, along with the readily available resources to quickly seize on new opportunities as they are identified.

Currently both Registries and Data Linkage only provide sporadic research reports, but more effective contemporary continuous reporting is possible with provision of the appropriate capacity.

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Planning the health landscape is inevitably tricky as it is hard to predict the success, and significance of an innovation. The rate of introduction of new innovations in therapeutics, procedures and devices, and how these may impact on existing services is also difficult to predict and manage. Contemporary feedback will help better short term management, but adopted changes will of necessity impact on long term capacity planning, specifically, workforce needs and infrastructure. So a degree of redundancy to allow flexibility in the system is required.

In eye health, the last two decades saw a number of changes to ophthalmology which have made significant impact on treatment options for patients and the workload for ophthalmologists. For example, intravitreal injections to treat Age-related Macular Degeneration (the leading cause of vision loss in Australia) quickly become *the* 'standard-of-care' treatment option. To date the public sector was slow to adopt and adjust to such new systems and effectively provide these new treatments. There is no inbuilt contingency for the flexibility to adopt new efficient and safe treatments in a timely manner. This exacerbates inequity not only in the community, but specifically in the public sector.

When planning the Western Australia health system with view to the future, it is vital to ensure flexibility for change in the system, to make it more "future-proof". In practical terms, this means accounting for possible changes in practice patterns and making appropriate provisions in advance. An overall ophthalmic service for the public sector will be placed to co-ordinate current and future needs.

The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring

The limited training positions combined with attrition rates and illness of ophthalmologists in WA has recently made it difficult to maintain a consistent level of service.

Currently, there are 11 training posts with trainees in years 1-4. Ideally, the state government should consider offering training at other hospitals such as Joondalup or Midland that already have a strong surgical ophthalmic presence. An expanded North West ophthalmology service would provide more much needed rural training opportunities. RANZCO would appreciate an opportunity to work with the state government to provide support for training, also considering linking up with the Specialised Training Program Integrated Rural Training Pipeline (STP- IRTP) funding available through the Federal government.

Improved communication between GPs, optometrists and specialists is increasingly being facilitated though electronic communication.

In the private sector, ophthalmic assistants now play a vital role in providing enough capacity to meet the demand for specialist eye care within our state. They perform routine assessments such as visual acuity testing, imaging, and performing pre-operative measurements, so that the ophthalmologist is able to devote enough time to assessment, communication and decision making for each patient. Assistants are generally trained in-house by each practice with practical instruction as well as use of online course material. As yet there is no job description or pay scale for ophthalmic assistants in the public sector. Developing a public sector training program for ophthalmic assistants would provide more skilled technical staff and reduce the need for expensive tertiary qualified professionals like nurses and optometrists. Addressing this

shortcoming in the public sector will help provide a more cost-effective and streamlined public ophthalmology service.

In conclusion

RANZCO's mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific region through continuing exceptional training, education, research and advocacy. Underpinning all of the College's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality. RANZCO also seeks to educate the general public in all matters relating to vision and the health of the human eye and advocates for accessible ophthalmology cost effective services for patients.

We look forward to discussing the above issues and the development of a more sustainable, patient centred health system in Western Australia.

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Chair, Western Australian Branch

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