OPTOMETRISTS
ASSOCIATION AUSTRALIA

Comments on the Productivity Commission Position Paper on Australia's Health Workforce

Optometrists Association Australia is pleased to offer the following observations in respect of those draft proposals on which we feel qualified to comment. In general the draft proposals are supported. Optometrists Association Australia believes the proposals if implemented will encourage a more integrated approach to policy formulation and delivery of services across current professional boundaries. In some instances we believe the intent of the proposals is sound but there appear to be issues that have not occurred to the Productivity Commission and on which we offer what we trust is constructive comment.

Facilitating workplace innovation

Draft Proposal 4.1

The Productivity Commission has correctly recognised that there is a lack of timely and objective processes to assess significant job redesign. It also correctly recognises that the absence of these processes leads to lost opportunities and less than ideal use of available health workforce skills.

Optometry provides some excellent case studies of how available expertise can be better used and the difficulties of implementing reforms that would lead to best use of available expertise.

> Example 1 - Opposition to Prescribing of Medicines by Optometrists
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> The role of optometrists as providers of primary health care has expanded considerably. The training that optometrists receive in the diagnosis and management of ocular disease at under-graduate level and during post-graduate courses more than adequately prepares optometrists to treat the small but significant proportion of people suffering from conditions that require a simple, well-established treatment using a topical ocular drug. In the past, because optometrists were not permitted to prescribe drugs, patients requiring these treatments had to be referred to either their general practitioner or an ophthalmologist for the prescription. Referral was necessary even though the optometrist possessed the knowledge and the clinical equipment to diagnose and manage the condition.
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> Legislation regulating the prescribing of medicines by optometrists is contained in the various State and Territory drugs and poisons Acts. Changes to these Acts were needed to enable optometrists to prescribe but State governments adopted processes that had the effect of pitting optometry against organised ophthalmology, which regarded optometric prescribing as contrary to its interests.
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> Despite quickly recognising that legislating to allow optometrists to prescribe medicines would have significant benefits to the community, changes to legislation were delayed significantly and are yet to occur in some jurisdictions.
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> These benefits include making best use of available expertise and the workforce, improving access and reducing delays in implementing treatment, freeing valuable specialist and general medical resources for better use and lowering costs of eye care to government and the community.

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State and Territory Governments established committees to assess significant job redesign issues but these committees were generally dominated by medical practitioners. Consideration of the changes was delayed by committee members who were medical practitioners not being available for meetings and by them taking different stances from one meeting to the next so that obtaining consensus became impossible. Medical practitioners made outlandish claims of the harm that would come to the community if optometrists were to prescribe medicines.

The result has been an increasing realisation by State Governments that processes dominated by entrenched interests do not deliver required outcomes in a timely and objective way. The Tasmanian Government has abandoned the committee it established for the purpose after some years, recognising that it was dysfunctional. In New South Wales the committee established to advise the Government on the drugs that optometrists would be permitted to prescribe has not reported after three and a half years. The Queensland Government altered its legislation permitting optometrists to prescribe medicines after the ophthalmologists working in public hospitals threatened to resign if the legislation was not withdrawn. Under pressure from ophthalmologists the Government formed a committee dominated by medical practitioners, which is already proving dysfunctional.

Example 2 – Non-Employment of Optometrists in Hospitals

Opposition from ophthalmology has almost completely excluded optometrists from working in public hospital eye clinics. In the few instances that optometrists have been employed in public hospitals there is anecdotal evidence that patients are treated more promptly and waiting lists for eye surgery (for example, cataract surgery) have been reduced as ophthalmologists are relieved of treatment of conditions adequately managed by optometrists and portions of pre- and post-operative care.

Example 3 – Refusal of Ophthalmology to teach Optometrists

Ophthalmologists have limited opportunities for optometrists to gain clinical experience and specialised expertise by refusing to teach optometrists or allow students into clinics within hospitals and private practices. The by-laws of the Royal Australian and New Zealand College of Ophthalmologists, which expressly prohibited ophthalmologists from teaching optometrists, were amended only in recent years. The President of the College nevertheless wrote to members of the College in 2005 to discourage ophthalmologists from teaching optometrists saying:

"I strongly advise you to consider whether your role in the teaching of ocular therapeutics to optometrists is contributing to perpetuate a false sense of competency in the minds of optometrists and whether this seriously puts at risk the welfare and health of the community."

Subsequently some ophthalmologists who had been teaching optometrists have withdrawn their services and clinical placements that were previously available to optometrists have become unavailable.

Optometry's experience strongly suggests that processes should be established to provide knowledgeable and impartial advice to government relating to proper use of available health workforce skills. Such processes will facilitate the evolutionary changes to the workforce, which now happen more spasmodically.

Optometry's experience also suggests that the professions with entrenched interests will vigorously and sometimes unreasonably oppose any entry of another profession into that which they perceive to be their bailiwick. If there is to be any success in implementing workforce change to make best use of available skills, it is essential that capture of the process by entrenched interests be avoided. Any agency established to consider workforce deployment must be and be seen to be independent and impartial.

More responsive education and training arrangements

Draft Proposal 5.1

It is not clear that transferring responsibility for allocating funding of the training of health-care workers from the Department of Education, Science and Training (DEST) to the Department of Health and Ageing (DHA) would achieve the objective that the Productivity Commission suggests. The DHA may understand the health needs of the community and the health workforce but has little knowledge of training and the education system. It is probably less difficult to gain knowledge of the health workforce than become familiar with the workings of the education system and the training of health-care practitioners. If this is the case, then the function of allocating funds for the training of health practitioners would be best left with DEST.

In recognition of the special consideration that is required to ensure an adequate and competent health workforce, there may instead be merit in establishing a unit within DEST that has particular responsibility for allocation of funds for training of health professionals.

Dividing responsibility for determining funding for education between DEST and DHA would also complicate matters for institutions offering both health and other education. Applications for funding would be even more complicated for health courses that incorporate subjects from more than one faculty. For example, the optometry course at The University of Melbourne includes physics, mathematics, chemistry and other subjects that are not, at first glance, related to health. In many cases these subjects are shared with students studying for degrees in non-health related areas.

There is also a potential for duplication of many of the services currently provided by DEST. It may be more efficient for DEST to take advice from DHA in allocating funding for health courses while retaining overall control of education funding.

A consolidated national accreditation regime

Draft Proposals 6.1 and 6.2

There are good reasons for and against the establishment of a single national accreditation agency for university-based and post-graduate health workforce education and training. If such a body is to be established, it should be because it will do the job better than existing agencies and not because of the sense of order that uniformity conveys.

The Australian Government in the 1990s promoted the formulation of competency standards for the professions to allow articulation of qualifications and to a facilitate entry into a profession of persons with sufficient skills but without formal qualifications. The Government, in fact, funded the development of competencies by many professions.

Many professions, including optometry, established competency standards and methods of assessing competency. These standards and methods have been used by accreditation authorities to assess applicants for the profession and to accredit training courses. The competencies and the methods of assessment addressed the special circumstances of each occupation.

While there may appear to be merit in uniformity in approaches to assessment processes and recognition of overseas training courses, it may be that the community is best served by approaches that recognise the differences between occupations.

Australian Education International—National Office for Overseas Skills Recognition (AEI-NOOSR), the Australian Government's expert body on recognition of overseas qualifications, publishes a document entitled *Best Practice Guide for Professional Bodies*. The Guide, which is currently under revision, includes sections on principles, a step-by-step guide to good assessment processes, tools such as templates and wording for letters, discussion on issues such as fraud, fee setting and client liaison, case studies covering good practice, lessons learned and the clients' perspective, and links to other relevant materials.

AEI-NOOSR may be doing most of the work expected of the Productivity Commission's proposed agency and the Guide in modified form may be sufficient for the purpose of unifying approaches to assessment of overseas applicants for registration. The Commission may wish to consider expanding the role of AEI-NOOSR rather than recommend a new agency.

Most, if not all, of the existing accreditation bodies are self-funded. Government intervention requiring the establishment of a new agency would involve Government funding for the purpose.

The Commission has identified the problem of inconsistent requirements of individual accreditation agencies imposing costs on educational institutions and trainers. It is questionable whether the establishment of an agency that would establish uniform standards for accreditation of courses would solve the problem as different bodies accredit courses for different reasons. Health practitioner registration boards accredit courses with the aim of establishing that the graduates of the course are able to practise safely and competently. Universities accredit courses for funding purposes, to determine quality of research and teaching and a variety of other reasons. Other bodies may accredit courses for other reasons again. An accreditation that satisfies the boards may not satisfy university authorities and vice versa.

Supporting changes to registration arrangements

Draft Proposals 7.1

It is beyond the capabilities of most heath practitioner registration boards to properly manage standards for accreditation. Most boards already rely on outside organisations to establish standards for accreditation and to carry out the accreditation process on their behalf. It appears that the arrangements that boards have adopted have been made on ad hoc bases and over time have become accepted protocol without formal Government policy underpinning. The Commission's proposal that the boards concern themselves less with accreditation procedures is sound, however, it remains unclear whether one body should be established to handle all accreditation issues or whether individual accreditation bodies for each profession should be given greater powers.

Against this, the smaller professions would have difficulties in funding accreditation processes and finding sufficient expertise within the profession to carry out the function. In the case of optometry, there is an inordinate and undesirable reliance on the three schools of optometry in Australia in the process of accreditation of optometry schools and assessment of overseas applicants for registration. The schools are dominant in the drafting of guidelines for the processes, establishing mechanisms and carrying out assessments. It is unreasonable to make such demands on the schools and undesirable to be so dependent on their goodwill in carrying out such important tasks.

Draft Proposals 7.2

While it would be good to simplify and streamline mutual recognition procedures and moves to do so would be welcome and supported, it is difficult to believe that the current arrangements are so burdensome that they substantially affect workforce distribution or mobility.

A national register of practitioners would eliminate many of the difficulties and costs associated with movement of practitioners across State and Territory boundaries. These impediments include the cost for practitioners of registering in several jurisdictions and delays in registering in second jurisdictions under mutual recognition arrangements. Practitioners would not need to register in more than one jurisdiction and boards would not be burdened with having to process applications for registration from practitioners who, in effect, are automatically eligible for registration under mutual recognition principles.

In the short term, apart from establishing a national register, there are at least two good reasons for leaving the regulation of the professions in the hands of the State and Territory boards. First, local administration facilitates administration of the Act and ensures fractioned compliance. Second, the circumstance of practice are different between jurisdictions, for example, the sparseness of the population and of practitioners in the Northern Territory may make it desirable that the rules of practice that apply there are different from those in the more densely populated States.

Draft Proposals 7.3

The legal and ethical complications of delegation are a significant deterrent to delegation. The community is currently deprived of the benefits that delegation can confer because of the uncertainty that practitioners have. In the eye-care field ophthalmologists may wish to delegate pre- and post-surgical care to optometrists, particularly in rural areas in which there is no permanent ophthalmological presence. Ophthalmologists and optometrists have little confidence that they understand their respective responsibilities or the legal demands that delegation confers on each practitioner and the proper behaviour in their interaction.

Boards and professional bodies may issue guidelines and advice but practitioners would be unwise to place much reliance on the advice offered because the situation is so speculative. A formal regulatory framework would be of considerable assistance in promoting delegation.

Improving funding-related incentives for workplace change

Draft Proposals 8.1

Optometry provides a graphic confirmation of the Commission's view that funding and payment arrangements affect consumers' choice of health services and the practitioners they attend.

Optometry and ophthalmology substantially overlap in the provision of primary eye care, particularly in the areas of treatment of refractive and binocular disorders, and detection and treatment of simple eye disease. The overlap means that trends in the supply, demand and price of optometry or ophthalmology cannot be viewed in isolation but rather as components of a single eye-care market.

The national health insurance system established in 1953 included ophthalmology but not optometry. Over the following two decades the proportion of people attending ophthalmologists compared with optometrists rose from approximately 20 per cent to 80 per cent. The introduction of Medicare benefits for optometric services in 1975 saw the situation reversed to what could be said to be the natural state with optometrists now seeing approximately 80 per cent of people seeking primary eye care and ophthalmologists seeing 20 per cent.

The introduction of benefits for optometric services has delivered significant benefits to the community

- There have been savings to Medicare in the tens of million of dollars annually. Access Economics in its 1993 report, *Vision Care in Australia: Focusing on the Role of Optometry*, estimated that if all current optometric patients were to seek care from an ophthalmologist, the total number of consultations for which Medicare rebates were paid would remain unchanged. However, the cost to the budget would rise by $54 million because of the higher average unit cost to the budget of an ophthalmological consultation. The continued movement of patients from ophthalmology to optometry for primary eye care and inflation would make the savings figure significantly higher in 2005.

- Out-of-pocket costs to the consumer have fallen dramatically. More than 95 per cent of optometric Medicare services are bulk-billed, meaning the patient is not out of pocket for the service. Patient out-of-pocket expenses for consultations (excluding procedures) with ophthalmologists are estimated to be of the order of $35 million per annum.[1]

- Access to eye care has been improved. Optometric care provides a low-cost entry point for eye care. There is no referral process nor any other administrative complexity. The extremely high rate of bulk-billing by optometrists simplifies accounting procedures. No referral is required to have Medicare benefits apply. In contrast, entry into the ophthalmological care requires referral from a general medical practitioner with the attendant costs.

  Waiting time for a consultation with an ophthalmologist has been found to be 2.4 to 9 weeks in private practice and 5.6 to 21.5 weeks in the public system.[2] Consultations with optometrists can usually be arranged within a matter of days and almost immediately in cases of urgency or emergency.

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[1] Calculated by multiplying out-of-pocket expenses for specialist attendances multiplied by number of consultations with ophthalmologist. Figures from Health Insurance Commission.

[2] Australian Medical Workforce Advisory Committee. The Ophthalmology Workforce in Australia. 1996, Sydney Australia.

There are more than 3,000 practising optometrists in Australia and approximately 650 ophthalmologists. Optometrists serve approximately 1,200 communities around Australia. There are few communities in Australia that do not have reasonable access to regular optometric care. Ophthalmologists are restricted to the larger cities of Australia, requiring the facilities of a well-equipped hospital to carry out their professional responsibilities.

- There is more appropriate use of professional expertise. Ophthalmologists spend up to 12 years in training and learn very specialised skills that should not be wasted by dealing with primary health care treatments that can be readily managed by optometrists. Optometry reduces the wasteful use of this expertise, and saving time and cost.

New Advisory Medicare Benefits and PBS Advisory Body

The Commission has correctly recognised that there is no transparent process for considering the possible extension of Medicare Benefits Schedule and Pharmaceutical Benefits Scheme (PBS) rebates to a wider range of practitioners. It also correctly recognises that there is a need for a body to advise the Minister for Health and Ageing on these matters as there is currently no body in existence that has the terms of reference that permit it to advise the Minister on such matters.

Optometry's experience in seeking PBS coverage provides a good example of the need for a body that can recommend major funding policy change to the Minister.

Prescriptions for ocular medications written by optometrists are currently not covered by the Australian Government's PBS. The PBS does cover prescriptions for the same drugs when the prescription has been written by a medical practitioner. To rectify this inequity, Optometrists Association made submissions to Government. It became immediately apparent that there was not the expertise within the Department of Health to give the Minister advice on adding a profession to the PBS as no other group had sought to have PBS coverage since Dentistry in the 1970s.

The matter was referred to the Pharmaceutical Benefits Advisory Committee (PBAC) for advice. The PBAC initially responded that it did not have the necessary expertise to give advice as its function was primarily to advise on changes to the PBS and it did not have any experience in adding professions to the purview of the scheme.

There being no obvious alternative, the PBAC was eventually given the task of advising the Minister on the matter.

While there is a demonstrated need for an independent body to consider possible extension of Medicare Benefits Schedule and PBS rebates to a wider range of practitioners, it is not clear that it is desirable for this body to subsume the functions of the Medical Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Optometrists Association Australia has been intimately involved in the operations of the Optometric Benefits Consultative Committee (OBCC) and can comment knowledgeably on its function and operations. (We assume that the other related committees operate in a similar way.)

Subsuming the OBCC into a larger body with wider responsibilities would in the eye-care field be counterproductive to the Commission's aims of making best use of available expertise and expanding Medicare coverage. The OBCC has been the principal vehicle in expanding the range of optometric services for which Medicare benefits are paid and has thus made eye care more accessible to the community.

The OBCC has also played a broader role in ensuring that the optometric portion of the Medicare program runs efficiently and effectively. The OBCC comprises two representatives from the Department of Health and Ageing, two representatives from Medicare Australia and three representatives from Optometrists Association Australia. Its functions are:

(i) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;

(ii) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

(iii) to provide a forum for discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);

(iv) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations that determine the payment of benefits for optometric services or the level of benefits;

(v) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

The carriage of these functions requires special knowledge of practice in optometry. A general committee that has representation from other non-optometric professions cannot be expected to understand the special circumstances of another profession and to make sensible changes to the Medicare tables relating to the profession or to interpret the optometric arrangements.

For making informed decisions and doing the other work that the OBCC currently does, it would be necessary to establish an equivalent subcommittee within the proposed advisory body. The subcommittee would then report to the chief committee governing the body, which would then make recommendations on relatively mundane matters to the Minister and the Department. Presumably the Minister would then seek comment from the Department on any advice offered before taking any action. This is a convoluted process compared with the simple current OBCC arrangements.

Also, a general committee is likely to have serving on it some and probably a majority of medical practitioners or at least a representative of the medical profession. This submission has discussed the vehemence with which the medical profession has opposed any progress in the practice of optometry. Experience would justify scepticism and little confidence in impartial decision-making from representatives of the medical profession when decisions affecting optometric services were under consideration.

Optometrists Association Australia and its members would find it totally unacceptable to have representatives of medicine deciding on benefits to be paid for optometric services.

More effective approaches to improving outcomes in rural and remote areas

Draft proposals 10.1 &10.2

Optometrists Association Australia supports the proposal to initiate a cross-program evaluation of ways to ensure consideration of appropriate service delivery to people in rural and remote Australia.

In the case of optometry there are presently few systematic shortages of practitioners serving such areas but there are some problems that should be addressed. Potentially there could be workforce shortages if changes are not made.

Specifically, rural and remote optometrists provide the first line of primary care for rural and remote Australians. Generally, they are more accessible and better trained and equipped to handle primary eye health cases than hard-pressed country GPs with whom they work closely and effectively. Such optometrists are much more accessible than ophthalmologists, few of whom are based outside the major centres.

While there are presently sufficient optometrists working in rural and remote Australia, these practitioners face the same problems as country GPs and pharmacists. These problems stem from the inability of country practitioners to be able to leave their practices for training or other purposes and the need to enable succession planning and attraction of new graduates away from the cities.

While there are approximately forty Australian Government programs specifically designed to support and retain country GPs and pharmacists in their practices, there is none for optometrists. Indications are appearing that suggest shortages of optometrists could soon develop if these problems remain unaddressed.

Optometrists Association Australia endorses the Commission’s observation that many of the broad reforms proposed would benefit rural and remote areas and that the proposed workforce improvement agency should explicitly cover rural and remote job design issues.

Ensuring requirements of groups with special needs are met

Draft proposal 11.1

Optometrists Association Australia similarly endorses the Commission's conclusion that institutional frameworks need to make explicit provision to meet the needs of groups with specific interests, in particular indigenous peoples.

While we again agree implementation of the broad reforms proposed would benefit indigenous communities, Optometrists Association Australia believes the challenges remaining to be addressed in indigenous eye health require particular attention and intervention.

In this regard and perhaps outside the scope of this report, Optometrists Association Australia believes the Australian Government's decision to review the Visiting Optometrist Scheme (VOS) is timely and commendable.

The VOS was introduced in 1975 to defray some of the costs of optometrists who choose to travel to rural and remote areas of Australia to treat people who would otherwise not have access to primary eye care. Indigenous communities in particular are beneficiaries of the VOS and would be greatly disadvantaged if it were to be discontinued.

The support offered by VOS is modest and increasingly disproportionate to costs incurred and out of line with more recently introduced medical specialist outreach programs. To the Government's credit, it recognised the provision of these services to rural and remote communities is dependent on the goodwill and public spiritedness of the participating optometrists and moved to update the VOS to make it sustainable.

If a workforce improvement agency such as that proposed by the Commission were in operation, it might not have taken 30 years for this program to have been updated.