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

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Research Director
Health and Ambulance Services Committee
Parliament House
George Street
Brisbane Qld 4000

Inquiry into the establishment of a Queensland Health Promotion Commission

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to contribute to this inquiry. 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. Training ophthalmologists is our core business and training the next generation of Queensland registrars is a priority for RANZCO.

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 and cost effective services for patients with eye disease. Through world-leading research RANZCO fellows and research partners are reducing the burden of chronic ocular disease. This research is essential for tracking patient outcomes and finding innovative measures to minimise the impact and costs of chronic disease.

In summary, RANZCO supports the establishment of a Queensland Health Promotion Commission (Commission) as a central platform to advocate for balance in health promotion funding, equity in access to services including screening, and promotion of innovative, multidisciplinary models of care:

- In Australia, 75 per cent of blindness and vision loss is preventable or treatable if it is detected early. The loss of vision is a major public health issue as well as the cause of personal tragedy and a denial of human dignity that stems from the loss of sight-enabled independent living. Furthermore, visual impairment has a profound impact on other health conditions, leading to a higher risk of injuries, accidents, and depression (1).
- To meet the World Health Organisation (WHO)'s 2020 objective to reduce avoidable blindness a whole of government approach is needed. The National Framework Implementation Plan for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss is the first implementation plan for eye health and vision care outlining Commonwealth responsibilities. There is an urgent need for state governments to participate in the Plan and the Commission would be ideally placed to advocate for a Queensland Health commitment.
- RANZCO believes that an important role of the Commission would be to address inequalities in the provision of health services delivered via the public sector in Queensland. Public hospital outpatient clinics play a vital role in providing treatments

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for those living in Queensland who are unable to afford private health. Recently published data from the Australian Institute of Health and Welfare suggests that Queensland lags behind other states in providing access for patients to non-admitted public hospital services, denying those most in need of care.

- RANZCO believes the Commission could play a vital role in supporting screening programs and universal access to early intervention and treatment. The Queensland funded IDEAS VAN which provides access to specialist services and follow up care to regional and remote Aboriginal Medical Services and the NSW C-EYE-C model that utilises collaborative care to more efficiently see and treat patients earlier are included in this submission as examples that could be replicated to prevent avoidable vision loss and blindness.

Prevalence of eye disease

The loss of vision is a major public health issue as well as the cause of personal tragedy and denial of the human dignity that stems from the loss of sight-enabled independent living.
In Australia, 75 per cent of blindness and vision loss is preventable or treatable if it is detected early (1).

Despite this, visual impairment and blindness impose substantial morbidity and premature mortality on the population. Almost 575,000 Australians over 40 had vision loss in 2009, representing 5.8% of the population in that age group. Of these people 65,000 were blind with the largest proportion aged over 70. These numbers are expected to rise substantially with our ageing population.

Moreover, there are also well-established correlations between visual impairment and higher risk of falls, hip fractures, motor vehicle accidents and depression - with risk of death elevated to 4.3% for those over 40 compared to 1.6% for the fully sighted (1).

Section 1

RANZCO supports the establishment of Queensland Health Promotion Commission (Commission) to:

- advocate for a balance in funding and services across the health promotion spectrum to reduce morbidity and mortality rates associated with chronic diseases including preventable eye diseases that cause vision loss and blindness;
- advocate for equity of access to services and screening, particularly for disadvantaged groups;
- promote innovative and collaborative models of care that utilise the capabilities of a multidisciplinary team to improve patient outcomes and access to services.

National Framework Implementation Plan

To reduce avoidable blindness and vision loss a whole of government approach is needed. The Commission would be ideally placed to progress a jurisdictional commitment from Queensland to the National Framework Implementation Plan (NFIP) for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss.

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The NFIP is the first implementation plan for eye health and vision care outlining Commonwealth responsibilities. Signed off by Minister Dutton in 2014 this framework marks a significant milestone towards establishing a national integrated plan to eliminate avoidable blindness and vision loss and improving the participation of people who are blind or vision impaired in the community. The 2014-2016 NFIP outlines three key priority areas:

- Aboriginal and Torres Strait Islander eye health,
- preventing eye disease associated with chronic conditions (particularly diabetes); and
- improving the evidence base.

The NFIP directly corresponds with the 'World Health Organisation's Universal eye health: a Global Action Plan 2014–2019' which was endorsed at the World Health Assembly in May 2013. The intent of the NFIP is to identify a series of measureable actions to ensure Australia's strategic focus on eye health and vision care is aligned with its international obligations.

The current NFIP does not include the role of states and territories. A commitment from state governments, including Queensland to the NFIP is essential to the success of the plan.

Section 2

a) Approaches to addressing the social determinants of health

Addressing the social determinants of health requires a whole of government approach to reducing inequalities and the unfair and avoidable differences in health status seen within Australia and in Queensland. RANZCO supports the Commission in working with the Commonwealth and across the various departmental responsibilities to address the social determinants of health in Queensland.

b) Population groups disproportionally affected by chronic disease

Lower social economic groups

It is well recognised that lower social economic populations are more susceptible to lifestyle diseases. With high rates of obesity and smoking in Queensland (2), the population is at a greater risk of contracting chronic conditions and eye disease.

Moreover it is these groups that cannot afford private health insurance and are often placed on long waiting lists before receiving access to treatment.

Rural, regional and remote

The geographical barriers unique to Queensland add to the complexities in providing screening and treatment. Queensland has a decentralised population and its capital city is not centrally located. It has the third largest state population in Australia and the second largest geographical area of nearly 2 million square kilometres. These factors contribute to the provision and accessibility of ophthalmology services in regional centres and rural and remote

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locations. There are also barriers for patients in travelling to locations, out of their home environment to access services.

Indigenous population

Aboriginal and Torres Strait Islander people have six times the rate of blindness and three times the rate of vision loss than the broader population. Vision loss accounts for 11 per cent of the health gap between Aboriginal and Torres Strait Islander people and other Australians (3).

Indigenous Australians are 14 times more likely than non-Indigenous Australians to develop diabetic retinopathy (4). Median public hospital waiting time of cataract surgery for indigenous Australians was 112 days compared to 81 days for non-indigenous Australians (5).

There are still areas where Aboriginal and Torres Strait Islander people experience very limited access to both Indigenous-specific services and to GP services in general. Central and south-eastern Queensland are standout regions with high concentrations of service gap SA2s (5).

Indigenous Australians living in rural and remote locations rely almost entirely on public ophthalmology services and there are none from Caloundra to Townsville with lengthening waiting lists at other centres.

Weak regional ophthalmology services causes increased pressure on metropolitan departments to serve regional patients. This is particularly a problem at Royal Brisbane Hospital (which receives patients north of the river) and has the poorest funding of all the major Brisbane eye departments.

Moreover, transporting patients to Brisbane for appointments and surgery is socially dislocating and expensive and beyond many indigenous patient's ability to cope.

There is clearly a need for the Commission to address the needs of this population group, having a focus on health promotion and equitable access to services, working in partnership with AMSs to close the gap in eye services.

Children

Preventing vision loss and eye sight in children should remain on the public health agenda. Three of the top ten disorders that affect children are eye conditions. There are also many 'rare' eye disorders which collectively (there are 8000 different rare eye disorders) are not rare and effect 2.6% of the population (6). Screening programs and early intervention are essential to minimise the impact of the eye disorder on the developing visual system.

c) Economic and social benefits of strategies to improve health and wellbeing

Many Australians are needlessly experiencing vision loss and blindness. By addressing uncorrected refractive error and cataract alone – three quarters of those with vision loss in Australia could have their vision restored.

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It has been estimated that millions of dollars could be saved annually if avoidable blindness was prevented and that a return of $5 for every dollar invested could be achieved.

The total estimated economic cost of vision loss for those aged over 40 in Australia is estimated to be $16.6 billion. These costs are calculated on costs to the health system, financial losses such in productivity, participation in the workforce and taxation, cost of carers and indirect costs such as aids and modifications.

Visual impairment and blindness impose substantial morbidity and premature mortality on the population. Visual impairment can significantly affect daily living, increasing dependence on services and impacting on people's quality of life and independence.

Moreover, addressing vision loss also reduces a person's risk of falls and hip fractures and their likelihood of developing depression (1).

RANZCO believes that, given the significant impact of preventable blindness and vision loss on people in Queensland, a coordinated approach to health promotion via a Commission may hold significant benefit, if the commission focuses its efforts on best patient outcomes via equity in access to services including screening, and promotion of innovative and collaboration models of multidisciplinary care.

d) Emerging approaches and strategies that show significant potential

RANZCO believes the Commission could play a vital role in supporting screening programs and improving universal access to early intervention and treatment. Examples of best practice programs that seek to improve the efficiency of the health system and more equitable access to care are provided below.

Inala Centre of Excellence in Indigenous Health, Brisbane

Currently up to 50 per cent of Australians with diabetes do not undergo eye examinations at the recommended minimum frequency of every two years. The Inala Centre of Excellence in Indigenous Health in Brisbane has a model primary care diabetic photo-screening program running that reported a 6 fold increase in the percentage of indigenous patients receiving annual diabetic retinopathy screening in its 2010 report. Presently they have over 90% of their diabetic patients receiving annual photo-screening within the primary care facility graded by accredited GPs and overseen by a visiting ophthalmologist or optometrist.

RANZCO believes such programs could be replicated in other services to reduce the burden of disease experienced by Indigenous Australians.

IDEAS Van Indigenous Diabetes Initiative, Queensland

Diabetes complications account for most of the poor vision in indigenous Australians. A new initiative that provides both "Survey and Service" by combining a primary care based diabetic photo-screening program across Queensland with a mobile ophthalmology clinic has been successfully implemented over the last 15 months. This retinal screening model has been rolled out to 21 indigenous health centres using fully automated non-mydriatic cameras with 5 cameras on RFDS planes reaching 14 smaller centres. There are 51 communities benefiting

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from the screening program with a central reading centre providing grading to compile clinic lists for the IDEAS Van.

The complementary service component is a mobile ophthalmology and optometry van (IDEAS Van) that visits 18 AMSs throughout Queensland which act as regional hubs, they involve over 20 ophthalmologists and 40 optometrists. This model enables standard of care equipment to come to the door of regional and remote AMSs (ASGC 2-5) bringing standard of care therapies to the culturally appropriate AMS environment to improve access to specialist services and follow up care.

Since the IDEAS Van commenced services, there have been excellent attendance rates with over 1,000 patients treated. The flexibility to provide eye care in the comfort and convenience of the local community health service improves client compliance and therefore improves health outcomes thus reducing vision loss in indigenous populations.

To address the inequalities in access to health services experienced by indigenous Australians living in rural and remote areas, RANZCO would advise the Commission advocate for further investment in such services. For instance, the IDEAS Van initiative recommends a separate indigenous cataract pathway is developed through the private sector enabling timely surgery and continuity of care.

There is also the potential of this novel model of service delivery to go far beyond indigenous eye care enabling other services to be delivered to rural and remote communities.

Models of collaborative care, C-EYE-C project

The NSW based Community Eye-Care (C-EYE-C) project, the work of the Agency for Clinical Innovation - a board governed statutory health corporation in collaboration with eye health stakeholders including ophthalmologists, optometrists and orthoptists; professional associations; endocrinologists and GPs - has developed and endorsed two models of collaborative integrated care for chronic eye disease - one for diabetic eye disease and glaucoma and the other for uncomplicated cataract. Whilst the model in its current form may not be transferrable to Queensland there are useful insights and lessons to be learned.

C-EYE-C aims to improve access to public hospital cataract surgery and increase the efficiency of outpatient eye clinics. Patients with cataract, and no other ocular co-morbidities, can be referred for surgery and avoid unnecessary delay waiting for an outpatient clinic appointment to confirm the cataract. This improves efficiency for the treatment of the patients with cataract, and enables resources to otherwise be used to care for patients with other ocular conditions.

The initiative facilitates increased communication and enhanced training for the optometrists whilst ensuring that patients that may otherwise have been classified as not having disease or disease at risk of progression to blindness are seen and treated in a timely fashion. The model is based on overseas experience in Canada and the UK. The C-EYE-C project is generating a number of parallel research projects assessing the standards of current assessment and the efficacy of these new programs in an Australian context as they develop.

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Public Hospital Care

Public hospitals and outpatient clinics play a vital role in providing treatments for those living in Queensland who are unable to afford private health cover.

Public hospitals waiting lists are currently at unprecedented levels due to insufficient funding. Reduced overall financial resourcing to the public hospital sector will result in further fragmentation of services and potentially reduced patient care. In particular, further reductions to Commonwealth funding will likely have a detrimental impact on the State's ability to meet patient demand for eye care.

In Australia, age-related macular degeneration contributes to 50% of all blindness, making it the nation's most common cause of blindness. It is estimated that in 2010, there were 1.023 million Australians with AMD, equivalent to one in seven people over the age of 50. In 2006, less than 20% of those with macular degeneration could be treated. Several medicines represent a revolution in care for patients with AMD. In a recent study it was found more than 90% of patients in this Australian study seen by ophthalmologists avoided a substantial loss of vision, a result that was unachievable only one decade ago. The best visual acuity outcomes are obtained in patients who begin treatment at the first sign of AMD (7).

Public outpatient clinics play a vital role to ensuring equitable access to AMD treatments for all Australians. In the 2014 RANZCO survey a number of States identified a lack of access to non-admitted services in the public sector required for treatment of AMD. Recently published data from the AIHW suggests that Queensland lags behind other states in providing access for patients to non-admitted public hospital services, denying those most in need of care, refer to Figure 1(8).

RANZCO believes that an important role of the Commission would be to address inequalities in the provision of health services delivered via the public sector for those living in Queensland and unable to afford private health.

Figure 1: Non-admitted ophthalmology services by proportion of population

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Fee for Service in regional areas

Queensland experiences higher waiting lists and less overall access to public health services. For example as seen in Figure 2, the proportion of public patients undergoing cataract surgery in Queensland is only 15%. In New South Wales, Victoria, Western Australia and South Australia, the rate of public surgeries performed is 29-38% and in the Australian Capital Territory the rate is 52%.

Procedure	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Separations	71,682	56,738	47,030	26,233	17,206	7,039	2,503	1,262	229,693
Separations not within state of residence (%)	2	3	2	<1	2	<1	22	3	2
Proportion of separations public patients (%)	29	32	15	38	36	12	52	58	28
Separations per 1,000 population	8.3	8.7	9.6	10.6	8	10.4	7.4	9.1	8.9

Figure 2: Rates of Cataract extraction by Australian jurisdiction (9).

In all states in Australia, apart from Queensland, the public hospital system provides fee-for-service public cataract surgery in regional areas. This equates to free (to the patient), local, cataract (or other) ophthalmic surgery for the general public.

Fee-for-service in regional health is a proven, workable model that operates in every other jurisdiction in Australia. RANZCO believes the implementation of a fee-for-service model would help to reduce the inequalities experienced by Queenslanders accessing the public system.

The provision of regular, regional fee-for-service ophthalmic surgery (available in other surgical disciplines), provides the local population with the security that public ophthalmic surgery will be provided to them at their local general hospital. This prevents any needed referrals from regional zones to the capital city, as currently happens in Queensland.

It is estimated that 30% of cases seen at the Royal Brisbane Women's Hospital and the Princess Alexandra Hospital, do not need to be seen at these tertiary referral centres and should rather be treated within their local area (clinical audits performed at RBWH and PAH, 2013). Hence the provision of fee-for-service public ophthalmic surgery diminishes the number of unwarranted referrals from the regions to the capital city.

Furthermore, fee-for-service facilitates training opportunities for ophthalmic registrars in regional areas by ensuring a public operating caseload. Provision of regular fee-for-service ophthalmic surgery in regional zones also encourages regional ophthalmologists to continue to work within the public system.

Also included here in Figure 3 is a map from the Australian Atlas of Healthcare Variation, which suggesting that the rate of cataract surgery (identified by MBS item number) in Queensland, is higher than other states. However this is a misrepresentation because it does not consider the significantly lower rate of public hospital patient cataract services undertaken by Queensland compared to other states.

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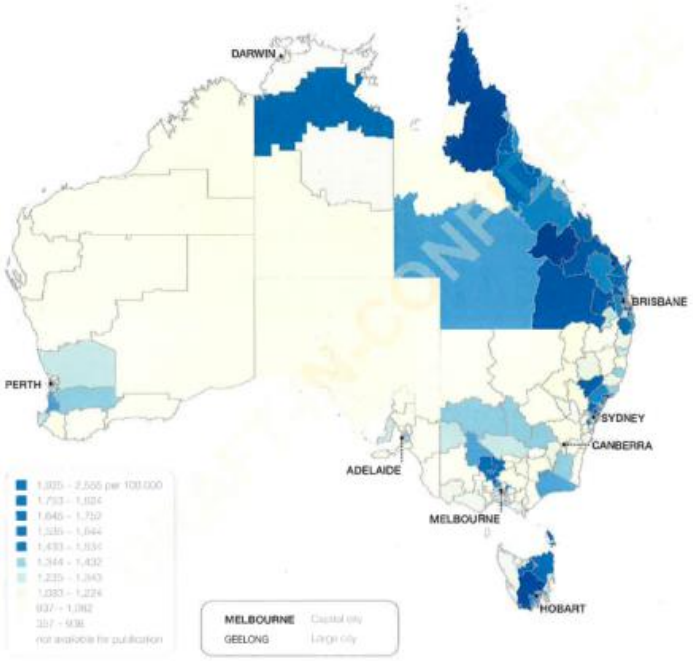

Figure 3: Number of MBS-funded services for cataract surgery per 100,000 people aged 40 years and over, age standardised, by local area, 2013–14 (10)

e) Ways of partnering across government and with industry and community including collaborative funding, evaluation and research; and ways of reducing fragmentation in health promotion efforts and increasing shared responsibility across sectors.

Research

Quality data and ongoing research is critical to advancing treatments, monitoring patient outcomes and the effectiveness of interventions.

Australia's first National Eye Health Survey (NEHS) is being undertaken by Vision 2020 Australia, the Centre for Eye Research Australia (CERA) and other partners. This work has commenced due to the advocacy and collaboration of the eye health sector working in partnership with the private sector and the Australian government to secure funding.

The project will be completed in mid-2016 with the eye health of all Australians being tested across 30 sites, including urban, regional and remote parts of the country. The NEHS will also help establish a baseline for tracking Australia's progress on "Closing the Gap".

The Save Sight Registries is an initiative of Save Sight Institute that collects real-world clinical data on patient outcomes. To date, the registry has accumulated over 120,000 treatments on 5000 eyes, after rapidly developing international interest with its unique patient focus.

The initiative seeks to promote improved outcomes for patients and organisations, particularly in the treatment of wet age-related macular degeneration, diabetic macular oedema and keratoconus. The Save Sight Registries have been endorsed as a preferred data collection system by the International Consortium for Health Outcomes Measurement, ICHOM. It is

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expected that by collecting measurable standardised outcomes, comparisons at a global level through the registry will lead to advancements in patient care by focusing on patient- centred results.

Conclusion

RANZCO is recommending that the Queensland government establish the Queensland Health Promotion Commission. The Commission would be ideally placed to advocate for a state commitment to the National Framework Implementation Plan for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss (NFIP), helping to establish a whole of government approach to eliminating avoidable blindness and vision loss.

The Commission would also be well positioned to address health inequalities in access to eye care services. Supporting the establishment of best practice models of collaborative care could help to improve patient access to screening, early intervention and treatment.

Should you have any queries regarding this submission, please contact Kellie Howe, Public Health Liaison Officer at RANZCO on or by email

Yours sincerely

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