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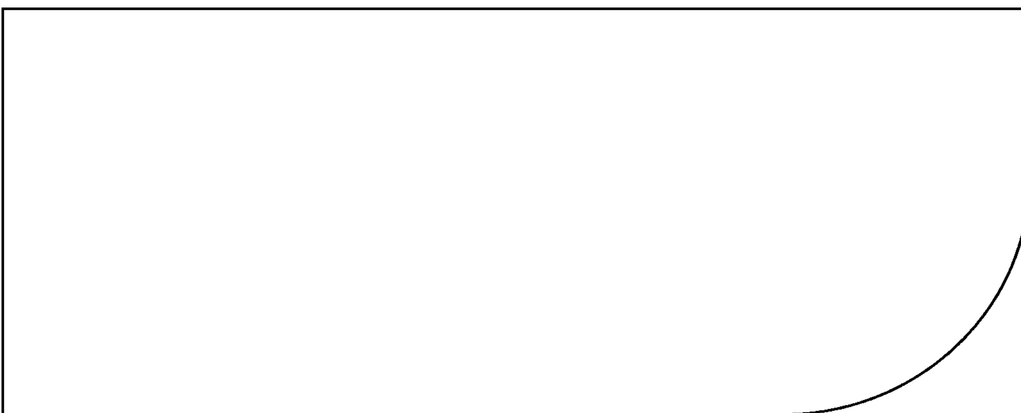
Victorian ophthalmology services
Report on stakeholder consultation

Department of Human Services



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Executive summary

Overview of stakeholder views

In its 2003 publication *Metropolitan Health Strategy, Directions for your health care system* the Victorian Department of Human Services identified the need to develop a state-wide service planning framework for ophthalmology.

This report documents the outcomes of a state-wide consultation, conducted by Phillips Fox Lawyers in conjunction with Campbell Research & Consulting, about ophthalmology services. Together with the results of a technical planning analysis and review of ophthalmology models of care, the results of the consultation will inform the development of an Ophthalmology Service Planning Framework.

A wide range of health care professionals, health care managers, consumers and consumer advocates participated in the consultation, through face-to-face interviews, workshops and written submissions.

All stakeholders consider that the quality of ophthalmology providers in Victoria is very high and that, overall, the Victorian ophthalmology service system provides excellent service. There is, however, widespread recognition that future demand for ophthalmology services will necessitate significant changes to the service system.

Stakeholders consider that everyone should have access through the public health care system to information and preliminary assessment, but that a lack of 'health literacy' for clients and health providers impairs access. There is strong support for ensuring access to services by the visually impaired and the socially disadvantaged, and for the provision of free eyewear for the most vulnerable members of the community. There is also support for Government taking a more active role in eye care health promotion.

Optometrists are highly regarded for their expertise and accessibility, and are recognised by many stakeholders as an under-utilised resource. Many providers suggested that there should be clear co-management guidelines between ophthalmologists and optometrists. Many stakeholders believe that other health care professionals including general practitioners, orthoptists and nurses also have considerable potential to contribute to more efficient, effective and accessible service delivery, and there is support for establishing and evaluating new models of multi-disciplinary care.

Most general metropolitan hospitals currently provide a full range of integrated ophthalmology services (consulting, emergency and surgical). The majority of providers believe that integrated ophthalmology services should continue to be locally accessible in all general metropolitan hospitals.

Stakeholders reported significant problems with access to both outpatient and inpatient services in many public hospital settings. Waiting times for outpatient appointments in many hospitals are unacceptably high, and surgical waiting times for public patients vary considerably across the system. Combined outpatient and surgical waiting times in many major metropolitan and regional hospitals are considered to be excessive.

Most regional centres provide comprehensive inpatient ophthalmology services, and some visiting surgical services are also in place in sub-regional centres. Some regional centres do not provide inpatient ophthalmology services, however, because hospitals and ophthalmologists have been unable to agree on a price for public patient surgical procedures. These regional 'gaps', combined with strong financial incentives for ophthalmologists to undertake fee-for-service work in smaller sub-regional and rural hospitals, have resulted in unusual patterns of referral within and between regions.

All stakeholders consider that this situation is extremely unsatisfactory and that the Ophthalmology Service Planning Framework must make provision for comprehensive services in all regional centres. Elective surgical services are considered essential to the attraction of ophthalmologists to provide medical and emergency services.

Services in sub-regional and smaller rural centres are highly valued by most stakeholders, although some stakeholders question the efficiency of a widely distributed service system, preferring instead a concentration of services at higher volume regional centres, for efficiency and quality reasons.

Some health service managers remain concerned about excessive medical costs and value for money for ophthalmology surgical services, and are seeking a higher level of direction and support from the Department of Human Services in an effort to ensure affordable services.

The Royal Victorian Eye and Ear Hospital is held in very high regard by consumers and the majority of providers, although there are concerns about excessive waiting times for outpatient services. Most providers consider that its sub-specialty clinics are an essential component of a current and future high quality tertiary service system. Its concentration of patients and academic and teaching expertise is seen as vital to continuing high standards of training.

There is a strong but not universal view amongst providers that public hospital services should complement rather than duplicate services available in the private sector, particularly for non-admitted patient services. Consistent with this view, providers consider that the Royal Victorian Eye and Ear Hospital resources should be more actively targeted towards more complex conditions for which services are not readily accessible in the private, community-based sector, and that emergency department presentations and routine reviews for low level care should be actively triaged and referred to community-based public or private ophthalmology providers. More active triaging of emergency patients and discharge of patients from public hospital outpatient services is seen as an essential demand management strategy for the future.

Many regional, and some metropolitan, hospitals have limited their volume of public ophthalmology operating because of concerns about its financial sustainability, with excess theatre capacity made available for the treatment of private patients, many of whom are uninsured and, therefore, self-funding. Private patient waiting times in these hospitals are often significantly less than public patient waiting times. Some health service managers are concerned about equity of access and consider that public facilities should be available solely on the basis of clinical need rather than capacity to pay, whereas others consider that the admission of higher numbers of private patients enables better use of facilities and assists in the retention of ophthalmologists, for whom public operating is financially relatively unrewarding.

While ophthalmology surgical procedures are, generally, considered to be efficient in comparison to other surgical procedures, many providers recognise that there is potential to

enhance the efficiency of the system through better co-ordination of care, better use of dedicated facilities and better utilisation of optometrists, orthoptists, nurses and general practitioners. It is recognised that public teaching operating lists are slow and there is potential to replace some registrar training lists with higher volume specialist public operating lists. There is also support for investigating a state-wide purchase of lens, with potential considerable cost savings.

Providers believe that funding for ophthalmology services is inadequate, especially in rural areas where medical costs are high, and that there should be a specific additional payment for cataract surgery in rural areas where fee-for-service applies.

Most ophthalmologists are convinced that only those patients with a justifiable clinical need are currently receiving surgery in the public system, while other providers and consumers were in favour of a more explicit system of ensuring appropriateness and prioritising need. There is also support for more systematic and transparent evaluation of clinical effectiveness, and various performance indicators were suggested for local, regional and/or state-wide adoption and monitoring.

Leadership and accountability for access, efficiency and other performance parameters currently rests mainly with individual hospitals. Generally, it was agreed that the Department of Human Services, hospitals and health care professionals have a shared interest in ensuring optimal use of resources within the system, and, therefore, a shared responsibility for leading and monitoring system-wide performance. It was agreed that governance arrangements could be instituted at a regional and/or state-wide level.

There is strong but not unanimous support for the maintenance of a specialist tertiary hospital with a concentration of highly specialised services (for efficiency and quality reasons), either in the current form of the Royal Victorian Eye and Ear Hospital or in a streamlined form, possibly more closely co-located with St Vincent’s Hospital. Under this model, most providers also support the maintenance and growth, over time, of integrated services in all general metropolitan general hospitals, and in all regional hospitals.

There was also support for reviewing the potential to collaborate with the private sector in appropriate areas to utilise existing capital and infrastructure for high volume, efficient public operating.

Specific proposals for further consideration

The following suggestions were made by stakeholders during the consultation period, and should be considered further:

General proposals

- Establish role delineation guidelines to guide decision-making about service provision in hospitals of different sizes and capabilities, taking into account factors such as the importance of services to the community, and the cost and utilisation of equipment;
- Consult with the Royal Victorian Eye and Ear Hospital and the Royal Australian and New Zealand College of Ophthalmology on ongoing methods of establishing and evaluating new models of care, and on methods of monitoring and improving system-wide performance;

- Review payments to hospitals for ophthalmology services generally, and in particular the payment for rural services, taking into account 'reasonableness' of medical payments;
- Consult with medical schools on the adequacy of ophthalmology education in undergraduate training;
- Consult with the Royal Australian College of General Practitioners and the Victorian Divisions of General Practice on ways in which the ongoing competence of general practitioners in eye care can be maintained;
- Invest in data collection and management systems for monitoring and improving the ophthalmology service system, and develop a system of reporting to the Department and the community on key outcomes; and
- Establish a central and/or regional governance structure for ophthalmology services, with a focus on ongoing service planning, monitoring of and responding to access, efficiency, safety, effectiveness, appropriateness and acceptability.

Proposals regarding primary ophthalmology services

- Enhance community education and eye care health promotion;
- Promote the establishment of eye care screening services in community-based locations, and review the need for eye care screening services in schools;
- Review the restriction on prescription of spectacles by orthoptists;
- Monitor the coverage and accessibility of the Victorian Eyecare Service;
- In conjunction with the Victorian College of Optometry, review opportunities for post-discharge spectacle prescriptions by ophthalmologists to be provided through the Victorian Eyecare Service, taking into account appropriate assumption of risk in relation to prescription quality and any potential impact on the Victorian Eyecare Service of an increase in overall demand; and
- Establish, and formally evaluate, model referral protocols between general practitioners and optometrists, and between public hospital emergency departments and optometrists.

Proposals regarding secondary ophthalmology services

- Maintain and develop (according to demand) comprehensive integrated ophthalmology services at all major metropolitan and regional hospitals;
- Ensure a basic 'kit' of ophthalmological equipment for diagnosis and emergency treatment is available at all major metropolitan and regional hospitals;
- Evaluate the potential for regional hospitals and/or the Royal Victorian Eye and Ear Hospital to assume a greater region-wide responsibility for the provision of emergency and consulting ophthalmology services in regional and rural hospitals that do not have satisfactory local arrangements;

- Specifically designate inpatient and outpatient activity allocations in each region and/or each hospital;
- Review community transport arrangements in rural and regional areas in which there are no ophthalmology services;
- Review the role of telemedicine in rural and regional centres in which there is no resident ophthalmologist;
- Establish rural registrar rotations with a view to enhancing training, services (particularly public non-admitted services) and succession planning.
- Review the impact of current policy and in particular of financial incentives on the extent to which hospitals and/or ophthalmologists preferentially allocate theatre resources to private (insured or self-funding) patients;
- Co-locate a branch of the Victorian College of Optometry at the Royal Victorian Eye and Ear Hospital, and an outreach ophthalmology clinic from the Royal Victorian Eye and Ear Hospital at the Victorian College of Optometry;
- Establish and evaluate rigorous triage protocols at the Royal Victorian Eye and Ear Hospital emergency department;
- Establish and evaluate rigorous discharge protocols for appropriate patients from the Royal Victorian Eye and Ear Hospital general ophthalmology clinics;
- Review the number of cataract operations that are necessary for registrar training, and consider the development of higher throughput public hospital service lists, to be performed by senior registrars or specialist ophthalmologists;
- Consider options for collaboration with the private sector for high volume services such as cataract surgery;
- With the Royal Australian and New Zealand College of Ophthalmologists and the Victorian College of Optometry, develop and evaluate formal co-management guidelines between ophthalmologists and optometrists for routine cataract surgical care; and
- With key stakeholders, evaluate the relevance and utility of practice guidelines for appropriateness of cataract surgery in the Victorian context.

Proposals regarding tertiary ophthalmology services

- Maintain the Royal Victorian Eye and Ear Hospital as the state's tertiary ophthalmology service, training and research centre, but refocus its activities towards more complex care.

Introduction

Background to this consultancy

1 In its publication: *Metropolitan Health Strategy, Directions for your health care system* (the **Metropolitan Health Strategy**),[1] released in October 2003, the Victorian Department of Human Services (the **Department**) identified four strategic directions to position the health service system to meet future demand for services:

1.1 Increase capacity;

1.2 Redistribute and reconfigure capacity;

1.3 Service substitution and diversion; and

1.4 New service models.

2 Key service goals include safety and quality, responsiveness, timeliness and efficiency.

3 Under the strategic direction of *redistributing and reconfiguring capacity*, the Metropolitan Health Strategy identified as a priority the establishment of a service planning framework for ophthalmology services (the **Service Planning Framework**).

4 The Metropolitan Health Strategy focused on metropolitan health services. The state-wide leadership and referral role of the Royal Victorian Eye and Ear Hospital (**RVEEH**) and the close integration of service delivery, research and teaching in ophthalmology services require, however, that the Service Planning Framework addresses clinical service provision, teaching, training and research needs across the state.

5 To inform the development of the Service Planning Framework, the Department:

5.1 Established an advisory committee (the **Advisory Committee**);

5.2 Developed and widely circulated a discussion paper (the **Discussion Paper**), and invited written submissions; and

5.3 Initiated a request for tender for consultants to undertake stakeholder consultation.

6 The Department, in collaboration with the Advisory Committee, has undertaken a technical service planning analysis and review of models of ophthalmology care, which, together with the results of the stakeholder consultation, will contribute to the development of a Service Planning Framework that is comprehensive, state-wide, evidence-based and fully informed by the range of stakeholder views.

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[1] Victorian Department of Human Services. *Metropolitan Health Strategy, Directions for your health care system.* October 2003. Accessed on 14 May 2004 at http://www.health.vic.gov.au/metrohealthstrategy/strategy.pdf

7 The Department contracted Phillips Fox Lawyers (Dr Heather Wellington) in conjunction with Campbell Research & Consulting (Ms Jacqui Hagen) to undertake the stakeholder consultation. The consultants were required to review stakeholder feedback on the discussion paper, and engage key stakeholders through forums and face-to-face interviews, to determine stakeholder views on a range of issues pertinent to the delivery of ophthalmology services.

8 Stakeholder views were determined through:

8.1 Review and analysis of responses to the Department's discussion paper;

8.2 Five forums, three in rural areas and two in metropolitan areas, with a range of service providers (including ophthalmologists, nurses, optometrists, orthoptists, registrars-in-training, health service managers and regional office personnel);

8.3 One forum with consumer representative groups and two forums (one metropolitan and one rural) with 'grass roots' consumers; and

8.4 A number of face-to-face interviews with individual providers and small groups.

9 A list of individuals and organisations that responded to the Department's discussion paper is included at **Attachment 1**.

10 A list of individuals and groups who participated in interviews is included at **Attachment 2**.

11 A list of workshop attendees is included at **Attachment 3**.

12 A comprehensive report of consumer consultations is included at **Attachment 4**.

13 This report provides an overview of the stakeholder views assembled through these activities.

Scope of the consultation

14 The term "Ophthalmology Services" was interpreted to encompass medical and non-medical eye health care and related services provided by a full range of health care professionals. It includes services provided by general practitioners, orthoptists, optometrists, nurses, health care professionals working in emergency department settings, and specialist and sub-specialist ophthalmologists.

15 During the consultation, the service system was conceptualised according to primary, secondary and tertiary service delivery.

Primary care was characterised as care provided following self-referral. It includes care provided by community optometrists, general practitioners and hospital emergency departments for conditions such as refractive error, screening for eye health, monitoring of chronic eye conditions, removal of foreign bodies and management of conjunctivitis.

Secondary care was characterised as specialist care provided following referral from another practitioner, but not including highly specialised care which, because of cost, quality or technical issues, is best provided from a small number of service sites. It includes most ophthalmic surgical and medical services (including monitoring and management of cataract, glaucoma, diabetic eye disease and macular degeneration, management of most eye trauma, and optometry services provided on referral from another practitioner).

Tertiary care was characterised as highly specialised care provided in a limited number of locations following referral from another practitioner. It includes the monitoring and management of complicated glaucoma, diabetic eye disease, trauma and complicated and/or rare vitreo-retinal and other conditions.

16 The project primarily focused on the provision of services funded and/or provided by the public sector. Issues were, however, discussed in the context of the public sector as an integral component of an overall service system that has a substantial private component.

Interpreting qualitative research

17 Group discussions and depth interviews are qualitative research techniques. They enable specific issues to be explored in depth. They enhance the understanding of decision making processes and stakeholder values. The number of respondents in some stakeholder groups was, however, relatively small and the findings of qualitative research cannot be generalised to the broader population. The extent to which the findings of qualitative research can be extrapolated to the broader population requires the utilisation of quantitative research techniques.

Framework for this report

18 The report presents, in initial form, stakeholder views, gathered through the mechanisms described above and organised according to a framework developed by the Victorian Quality Council: *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services*[2] (the **Quality Framework**).

19 The Quality Framework was developed as a component of a strategic approach to improving the safety and quality of patient care in Victoria. Whilst it was developed for application by health services rather than across the health care system, it identifies six 'dimensions of quality' (safety, effectiveness, appropriateness, acceptability, access and efficiency) and four key 'organisational elements' (governance and leadership, consumer involvement, competence and education, and information management) that are equally applicable to system-wide safety and quality of care.

20 The six dimensions of quality and the four key organisational elements described in the Quality Framework are defined in detail in **Attachment 5**.

Eye disease in Victoria

21 The Visual Impairment Project, undertaken by the Centre for Eye Research Australia, is a population-based study of the prevalence, incidence and risk factors for age-related eye disease in a random sample of Victorian residents aged 40 years and over. The study was conducted between 1992 and 1999, and revealed the following:

21.1 More than 80% of vision loss is caused by just five conditions: refractive error; cataract; diabetes; glaucoma; and macular degeneration;

21.2 35% of elderly people have poor vision due to refractive error;

21.3 The prevalence of cataract exceeds 50% in people aged more than 70, and by the age of 90, 100% of the study population had developed cataracts;

21.4 Only half the people with diabetes have a regular eye examination, and more than one third have never been checked;

21.5 Glaucoma affects 210,000 Australians, half of whom have not been diagnosed; and

21.6 Two out of three people will develop age-related macular degeneration. In most cases, there is no effective prevention or treatment.

[2] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

Ophthalmology services in Victoria

22 The distribution and activity of ophthalmology services in Victoria is described in the Discussion Paper. In summary:

22.1 More than one million services per year are provided on a non-admitted basis in private ophthalmology and optometry consulting rooms;

22.2 1.8% of encounters with general practitioners relate specifically to eye conditions. 7.3% of referrals from general practitioners are to ophthalmologists and 0.9% are to optometrists;

22.3 The Victorian Eyecare Service (**VES**) provides eye tests and glasses at a nominal cost for Victorians who hold a pensioner concession card or have a health care card, and their dependents;

22.4 There are five refractive laser surgery centres in Victoria;

22.5 In 2002/03 there were more than 35,000 public ophthalmology emergency presentations to Victorian public hospitals with 24 hour emergency departments. The RVEEH managed almost 50% of these patients; 32% of presentations were in rural and regional areas;

22.6 12 public hospitals accounted for nearly 90,000 ophthalmology outpatient encounters. 70% of services are concentrated at the RVEEH. Overall, ophthalmology accounts for 8% of all publicly funded outpatient encounters;

22.7 There were 49,700 ophthalmology inpatient separations reported to the Department in 2002/03, from 102 public hospitals and 76 private hospitals. 56% of inpatient separations were from private hospitals. 22% were from rural and regional hospitals;

22.8 Compared with 1998/99, there was a 26% increase in ophthalmology separations in 2002/03. The growth rate in the rural sector was 35% compared to 23% in the metropolitan sector. The growth rate in the private hospital sector was 37% compared to 14% in public hospitals; and

22.9 Overall, approximately 30% of ophthalmology separations from public hospitals are private or compensable patients.

Overall stakeholder comments about Victoria's ophthalmology services

23 Whilst a vision problem that requires wearing of correctional lenses was considered by consumers as acceptable and something that was likely to occur to almost everyone at some stage in their life, the concept of any eye condition that threatened a reduction in the capacity of personal independence, or the ability to live a normal life, was viewed with dismay. Those who had suffered an undiagnosed eye problem voiced their relief when it was discovered not to be something that could lead to blindness – always the most feared outcome: "*I was just so relieved that I didn't have cataracts and I didn't have anything really bad wrong with me that I think I could have cried with relief you know" …"It was a damn relief to know that I didn't have something really wrong with me, because having diabetes it's the first thing you think of 'am I gonna go blind?' you know" … "Oh well the first time I went I had shocking pressure and she thought it was glaucoma. You know for those few weeks it was really hectic. Then she said oh the pressure has dropped and I had another test and it was looking good. You know I felt really relieved. But up until then, oh it's a terrible feeling isn't it? And as you get older. Look all I could think of was going blind*."

24 Overall, providers believe that:

24.1 Victoria has a very high standard of ophthalmology services;

24.2 Access to services is generally good but does vary, particularly in rural areas;

24.3 Victoria has an adequate workforce at present but it is mal-distributed and not used effectively; and

24.4 Current services will not be able to cope with the expected increase in demand unless they are significantly developed. There is a need to build on the current provision of services, and to ensure that the services continually improve.

25 The co-location of eye and ear services at the RVEEH reflects past synergies in clinical practice. There is no current clinical imperative to maintain co-location, although internationally there are several examples where eye and ear services continue to be co-located.

26 Some consumers and Consumer Representatives also identified research as being a strength of both Victoria and Australia overall. The standing of the RVEEH and the work done by Fred Hollows both went some way to creating this perception. *"There is research happening here … and it's not happening anywhere else in Australia … but most definitely you could say that Victoria is the leader" … "Now there is a significant amount of research done here in Australia. For some people, say someone with some form of serious diagnosis, they can find treatment" … "That man who went out to the bush with the aboriginals … The Fred Hollows Foundation. That Foundation does a marvellous job*."

Predicted changes to ophthalmology services

27 Providers predict the following incremental (not large, step-wise) changes in the provision of ophthalmology services:

27.1 More emphasis on preventative models of care;

27.2 An increase in ambulatory/day procedure service provision;

27.3 A greater focus on multidisciplinary collaboration and holistic disease management models;

27.4 A major effect on ophthalmology practice, in particular on the management of glaucoma, resulting from the ability of optometrists to prescribe S4 medications;

27.5 A decrease in stand-alone specialist hospitals, unless linked to general hospitals;

27.6 Increased use of highly specialised expensive equipment, both diagnostic and therapeutic;

27.7 New prostheses, which will improve outcomes and increase demand for the surgical correction of presbyopia – a potentially vast burden;

27.8 More expensive targeted drug therapies, including new injectable drugs for the treatment of inflammatory eye disease;

27.9 An increasing role for molecular engineering techniques and stem cell technology;

27.10 An increase in the ability to correctly diagnose genetic diseases and provide accurate counselling information on prognosis and the recurrence risk; and

27.11 An increase in the need to provide “appropriate perspective” and realistic information to patients based on the partial information that they have.

Access to ophthalmology services

Access refers to the extent to which a population or individual can obtain health services. This may include when it is appropriate to seek health care and the ability to geographically, physically and economically seek out appropriate care.[3]

General access issues

28 Access was discussed generally, and also in terms of access to primary, secondary and tertiary services.

29 Providers advised that:

29.1 The private sector is the major provider of eye services in Victoria;

29.2 Everyone (public/private) should have access to information and preliminary assessment, but a lack of 'health literacy' for clients and health providers impairs access;

29.3 Access to services by the visually impaired and the socially disadvantaged should be ensured;

29.4 There should be provision of free eyewear for the most vulnerable members of the community whose quality of life is being compromised by their inability to afford eyewear; and

29.5 There is still unevenness in the distribution and utilisation of ophthalmology services. Services are often available but not well accessed, and there are under-served areas and groups. The cost (both perceived and actual) of eyewear and ophthalmological services is a significant barrier to access for some client groups (although a minority of providers thought there were no cost barriers).

30 It was suggested that many people on low incomes do not prioritise eye care as an important health issue and are unaware of the benefits of a regular eye examination. Many patients, particularly the elderly, are unaware that their vision is capable of correction, or do not want correction. Inadequate monitoring of conditions such as diabetes reflects a lack of patient understanding of the need for or availability of services, or poor referral practices, not a lack of available services.

31 Consumers and Consumer Advocates advised that:

31.1 The paper work and perceived bureaucracy of accessing public ophthalmology services and the VES is a barrier for people who are illiterate or speak English as a second language, those living in transient accommodation and the homeless;

[3] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003, page 38. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

31.2 Physical access can be a problem for the aged and disabled, a lack of easily accessible interpreting and translating services is becoming increasingly problematic, there is a lack of outreach programs for people who have difficulty accessing mainstream services, and in particular there is a lack of access to ophthalmology services in residential aged care settings; and

31.3 In rural areas, referral pathways are poorly defined as a result of a shortage of general practitioners, and transport can be a problem.

32 The cost of medication is a factor for consumers required to use medication to treat an ongoing eye condition. Whilst this is not a common occurrence among group participants it is a cost burden for those to whom it applies. The fact that no rebates or benefits are available for this type of medication is an issue that was raised as a criticism: "*Well as I say, I've been having these drops or gel and it's about $8 a tube and I use about 2 a week of these other drops …. well the last time I got it I had to buy a tube we were away and they were $9. So I mean how many people my age on a pension can afford that every week out of their pension. It mightn't sound much but it darnn well is*."

33 Whilst there was a strong belief expressed by most consumers that the system should require ophthalmologists to make a greater contribution to the public sector, a few defended them on the basis they were business people and therefore had the right to make their own decisions about how they practised: "*But not only are they specialists they're business people and if you are in business you have to maximise your profit don't you and there's no profit in going and spending your day at the public hospital' … "And not knowing the actual issues I don't think we can really make any sort of comments regarding that's the way they run their business. And they have a perfect right to don't they*." Thus there were differences in the views expressed by the majority of consumers regarding the ethical and moral obligations of health professionals to the public system and a minority who had a greater acceptance of a capitalist model of society: "*That's the way the capital society works.*"

34 Older people in the groups recalled that public health services were more readily accessible and/or cheaper in the past. Some believed that this was due to requirements imposed on medical professionals to spend time in public hospitals: "*But that was the system wasn't it years ago? Every specialist worked in public hospitals didn't they. They did a certain amount of their time there it was accepted wasn't it*."

35 All consumers and Consumer Advocates recognised the benefits associated with specialists of all types working in the public sector to some extent: "*Surely it brought experience to the hospitals so in that sense it had to be good …..*"

Access to primary ophthalmology services

36 Providers advised that:

36.1 There are well-established referral patterns in some communities;

36.2 Geographic access to optometrists is generally excellent, but optometrists are an underutilised resource and their role is not well understood. In small to medium rural towns access to and/or choice of primary ophthalmology providers is not good;

36.3 Access to general practitioners, particularly in some rural areas, can be problematic; and

36.4 Obtaining glasses at outlets such as supermarkets and chemists is not as good or desirable as seeing an ophthalmology provider (but others thought they were a suitable product, there was no evidence of harm, and their use should be encouraged).

37 Consumers believe eye health is a health issue that does not receive enough attention in the broader context of health promotion from the Government: "P*eople do not have a good awareness of eye issues, not very good, or have never come across education programs. They are not aware of the services."*

38 Although responsibility for education and early diagnosis is largely seen as a Government one, it is also felt to be the responsibility of the individual to monitor their eye health as they got older, as they would other aspects of their health: "*I do believe that when you're getting older, it's good to go to an optician to have an annual check up. Your optician will be able to detect anything more serious and he or she can write a referral to an eye specialist.*"

39 The consumer consultation confirmed that, in general, consumers have only a vague understanding of the distinction between the roles and responsibilities of various ophthalmology professionals and ophthalmology support services. This situation was reinforced by the experiences and perceptions of Consumer Representatives: "*A lot of the consumers get confused what people's roles are. They get conflicting messages ….* "

40 Consumers, however, were more readily and clearly able to identify the functions performed by optometrists than those of other eye professionals. The main functions of optometrists were perceived to be:

40.1 Vision testing and monitoring;

40.2 Prescription of optical lenses; and

40.3 Selection and purchase of frames.

41 Depending on experience, consumers also perceived optometrists played a vital role in:

41.1 Broader screening for conditions such as glaucoma, cataracts and other eye diseases; and

41.2 Preventive advice and products.

42 There was considerable criticism about the cost of glasses in both consumer groups and among Consumer Representatives. Consumer Representatives with experience of lower socio-economic constituents were strongly critical of the costs associated with prescription glasses, claiming it acted as a serious deterrent for many who needed corrective lenses in order to lead a satisfying and safe life. They also believed that by not updating their prescriptions and/or using glasses that were inappropriate, purchased from an op shop or borrowed from someone else, they could risk further damage to their eyes: *"Even if it is $28, it might be a bit too much for some people on the low income end" … "I think that many people find that it is very expensive to get the prescription they need, whether they continue with the old prescription they have …. borrow someone else's glasses …. or get something from the op shop."*

43 This was reinforced by consumers in the groups who admitted they deferred visits to the optometrist, even knowing their eye sight was deteriorating, because they could not afford new glasses: "*It is a deterrent yeah I won't go and get glasses at the moment because I can't afford them*."

44 Whilst lenses were recognised as a component of the overall cost, criticism was primarily levied at:

44.1 The general cost of frames;

44.2 The seeming inability to use existing lenses in new frames; and

44.3 The prescribing of more than one pair of glasses.

45 The cost of vision aids for people suffering from more serious or complex eye conditions was also an issue raised by these people and Consumer Representatives: "*I got it from Vision Australia and this can cost you up to $60. It was made in Germany or Britain. It's very expensive and that's just ridiculous. I believe that it could possibly be made in China or imported from there.*"

46 A number of people questioned why glasses with magnifying lenses could be purchased from the chemist or reject shops for a low cost when frames from the optometrist were always expensive: '*Well these were cheap but they still cost me over $300 for the glasses" … " One thing is the high cost of glasses. I'm not talking about medical services but, in particular, frames. Why is it that I can go to the $2 shop and get a pair of $2 magnifying glasses that I can't really tell the difference between that and my prescription glasses and they cost you know $200 or $300 at the optician.*"

47 Eye health was a highly emotive issue to most consumers – particularly so for Consumer Representatives. The fact that the people who most needed their services were often unaware of them and not advised by ophthalmology professionals was a continuing issue of contention: "*We get a lot of calls from people just wanting basic information …. How many people are suffering, what they are suffering … we are able to provide them with the type of information and then direct them to wherever we think that they need to be.*"

48 It was noted by some providers that the school vision services were discontinued about ten years ago and this is an area that requires more surveillance.

Access to the Victorian Eyecare Service

49 Providers advised that:

49.1 Access to spectacles is restricted by waiting lists;

49.2 There is unnecessary duplication of services and cumbersome referral requirements; and

49.3 In rural areas, some practices are withdrawing from the VES because of perceived excessive bureaucracy and costs.

50 The Victorian College of Optometry (**VCO**) advised that the current funding arrangement for the VES is for an integrated eyecare service with comprehensive ocular examination (including refraction) and provision of spectacles if clinically necessary and that the funding model does not support the provision of spectacles on external prescription alone because:

50.1 The level of funding provided by the Department would not meet the spectacle needs of all Victorian pensioners who require spectacles each year;

50.2 The funding provided is used to deliver a comprehensive eyecare service to the most needy in the community and not for those pensioners who seek services on a partly private basis;

50.3 Disintegration of services to allow, for example, a spectacle dispensing service introduces complications in managing quality of eyecare services contracted and incorrect and non-tolerated prescriptions for both patients and practitioners; and

50.4 Offering a spectacle dispensing service only would result in the loss of participation of private practitioners in rural Victoria in the delivery of the rural VES service.

51 The VCO advised that currently less than 50% of Victorian pensioners are able to access subsidised eyecare with the funding currently available and it is important that this is targeted at the most needy in the community.

52 One provider advised that the subsidised spectacles scheme in NSW seems to work much more smoothly, although it is means tested whereas the Victorian scheme is

not. In addition NSW glasses are provided at no cost and are produced in a central facility.

53 No one in the consumer groups mentioned the VES. It was, however, mentioned and discussed by Consumer Representatives. They believe that insufficient publicity is given to the scheme especially among the population base that had most need of it. Whilst seen as a positive initiative, it is thought that some optometrists could ultimately be disadvantaged by participating in the scheme, particularly those who:

53.1 Live in an low socio-economic area where there is a high incidence of benefit recipients and health card holders; and/or

53.2 Strongly promote the scheme to clients because of their own social commitment.

54 For these practitioners, Consumer Representatives believe that the balance of their client base could become weighted toward patients on the VES. This is perceived to have the potential to make the business financially unviable in the long term.

Access to secondary ophthalmology services - metropolitan

55 Some providers consider that equity of access should be a goal across the public system, and some suggested that waiting times for public services should be the same as waiting times for private services.

56 The majority of providers believe that a full range of specialist ophthalmology services (emergency, consulting and surgical) should be locally accessible, in all general metropolitan hospitals. Some, however, favour centralisation of integrated services to a small number of metropolitan centres for volume, quality and efficiency reasons, with only emergency consulting services being provided at other general metropolitan hospitals.

57 Those who favour provision of integrated services at a more local level advised that staff would not be attracted to general hospitals to provide services if they did not have the opportunity to provide fully integrated services. As consulting services are necessary in all hospitals, a full range of surgical and non-surgical services therefore needs to be provided. On the whole, they suggested that it is impractical to provide emergency, inpatient and outpatient services without also providing surgical services on the same site.

58 Many commented that the RVEEH is well located centrally and is, therefore, very accessible to patients.

59 Some providers have had positive experiences with private clinics collocated with public hospitals: "*In public hospitals where the initial entry point is a collocated private clinic, an appointment can be arranged over the phone and there is usually a written response from the ophthalmologist once they have seen the patient. The disadvantage is if the collocated private clinic does not bulk bill pensioners. There do not seem to be any disadvantages in terms of surgical outcomes. Further consideration of the public/private collaborations in public health care may have some benefits.*"

60 Many providers suggested that current waiting times for an outpatient appointment at a number of identified hospitals, including the RVEEH, are unacceptable. Suggestions for acceptable waiting times for non-urgent outpatient appointments ranged from 4 weeks to 3 months.

61 Some providers suggested that current surgical waiting times in Victoria are generally 'not too bad' and in some geographic areas have improved significantly in recent years. One submission pointed out that waiting times for cataract surgery at the RVEEH are almost half the state's average. Others noted that the particularly long waiting times for outpatient appointments in some hospitals compound surgical waiting times. According to one provider, patients wait 55 weeks for an outpatient appointment at X hospital before going on the waiting list, so the true waiting time is closer to 20-24 months.

62 Suggestions for acceptable waiting times for non-urgent surgery varied, with up to 18 months considered acceptable if there is a triage system to expedite urgent patients. Providers advised that in other cases patients are put on the waiting list early, as a demand management strategy.

63 Consumers cited examples of waiting times of 3 or 4 months, and generally considered them reasonable for access to treatment in the public system: "*In my experience I have not had to wait and my mother's in the public system as well and not excessive times, no. Mind you none of this was life threatening" … "I had it done at Dandenong and I was prepared to wait …. I thought 'oh 3 or 4 months who cares?' It wasn't life threatening and the next thing you know a month later I'm there having the tests and I found it excellent. I actually stopped my private insurance only because of the cost and I can't afford it" … "I contacted the eye and ear hospital and I had to wait of course ….*".

64 Consumers perceived, however, that waiting times in the public system could vary considerably depending on the specialist seen and the facility where the treatment was being provided: … "*It all depends on the specialist too doesn't it? You know I think really it's up to the specialist. I think sometimes they can get you in early and sometimes they can't sort of thing you know" … "You've got to be lucky where you live I think, or who you go to" … "You know, as I said, he was the one who did the tests and he was the one who practised at that hospital as well."*

65 Although consumers who had received treatment through the public system had no complaints about the waiting times they had personally experienced for their eye treatment, Consumer Representatives were more critical about this aspect of the public system. From their experience they claimed that patients had often had to wait a considerable time either to see a specialist or receive treatment: *"Well they make an appointment and it's not until 6 weeks before they can see anyone."*

66 One provider emphasised the need to refer to low vision services, noting that only 10% of people with vision loss actually use low vision services and only about one third of those who are blind access them. This concern was echoed by consumers. Criticism was particularly levied by consumers at ophthalmologists. Whilst, there were some exceptions, in general they believe that ophthalmologists (and to a lesser extent, optometrists) have a very narrow focus on the treatment of people diagnosed with eye conditions, especially ongoing and incurable ones. It was pointed out that

often someone who had been diagnosed with a serious eye condition was in shock after they had been told. Usually they knew little about the condition, or what the longer term implications might be: "*I think that professional people are very aware of the situation but they choose to do the things that they do for various reasons …. You go to them as a patient and they treat your eye, or the eye condition. But they do not treat the person" … "A real contention is, we really need to somehow educate the ophthalmologists …. People are not getting services" … "They can be diagnosed with something that sometimes they can't understand what it is or even pronounce. What my main concern is, ophthalmologists in particular, not all of them, unfortunately too many of them, they tell a person they have a certain condition and cannot do anything about it and off they go. They become traumatised. Instead of referring them to, say, Vision Australia or one of the other agencies where they can get some assistance."*

Access to secondary ophthalmology services - rural

67 Providers advised that:

67.1 The rural population is ageing faster than the metropolitan population and demand is increasing at a faster rate;

67.2 There should be an equitable distribution of resources between regional areas. Some providers consider this is not currently the case;

67.3 Generally, there are good relationships and referral patterns between ophthalmologists and optometrists in rural Victoria;

67.4 Rural patients are disadvantaged by transport costs and inconvenience if they need to travel to Melbourne. Ambulance costs can also be a problem for small rural hospitals;

67.5 It is essential that all regional areas have comprehensive local ophthalmology services - emergency, consulting and surgical services. Most providers advised that if surgical services were removed from regional or sub-regional centres, there would be little incentive for ophthalmologists to provide medical support. Many providers also believe that services should be provided from sub-regional centres;

67.6 Overall, access to ophthalmology services is reasonable, but there are some significant gaps and there are serious concerns about the costs of some services. In many areas, resident ophthalmologists provide a comprehensive public and private service. In other areas, visiting ophthalmologists provide a periodic surgical and consulting service. Most centres with resident or regular visiting ophthalmologists are relatively self-sufficient – on-referral is rare. In areas where there is no resident ophthalmologist, access to emergency care is also generally good, through links with individual ophthalmologists or regional/metropolitan hospitals, but some patients have to undertake long trips to Melbourne for problems that subsequently are deemed not to warrant admission;

67.7 Some hospitals have clearly specified the volume of surgical services for which they are prepared to pay, ensuring certainty for ophthalmologists and hospitals; and

67.8 Surgical waiting times for public patients in rural areas are generally not known - waiting lists are maintained by surgeons in their rooms. Most providers consider that this is satisfactory, but others believe the system should have access to waiting list data.

68 Smaller rural hospitals with visiting ophthalmological surgical services believe these services provide a major benefit to their communities, and also help their hospitals to remain viable. Providing local access to surgical services also means that there is better ophthalmological medical backup.

69 The financial sustainability of many services is in doubt, however, and depends on the hospitals' successful price negotiations with the ophthalmologist(s) and their ability to replace ageing and expensive equipment. The Rural Patient Initiative funding has been welcome, but its future is uncertain. Most hospital managers do not support service provision "at any cost" – affordability for the public sector is considered important - and many hospital managers are concerned about the high 'market rate' for ophthalmologists to undertake cataract surgery in rural areas.

70 Some ophthalmologists consider, however, that the higher prices they charge for fee-for service surgery in rural areas compensates to some extent for their provision of equipment sufficient to treat all patients in the absence of publicly funded ophthalmology outpatients, and that there needs to be more effort made to understand the issues that make it undesirable for ophthalmologists to do more public work e.g. the costs of leaving a private practice for a day.

71 There are few publicly-funded outpatient services in rural Victoria, and ophthalmologists are providing the equipment and infrastructure to support these services for all patients, both 'public' and private. There are some concerns by providers about the affordability for individual patients of these private non-admitted patient services. For example, rural patients generally do not have access to publicly-funded laser surgery. Equipment is only held in private rooms. There is a problem of cost of this service for low income patients. Every major Melbourne hospital has the equipment and this is considered inequitable. The registrar-run publicly-funded clinic conducted in private rooms in Albury-Wodonga is a success, and could be a useful model for others.

72 Access by rural patients and hospitals to the RVEEH is generally good. More system-wide leadership from the RVEEH would be welcome – leading education, formalised support arrangements, academic and service leadership- and also support with coordinating the care of individual patients. There is a sense that the RVEEH should be invaluable to rural Victoria but needs to improve its services.

73 Professional isolation is a concern. Encouraging rural ophthalmologists to retain a link with the RVEEH would help reduce professional isolation.

Gaps in secondary ophthalmology service provision - rural

74 Providers advised that across rural Victoria, current patterns of surgical service provision are neither sensible from a planning perspective, not 'consumer-friendly'. Most gaps relate to the inability of some regional hospitals and ophthalmologists to agree on an acceptable price for cataract surgery. Some hospitals are also concerned that some ophthalmologists are unwilling to undertake procedures other than cataracts because other procedures are not as financially rewarding.

75 As some regional and sub-regional hospitals have ceased providing ophthalmology services, others have had to assume an added load, which they perceive as unfair. "Bussing patients to Melbourne", a strategy which has been instituted in some regional centres in response to growing surgical waiting lists, is also not seen as an acceptable long term solution for most providers. Similarly, rural consumers experience problems with transport and do not see travelling to Melbourne as an acceptable alternative.

76 Consumers in rural areas in which there was not a publicly-funded service were very critical: *"I mean we've got a public hospital here in X, we should be using it" … "They took me to Melbourne they did the operation there and I said why don't you do the operation here and they only work in Melbourne*." Consumer Representatives felt that waiting times added to the problems faced by rural and regional consumers in accessing public facilities: *"You have people coming down to Melbourne … the cost of their transport …. cost of treatment … long waiting lists."*

77 Most believed that it was the responsibility of a public hospital to provide specialist ophthalmology services. Whilst some blamed the power they perceived exerted by certain ophthalmologist as the reason ophthalmology services were not being provided, others felt that the Government had a responsibility to ensure these services were provided, regardless of individual ophthalmologists: "*There are some groups in Australia that are so powerful amongst the surgeons and those kind of people they're the ones who have forced the closures in these places" … "The thing is we've got to have a public hospital here and experts in the area who can do these procedures. It seems ridiculous that you've got to go to the eye and ear hospital" … "There's been a dispute over the hospital for years. That it's a public hospital that's paid and maintained by tax payers as hospitals are, and it's here to do a service for the public ….. It's time that something was done to make the public hospital responsible*."

78 Getting to and from the RVEEH had been a distressing experience for most of the consumers who had been sent there, for a variety of reasons. The major concerns related to:

78.1 The costs associated with train fares, lunches etc;

78.2 Transport, including lack of familiarity with trains; not wanting to drive themselves and the problems of finding someone else who was willing and had the time;

78.3 Lack of confidence in the city, including getting around, tram routes etc.; and

78.4 Stress regarding how long things would take and allowing sufficient time.

79 Comments from consumers included: "*I don't know Melbourne at all. I've been to Melbourne once a year on a shopping trip. Coming from the bush I had to learn to get on and off trams and it was a most traumatic time of my life, and for him too because she put drops and stuff in his eyes" … " We'd go to the eye and ear hospital then we'd have to be back at the bus by 4.00 to get home or wait for the 6.00 train. It was very tiring and we had to buy lunch" … "My husband went to the optometrist here and they sent him to the specialist here and he said oh you've got such and such I want you to see the specialist in Melbourne tomorrow. So we went down to see <Dr xx> in Melbourne. Our son took us down but then we had to come home and sit for a month and sort of think about things go back down again" … "It was the most expensive time and we were only on a pension …. so we were on a very limited budget and we found it very, very hard*."

80 One person in the rural consumer group had been told about a courtesy car service by their referring ophthalmologist and had arranged to use the service for transport from Shepparton to the RVEEH a number of times. Hardly anyone else was aware of this service, although after some exploration, a few recalled a similar service which operated in the surrounding geographic area. However, they had not thought to investigate it for eye treatment, even thought the concept of travel to the city (or to anywhere else of some distance) was daunting for them. When transport services of this type were discussed, a number of issues emerged:

80.1 It was a service believed to be provided by volunteers;

80.2 The costs were considered reasonable and affordable by everyone;

80.3 It was a highly desirable and needed service;

80.4 It had the ability to remove much of the stress associated with a visit to Melbourne or somewhere else;

80.5 Why was it not publicised more?; and

80.6 Why did their specialists not tell them about it when referring them to services in Melbourne or some distance away?

81 Most providers and consumers view lack of access to public ophthalmological surgical services in major regional centres as a major failure of the service system. From their perspective, rural ophthalmology is not enhanced for the patient, the health care service or the public health care system by transferring patients to a regionally distant hospital. There is almost uniform agreement that these services should be provided locally, but that hospitals need assistance to manage services, and in particular to negotiate a fair price for surgical services.

82 Hospital CEOs are seeking assistance from the Department to resolve these problems, and would prefer an increased central service planning role, but with significant local input. Some CEOs are having great difficulty arbitrating what their communities need or should have, in the context of a service which they feel is unaffordable, and are looking for more centralised planning and decision/making support.

83 Many providers associated with smaller hospitals in which ophthalmology services are provided are strongly supportive of continuation of the existing distributed model of care, because of the value placed on ophthalmology services by their community, and the financial contribution of these services to the viability of their hospitals. Others consider, however, that services should be concentrated in well-equipped regional centres, which would have an obligation to ensure access and equity across the region.

Access to tertiary ophthalmology services

84 The majority of stakeholders believe that the RVEEH provides a very good service for tertiary patients. Many stakeholders noted that it is centrally located and accessible.

85 A minority or providers suggested that tertiary services can be (and in many cases are) provided in tertiary hospitals throughout the metropolitan area, and do not need to be concentrated at the RVEEH.

86 One ophthalmologist noted that: "*There is a positive trend of presentations classified as emergency and urgent moving toward other public hospitals in metropolitan and rural areas, with the RVEEH mainly treating semi-urgent and non-urgent presentations. The discussion paper highlights changing referral patterns of patients to the RVEEH and other public hospitals. A continuing trend toward hospital emergency departments other than the RVEEH treating ophthalmic emergencies requires a major review of medical staffing*."

87 One ophthalmologist commented that there is too much system-wide emphasis on secondary care to the detriment of rare and treatable diseases: "*It is clearly wrong that patients with vision good enough to drive are waiting less time for a cataract surgery than people with other more serious ophthalmic conditions who require a clinic appointment*". It was also suggested that the Medicare system does not cater for adequate provision of care for rare and complicated diseases. According to one submission, the reimbursement for a complex consultation of a condition such as Marfan's syndrome will result in the ophthalmologist being reimbursed less than a GP or an optometrist. "*Rare diseases need better care than what the government now offers.*"

88 It was noted that 8% of all ophthalmology consultations are paediatric, and it was submitted that the Royal Children's Hospital should be recognised as the designated State-wide service provider of tertiary paediatric ophthalmology services.

89 It was suggested by one metropolitan provider that there is a lack of locally accessible sub-specialty care in regional Victoria, but most providers in areas which have existing ophthalmology services considered the range of services to be satisfactory.

The balance of public and private patients in public hospitals

90 Providers noted that a relatively high proportion of private patients are treated in the public sector (compared with other disciplines) and that these patients, many of whom are self-funding, gain priority access in many hospitals. Many rural hospitals and some metropolitan hospitals are encouraging preferential admission of self-funding private patients to make their overall service viable.

91 Some hospitals are 'nervous' about this strategy and the perceptions it may create in the community. One hospital manager suggested that "*The funding system is creating bizarre incentives which should be addressed*". There were, however, some clear differences in views about the appropriate mix of public and private patients.

92 Most providers concur that private patients should have access to the public system, but vary in their views as to whether private patient waiting times for admission to public hospitals should be less than those of public patients.

93 For emergency, acute, and complex surgical patients, patient requiring specialised equipment and patients with trauma and intra-ocular infection, providers recognise that public hospitals do (and should) treat the majority of patients, and whether they are private or public is irrelevant.

94 With respect to the current relatively high proportion of private patients who receive care in some public hospitals, provider views, which tended to be strongly held, varied as follows:

94.1 Access to public hospitals should purely be based on clinical need and private patients should not have priority over public patients;

94.2 It is reasonable to give priority access to private patients if there are excess resources in public hospitals which would otherwise be idle because there is insufficient public funding to enable their use for public patient work. There is merit in increasing the volume of procedures in the public sector by admitting private patients, to achieve a critical mass; or

94.3 Enabling ophthalmologists to treat private patients in public hospitals compensates them for the low rewards they receive from their public appointments. If they were not permitted to undertake private work, they would not provide public services.

95 Some providers are strongly of the view that preferential admission of private patients is inappropriate. The major concern with this arrangement is the potential, in terms of access, for doctors to favour private patients ahead of general public patients. Ophthalmologists advised, however that there are sufficient private patients and there is no need for surgeons to divert public patients to private.

96 Most hospital managers suggested that they would like to admit more public patients but either could not attract ophthalmologists or could not afford to bear the deficit (in fee for service hospitals). Some hospital managers are very concerned that financial imperatives require them to provide priority access to private patients, many of whom are self-funding. There is some concern that patients may not be receiving complete information in all circumstances about their right to be treated as a public patient, and the waiting time to be treated as a public patient.

97 Ophthalmologists advised that the ability to treat private patients in the public sector is important for their practices but also helps to offset the low remuneration from public work, and assists to retain them in the public sector. As one ophthalmologist said: "*It would be impossible to recruit enough ophthalmologists to staff some hospitals, especially the RVEEH, if they did not have access for surgery for their private patients. Ophthalmologists do not in general 'financially require' the inadequate remuneration paid to them when they attend public clinics, but the State does need them to service the needs of the system. There has to be a bit of 'give and take' on both sides*."

98 Some providers are concerned that a significant number of uninsured patients are receiving treatment in both the public and private sectors on a fee-for-service basis, with significant out-of-pocket costs. It was suggested that there were a number of factors that may explain this trend including doctor of choice, but the most likely reason is the length of waiting time in the public sector.

99 One submission, advocating on behalf of consumers, noted that: "*Consumers in regional Victoria commented that perceived waiting times for accessing appointments with an ophthalmologist through the public system, long waiting lists and lack of public provision of eye surgery in their region was resulting in people going into debt to pay for eye surgery in the private system*."

Efficiency of ophthalmology services

> Efficiency refers to the way in which resources are utilised to achieve value for money. This can be achieved by focusing on minimising the cost combination of resource inputs in the production of a particular service (technical efficiency) as well as the allocation of resources to those services to provide the greatest benefit to consumers. Allocative efficiency informs decisions on what services or treatments to deliver, whereas technical efficiency is concerned with reducing costs and minimisation of waste.[4]

Technical efficiency

100 Providers noted that there is considerable expensive equipment available in optometry practices, that should be better utilised.

101 Providers suggested that good quality referrals from optometrists to ophthalmologists increase the effectiveness and efficiency of services.

102 There is a general but not universal view amongst providers that refractive services should not be provided in public hospitals as they can adequately be catered for in the community setting.

103 It was suggested that efficiency would be improved by making some attempt at the RVEEH for the consultant to see the same patient on return visits to outpatients, and if a diagnosis and management page were at the front of the medical record for long term non-urgent patients at RVEEH clinics. It was also suggested that the 'one stop shop' approach to preoperative assessment adopted at the Cranbourne Integrated Care Centre is much more efficient than the traditional model of referral to outpatients at the RVEEH.

104 Providers noted that there is considerable support in the literature for high volume elective surgery facilities, and that modern cataract surgery is extraordinarily cost effective compared to any hospital-based intervention and is one of the most cost-effective surgical procedures of any type. In their view, the fact that almost all eye surgery is same day provides enormous opportunity for further expansion of services without very high capital investment. It was suggested that general hospitals need to have day surgeries that allow for separation of overhead costs.

105 It was suggested that to be cost effective, throughput for an individual operating theatre needs to be at least ten operations per day, five days per week (2,500 operations per year, which would include approximately 2000 cataract operations per year).

106 Many providers advised that theatre efficiency is instrument dependent and often the public sector is inefficient because of lack of sufficient instrumentation or other equipment.

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[4] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003, page 11. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

107 Many providers consider that the use of dedicated elective theatres enables a critical mass of patients to be treated whose procedures will not be cancelled due to precedence being given to emergency cases from other specialties. It was noted by many providers that private day surgical centres have a high level of productivity and there may be more opportunity for collaboration between the public and public sectors. Surgeons prefer to work in the private sector because it is more efficient.

108 All providers agreed that teaching lists are slow and expensive, and there is an opportunity to establish guidelines to allow sufficient teaching lists to be retained whilst allowing consultant run service lists that could be remunerated at a rate appropriate to this model of care.

109 Many providers consider that a critical mass is essential to make the provision of expensive equipment and staff sustainable. Quality equipment needs to be properly utilised. Consistent with this view, some providers thought that very small hospitals should not provide ophthalmology surgical services because the cost of equipment is too high (although there may be other ways of maintaining access to consulting services on a regional basis) and that complex public outpatient services should only be provided in the tertiary sector where economies of scale will allow for efficiency.

110 One provider suggested that 'service spokes' operated by the RVEEH are popular with patients but cost between 25% and 40% more than similar services provided in East Melbourne. Another suggested that alternative models such as outreach provided by RVEEH or a mobile surgery model are probably cost prohibitive due to time consumed by travel which is unattractive to specialists.

111 Providers suggested that there should be state-wide guidelines about purchasing of lens, or a state-wide purchasing contract.

112 Some providers made various suggestions about improving physical infrastructure at the RVEEH, with the objective of improving efficiency.

Allocative efficiency

113 There is a generally but not universally held view amongst providers that public hospital services should complement rather than duplicate services available in the private sector, particularly for non-admitted patient services. One submission noted that ophthalmology VACS encounters comprise 6.4% of all private and public ophthalmology services in Victoria and it is unlikely that reducing or closing some public hospital outpatient clinics would cause problems.

114 There was considerable debate about the fact that a large number of low complexity patients present to the RVEEH emergency department for management, when they could/should be managed in other general hospital or community settings. It was suggested, however, that: "*Patients do not self-triage. They cannot be stopped from turning up at the RVEEH*" and that once they present, they need to be managed in that setting.

115 Others thought that emergency care should by preference be centred on the RVEEH, with other hospitals referring patients there. Overall, however, there was support for the concept of a much more active triaging system at the RVEEH, with on-referral of appropriate patients to community or other hospital settings.

116 It was suggested by many that discharge to the community from outpatients for follow up as soon as appropriate should become the norm at the RVEEH, rather than patients continuing to be reviewed in a hospital setting. This would free up capacity for new patients who currently experience excessive waiting periods for outpatient appointments. Some providers commented, however, that there is a lack of clear referral pathways and mechanisms back to the community.

Funding and price

117 Providers advised that funding models need to be much more transparent, that WIES funding is inadequate, and that efficiency objectives in the provision of patient care should be explicit and balanced with explicit objectives for teaching and training. Many providers, both metropolitan and rural, consider that there is a significant problem with WIES funding, and that the formula is flawed. All support an increase in the WEIS payment for ophthalmology services. It was noted that the WIES for cataract surgery has been progressively reduced by 5.9% from 0.6214 in 2001/02 to 0.5845 in 2003/04.

118 There was very strong representation that public WIES payments for cataracts specifically do not cover the cost of surgery in rural areas, because of the prevailing medical payment, creating an incentive for hospitals to admit a disproportionate number of private patients (self funded, or insured), or to cease service provision altogether. Rural providers believe that the cost weights are based on metropolitan services, that the true costs in rural areas are very high, that metropolitan hospitals are ‘protected’ via their training and development grants, and that there should be a specific rural ophthalmology price that reflects high medical costs.

118.1 Most providers consider that modified fee for service for ophthalmologists is appropriate in rural areas, but there is disagreement about the appropriate fee level. There was some support for a more centralised fee determination process.

Appropriateness of ophthalmology services

> Essentially, the appropriateness of health care is about using evidence to do the right thing to the right patient, at the right time, avoiding over and under utilisation.[5]

119 Amongst providers, there is some support for, and little objection to, formal role delineation in public hospitals, similar to that which applies in the trauma system.

120 The concepts of evidence-based practice and benchmarking are also generally supported by providers.

121 There is general support for improving the appropriateness of referrals through education, preadmission clinics and evidence based guidelines. One submission suggested that clinical pathways in conjunction with a delineated service model will ensure appropriate care.

122 It was noted that many ophthalmologists and optometrists have established a satisfactory model of care in the private sector, whereby optometrists perform the first postoperative review. Co-management guidelines were thought by some to be very useful. It was also suggested that there needs to be an agreed model of care between each hospital and its ophthalmologists.

123 There was much disagreement about whether there was any evidence of inappropriate intervention in relation to cataract surgery. One ophthalmologist submitted that: "The major factor for the huge growth in cataract surgery apart from the fact that patients have two eyes and they are getting older, is in fact that the threshold has plummeted, such that some lens are removed at 6/6 visual acuity. In fact some people do not have cataracts and still have their lens removed". Another suggested that Victoria has one of the highest rates of cataract surgery in the world. Others vehemently rejected any suggestion whatsoever of inappropriate intervention.

124 There was specific debate about whether surgery on a patient's second cataract should be prioritised over first eye surgery in other patients. Efficiency arguments (obviating the need to undergo another pre-operative assessment) support early operation on the second cataract while equity arguments may support the proposition that the patient should be placed on the waiting list behind others with a more urgent need (although others argue that the benefit from second eye surgery is almost equal to that of first eye surgery). There was no consensus on this issue.

125 Many believe that decisions about intervention should be left entirely to the ophthalmologist, in conjunction with the patient: "*Most eye surgery on waiting lists is level 3 with patient driven expectations of the level of care they should be provided. Prioritisation based on factors other than patient wishes after fully informed consent is not justifiable*". It was suggested by some that prioritisation systems for surgical intervention provide an artificial mechanism for management of long waiting lists and

[5] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003, page 11. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

are not necessary if waiting lists are well managed or there is adequate capacity within the system. The utility of these prioritisation tools was questioned by many ophthalmologists. Others strongly supported consideration of a more explicit and transparent prioritisation system such as the VF-14. There is some interest by the RVEEH and other providers in classifying their waiting list according to functional impairment. Caution was expressed about the potential diversion of resources, however, from clinical care.

126 There was robust debate about the new model of care that has been introduced at the Cranbourne Integrated Care Centre. On the one hand, the model was defended as being evidence-based and providing good patient outcomes. On the other hand, it was criticised for being introduced without evaluation in the Australian context. The absence of a routine day 1 post-surgical review attracted particular criticism by some ophthalmologists. Other providers noted that the traditional model of care had not recently been systematically evaluated either.

127 It was suggested that there is a current trend to consider cataract surgery as refractive - that is, “throw away your glasses” and customise the surgery with new intraocular implants, surgical astigmatic correction and early second eye surgery, to achieve emmetropia. According to one ophthalmologist, there is no current clinical evidence that this surgical management is cost effective but it has the potential to increase cataract surgical rate to unsustainable proportions.

128 There was considerable support for maintenance of the multi-disciplinary sub-specialty clinics provided by the RVEEH, and for ophthalmology care to be provided in a coordinated fashion with specialist care at other hospitals (e.g. diabetic and immunological) to ensure appropriate care for complex patients. A provider noted that: “*Eye care services are extremely specialised and in some cases if treatment is inappropriate it cannot be undone. Having the RVEEH ED available 24/7 is a fantastic thing for the public of Melbourne and Victoria as a whole. I am not sure that having lower levels of expertise and equipment more widely dispersed across Melbourne is necessarily doing the public a favour*.”

129 It was suggested by one provider that sub-specialty clinics at the RVEEH should only be available via referral from general ophthalmology clinics both to limit unnecessary referral and to try not to deskill the generalists who run the general clinics.

130 It was also suggested that some specialised procedures should be limited, through credentialing, to the RVEEH.

131 Consultation with RANZCO was proposed by many as essential to any efforts to change clinical practice.

132 It was noted that high quality imaging services are vital to the effective provision of tertiary ophthalmology services.

Acceptability of ophthalmology services

Consumer and community participation should enhance the level of acceptability of services which describes the degree to which a service meets or exceeds the expectations of informed consumers.[6]

133 Consumers have great confidence in Victoria's ophthalmology services: '*Well taking Australia as a whole I think they have the biggest and best reputation as far as eye care goes' … "I would say there are some excellent ophthalmologists and optometrists and other eye care specialists in the field in Victoria. There is absolutely no question about that" … "You'd have to say that Victoria have the geographical spread of those kind of services*."

134 From the consumer perspective: "*The opticians are very thorough. They not only check your short sightedness or long sightedness, they go deep into your eyes and if any there any symptoms of something wrong they can be readily detected, whereas I think a GP with a general knowledge they wouldn't know what's wrong they may not have the lenses that go deep into your eyes but the optician has.*"

135 Most specific comments by consumers about the acceptability of services related to the RVEEH, which is very highly regarded, because it:

135.1 Is a public facility, with emergency access;

135.2 Provides specialised, high quality treatment; and

135.3 Provides teaching and research.

136 The RVEEH was more commonly perceived by consumers as offering emergency care and treatment of specific eye conditions, rather than for vision testing and the prescription of lenses.

137 Some consumers in the study had personally been patients of the RVEEH. These, as well as those who had direct dealings via a family member or friend, spoke highly of the service received. Those who had not personally had any contact with the hospital appeared to hold an equally high opinion of the RVEEH: "*Yeah the eye and ear hospital for the eyes. Yeah they're fantastic" … "I've been there only to take my grandfather there but not for myself. But he sang their praises highly" … "If I had an emergency and I'm in great pain, I would go straight to the eyes and ear*."

138 The fact that the RVEEH was a public hospital and therefore freely available to everyone enhanced its perceived value and position: "*I went to the eye and ear hospital and I like to save as much as I can so what money I have I'm very lean with and I use it for myself and my own benefit. I went to the eye and ear hospital - bloody marvellous service. Great" … "I was referred to the eye and ear hospital by a GP.*

[6] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003. page 36. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

No, actually I was referred to an eye doctor and we discussed how much it was going to cost and I said 'oh go to hell you know I'll get out of this cheaper than that'. Then the big day comes and like all things unknown you're a little bit apprehensive. But if anyone has to go through it, forget it because it's so simple you just go in there and spend a rather pleasant day and come out with a patch over one eye and go back the next morning and have it removed and that's that."

139 Indications were that most consumers were aware that the RVEEH was a foremost teaching and training hospital and assumed that it was also a centre for important eye related research. These appeared to be significant factors contributing to its perceived status and reputation: "*Well apart from being a world class eye specialist hospital it also has very good research and training" … "Yeah well my mother has what they call age macular degeneration …. and she was referred by the doctor to go to the eyes and ears hospital. As you're aware the Royal Eye and Ear Hospital is also the teaching hospital of Melbourne University ….. there are students doing there PhD in micro-degeneration and cataracts … and because of that she was ushered in with no waiting ….. go through all the tests, then after that she went over to the eye and ear hospital for proper treatment for her cataracts. So the research department of Melbourne University and eyes and ear hospital work hand in hand to do research on the medical conditions of the patients*."

140 One consumer advocate advised that there is an apparent lack of training and skills for ophthalmology professionals working with people who have an intellectual disability, mental illness or special needs, and there is a lack of flexibility in appointment times (early morning and late afternoon) which make it difficult to make a one day round trip from the country.

141 Providers confirmed that there is tremendous loyalty from RVEEH patients, who can be very difficult to discharge.

142 There appears to be consumer dissatisfaction with the aesthetic appeal, choice and quality of low cost frames provided through subsidised schemes. Most participants in the consumer consultation admitted to wanting glasses that they felt enhanced their image or appearance and it was felt that this played a factor in the consumer marketing of glass frames and was a reason in the perceived high price: *"…. another set of glasses for that. So it cost me over $600 for two lots of glasses" … "Well you go into an optician to get new glasses and you've got a perfectly good frame and they say they can't get lenses that fit that frame and you only got them 12 months ago.*"

143 Only one person in both consumer groups was willing to trade off the choice of style for lower cost: "*But if you, as I did, go along to the eye and ear hospital as you know and I think I had a pair of spectacles prescribed for about $100. I don't care what they look like that doesn't matter to me terribly much. I can see through them. I can use them. They're efficient. But if I'd gone elsewhere I could pay, I don't know, $1000.*"

Effectiveness of ophthalmology services

> Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.[7]

144 One submission suggested that some ophthalmology professionals advise patients with cataracts that they should not change their glasses until their cataracts are taken out, leaving them with poor vision for many years in areas with long waiting lists.

145 There were some concerns expressed (relating to quality of care) about optometrists extending their services to chronic disease management.

146 It was generally agreed that public hospital emergency department services are of much higher quality since the advent of specialist Fellows of the Australian College of Emergency Medicine.

147 There was considerable debate about whether minimum volumes of surgical procedures for either ophthalmologists or hospitals were required to assure good outcomes. There was no consensus on this issue, with some providers considering this was correct, and others suggesting outcomes are more dependent on past training and experience than present volume. Where minimum volumes were agreed to be supportable, the role of the RANZCO in identifying appropriate volumes was highlighted. A figure of 200 cataract procedures per year for most practitioners was proffered. It was noted that adequate numbers of rarer procedures would be difficult to access in some areas.

148 Several providers commented on the need to centralise specialist outpatient clinics at the RVEEH, to ensure sufficient volume and, therefore, quality. For example: "*The RVEEH is of pre-eminent value to Victoria … The special clinics at the RVEEH should be available for consultation by non-ophthalmology specialties … Glaucoma is a less surgical disease and should be centralised on the RVEEH … Diabetic retinopathy and ARM is best handled by specialist ophthalmologists associated with the medical retinal clinic or vitreo-retinal clinics at the RVEEH … Subspecialty services can be provided for at a basic level but comprehensive clinics should be provided at RVEEH to ensure adequate catchment area*."

149 The collocation of the RVEEH and its research institutes was considered by many to be a vital contributor to the overall effectiveness of care, through stimulating service development and academic effort and inquiry.

150 There was considerable support for audit and quality assurance. Many providers suggested that practices at the RVEEH are leading the field in this regard. It was suggested that pre-operative functional assessment would be a good tool for auditing

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[7] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003, page 11. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

the waiting list and auditing outcomes. Some providers suggested specific key performance indicators that could be monitored - these are listed at **Attachment 6**.

151 Mostly, the view was that audit and outcome monitoring should be conducted and reviewed locally, although there was some support for regional or central monitoring, and reporting to the public.

Safety of ophthalmology services

> A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm arising from care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimised in care delivery processes.[8]

152 It was suggested by one provider that there is no evidence that safety of services is an issue although this is always rightly a consumer concern. It was also suggested that it would be expected that, in line with usual medical practice, patients treated by practitioners who are appropriately credentialed, experienced and managing higher volumes of patients are likely to have a lower morbidity.

153 Many providers advised that all ophthalmology units carry out clinical audit, and there is a strong tradition in ophthalmology of self regulation with respect to scope of practice. It was suggested that surgical procedures performed by ophthalmologists are normally self-limited to those in which experience has been gained during training, or in which subsequent training has been undertaken.

154 Providers consider that new models of care, in particular, should be subject to strict audit.

155 One submission noted that surgical complication rates are so low that it is difficult to determine the impact of any new model of care. Many providers suggested that resources for audit need to be identified and quarantined.

156 It was noted that Melbourne has a very multi-cultural community with many patients from non-English speaking backgrounds, creating additional safety risks related to poor communication.

[8] The Victorian Quality Council. *Better Quality, Better Health Care. A Safety and Quality Improvement Framework for Victorian Health Services.* November 2003, page 11. Accessed on 14 May 2004 at http://www.health.vic.gov.au/vqc/strat_frame.pdf

Governance and leadership

157 It was suggested that the objective should be to establish a total quality management system for ophthalmology, and that there needs to be a change management strategy with outcome measures. Several providers suggested that the RVEEH should have a central role.

158 Maintenance of independent governance of the RVEEH was specifically mentioned by some providers as vital to the protection of the specialty.

159 Some providers suggested that leadership capability needs to be developed and there should be more system-wide goal-setting and accountability.

160 It was suggested that health services should provide eye care as part of their core requirements with the Department providing guidance. A review of the care model and outcomes that each group sets up should be build into the system with system-wide peer review being an integral part of the governance model.

161 Many providers agree that access and waiting list management should be coordinated across the public system, and that the achievement of performance objectives should be monitored at a local level and possibly also at a regional or central level.

162 Some concerns were expressed by some ophthalmologists about commercial relationships in the industry and the potential for perceived or actual conflict of interest. Relevant relationships mentioned were between ophthalmologists/ optometrists, and in relation to ophthalmologists owning day procedure facilities to which they refer patients.

163 There is a view that the federal government also has a national leadership and ensuring that the planning, funding, monitoring and delivery of eye health services in every state is accessible to all people living on low incomes.

Consumer involvement

164 Providers agreed that consumers need much more information about referral pathways, treatment choices and choice of election as a public or private patient.

165 While choice of election as a public or private patient is currently left almost exclusively to the ophthalmologist, many providers considered that the public system has a responsibility to ensure appropriate information is available.

166 As is often the case with medical specialists overall, however, there was a level of reverence in the way consumers referred to ophthalmologists. Some consumers implied, and others openly admitted to being rather intimidated by the status and the working environment of medical specialists, including ophthalmologists. Intimidation regarding the attitude of ophthalmologists, the perceived indifference of staff and the environment in which they practiced was identified by Consumer Representatives as factors in creating barriers to access for some consumers.

167 Compared to the way in which people spoke of their GP, optometrist and other health professionals, indications were that ophthalmologists, who in many cases were seen only infrequently compared to other health professionals, were perceived to be somewhat remote, and rather unapproachable. Hence, there tended to be little questioning of the information or treatment prescribed by them, and rarely any expectations of a personal and open relationship.

168 Instances were relayed by consumers of mis-diagnosis and inappropriate treatment. However, where this had occurred, it was usually some time before the patient changed ophthalmologist, sought a second opinion, or made a complaint of any kind.

169 Consumers admitted they were reticent to question ophthalmology professionals, particularly ophthalmologists – as they were other medical specialists. This appeared partly due to the reverence with which most specialists were treated, as well as a lack of knowledge and inadequacy regarding what questions to ask. The reluctance to ask for information applied not only to their condition and its potential longer term implications, but also treatment options, fees and what alternatives were available to them, as well as support and other services.

170 From both a consumer and Consumer Representative perspective, ophthalmology professionals were, with exceptions, generally seen to be remiss at informing their patients, or involving them in decision making. This appeared to be more particularly the case with ophthalmologists than optometrists, who were usually perceived to be less intimidating and more approachable.

171 However, indications were that the reluctance to question ophthalmologists was changing. Many people in the groups claimed to be much more 'pro-active' in seeking information from them: "*Unless you ask they don't tell you what you're entitled to" … "I believe that you're entitled to it. I didn't for a few years. I was very nervous and that and then all of a sudden I started asking questions you know and they'd look at me* ….".

172 Those who had done so often found they had a number of options available to them, which they would have been unaware of if they had taken the information provided at face value, or not questioned the specialist … "*I was sent to the specialist for a test who sort of gave me a list of prices that it was going to cost me and I think he must have seen my face fall and he said 'oh but then you can go to Dandenong Hospital' and I said okay and that cost me nothing. But I think he operated in private rooms and he operated in the hospital, so therefore his first option was to give me his schedule of rates at his private practice in his private rooms ….. So he sort of gave me the second option of having it in the public hospital and that cost me nothing, except for his fee as a first consultation*" … "*Like me a couple of years ago, I went to a specialist and I went for a few tests ….. I said 'what's this for?' He saw I was upset and he said to me alright I'll bulk bill. It was gonna cost me $400 and he ended up bulk billing so you've got to speak out*."

173 A few consumers voiced the view, based on their experiences, that younger ophthalmologists were more approachable, more friendly, more willing to spend time explaining things to their patients, and more inclined to involve them in the treatment decision making process. "I *find I've had to go to a few specialists over the years. I find that the younger ones that have come in over the last 20 years or so most of them volunteer the information. So I've seen a great change in medical people*" … "*Yes I must agree with that too. They're more outgoing and they'll tell you. You don't have to bother asking they'll tell you*".

Competence, education and research

Education and training

174 The quality of the Victorian training scheme for ophthalmologists, optometrists and orthoptists is recognised almost universally by providers and consumers to be very high, and outcomes to be excellent.

175 Medical student training in ophthalmology was identified as 'woeful' by one ophthalmologist, but as 'very good' by others. Some ophthalmologists advised that there may be a difference in approaches by medical schools, and that as ophthalmology is a vital component of general practice, its focus in the undergraduate curriculum should be reviewed. Similarly, the quality of training of general practitioners is considered to be variable and should be improved.

176 It was suggested that optometry and ophthalmology students and practitioners should undertake training to sensitize them to the needs and issues of people living on low incomes, to develop their competencies in understanding social justice and equity issues and cross cultural communication.

177 It was suggested that there may be opportunities for sharing training between the professions.

178 Generally, the quality of training of emergency physicians is considered high but there are opportunities for enhancement and emergency specialists should be encouraged to complete an ophthalmology module in their training.

179 The critical mass of both patients and trainees at the RVEEH is seen by most as a key success factor in training, although others consider that the quality of training could be sustained without continuing the existing concentration of clinical material at the RVEEH, and that it is important to maintain services in general hospitals to ensure appropriate disbursement of training opportunities for other non-ophthalmological staff.

180 There is support for ophthalmology training to continue to be coordinated by RANZCO and the RVEEH with support from rotating hospitals. Many ophthalmologists suggested, however, that ophthalmologists are being 'overtrained' in cataract surgery, and 'under trained' in other aspects of surgery, because advanced trainees/Fellows are getting priority access to non-cataract training opportunities.

181 It was agreed that there may be some opportunity for training ophthalmologists in the private sector but this is unlikely to be 'mainstream' and some believe that it should be 'left to the profession to sort out'. Perceived problems with training in the private sector include medico-legal liability and patient acceptance/consent. It was noted that there are existing collaborative public/private models which are effective, where surgical training is undertaken publicly and follow up and outpatient work and training are undertaken in private. A significant proportion of training in orthoptics is currently provided in the private sector.

182 It was suggested that any privatisation of public outpatients could seriously affect training and would need to be accompanied by compensatory training opportunities.

183 It was generally agreed that there is underexposure of trainees to rural areas and there is support in principle for the creation of rural training posts. There may be opportunities to collaborate with the rural clinical schools.

184 There is disagreement about whether the appropriate number of ophthalmologists is being trained. Recent changes to the training scheme have reduced the number of potential annual graduates. Some ophthalmologists believe that these numbers will have to be made up, while others believe that changes in models of care and the advent of therapeutic optometry will reduce the role of the specialist ophthalmologist.

Research

185 It was suggested by several providers that the achievements of the Melbourne University Department of Ophthalmology and later, the Centre for Eye Research Australia would not have been possible had they not been co-located with the RVEEH. The association between the University and the hospital is seen to be of great benefit to both parties. The concentration of staff and patients on a single site, which aids the power of studies, the recruitment of research subjects, and promotes research by trainees and clinicians is considered to be the major factor in driving high quality research and clinical care. In addition, there is the ability to access shared facilities.

186 It was also suggested that there is not a single eye research centre of note globally that is not closely associated with a vibrant clinical service. A different point of view was that the trend in research was for national and international collaboration, and local collocation was irrelevant.

187 Most providers consider that the private sector has some role to play in research, but it is less than the public sector.

188 Some ophthalmologists consider that the model of care at Cranbourne does not support teaching and research, and is therefore not assuming its full share of training costs.

Information management

189 There is general support for the development of information management systems, to enable collection and utilisation of performance data and to assist with the delivery of quality care.

190 It was suggested that data collected by Victorian hospitals on the source of referrals for ophthalmology emergency presentations should include a specific category for referrals from optometrists. It was also suggested that data should be collected on community satisfaction relating to service provision and client care.

191 Some providers actively support state-wide monitoring of outcomes, or a state-wide database for ophthalmology services. Most expressed no specific objection to this concept. Many providers suggested that the RVEEH could have a central role in data collection and management.

Future ophthalmology service system improvements

Primary ophthalmology services

192 Providers at all levels in the system believe that care should be more multi-disciplinary - nursing and allied health workers could optimise assessment, access and early intervention. Orthoptists should be permitted to prescribe glasses. General practitioners and optometrists could have an enhanced role in diagnosis and therapy. There are also opportunities to enhance the role of the emergency nurse, particularly to improve triage practices. In rural areas, there could be better use of optometrists and orthoptists, to undertake routine screening and possibly fundus examinations with non-mydriatic digital cameras which link electronically to an ophthalmologist for review. There are opportunities to improve interactions between hospitals, optometrists and orthoptists, in community and hospital settings. Care could be improved with patient care plans.

193 There are opportunities to establish better links between the VCO and the RVEEH, with a suggestion that collocation of services could improve access for all components of eyecare for patients attending public hospitals and clinics. Outreach RVEEH services at the VCO would provide a broader scope of eyecare services to the 35,000 patients attending metropolitan VCO clinics and there may be potential in VCO outreach support of RVEEH services.

194 The VES while funded for, and committed to, a model of providing integrated eyecare service with ocular examination (including refraction) and provision of spectacles if clinically necessary has indicated a willingness to explore alternative service arrangements to resolve the specific issue of public hospital patient spectacle provision.

195 Screening in various forms and other public health measures were suggested by many stakeholders, together with public awareness campaigns and better education of GPs about how to screen and what referral services are available (although a few providers suggested that with notable exceptions, especially diabetes, there is little evidence of the value of screening to prevent long term morbidity). There was explicit support from individual providers for re-introduction of the public awareness campaign previously funded by the Victorian Government.

196 The need for better education was strongly supported by consumers. As each of the group participants suffered from some form of eye condition they were highly aware of the need to be more conscious of eye health. As such it was felt that insufficient emphasis was currently given on educating people about looking after their eyes and the services that existed.: "*We're all aware of things like obesity and heart disease and all that sort of stuff. But I don't think people really pay any attention to their eyes" … "I think people need to learn how to look after their eyes*" … "*To me the health department should print more information or pamphlets to be aware of eye conditions the different diseases" … "I think eye health must start at a young age. Surely, like anything else, if you lay a good basis for your physical wellbeing as a young person it pays dividends. Why shouldn't it be the same with eyes education at a very early age*."

197 Despite recognising that education would exacerbate the increase in demand, there was strong agreement among consumers, reinforced by Consumer Representatives that preventive strategies associated with creating greater awareness about eye health, together with broader based screening and diagnostic programs, especially among young people, were critical for the longer term health of the population.

198 The suggestion that screening services be introduced into schools was widely supported by consumers. In fact, older people and Consumer Representatives recalled that regular health checks were standard procedure in schools, but lamented that, unfortunately, this had now ceased: "*Like they have dentists coming to the schools and things like that they should have something for eyes as well. It was in the schools years ago but not now" … "There was a lot of things that were in the schools like when I went to school …. you used to have a health sister who used to go to the school every year or twice a year. They don't go there now" … "There is nothing in the schools …. the only way they can be tested with their eyes is if you take them voluntary yourself and pay*."

199 It was not only education and services aimed at young people that consumers felt were required. The incidence of eye conditions among older people was a readily recognised issue, and one it was acknowledged would increase with the aging population. Therefore it was felt that education and screening strategies should also be developed for older people: "*With all the senior citizen clubs they go there for socialisation, lunch, games, dancing, I think the health department should be able to send nurses or teachers or eye specialists to go and give a talk on how to maintain their eyes and all the diseases and have the information there for the senior citizens who are not aware*."

200 Many providers suggested that refractive services should be provided by as wide a group of appropriately trained specialists as possible (ophthalmologists, optometrists and orthoptists) and across as broad a geographic area as possible. Increased use of orthoptists in the primary care sector may improve access. Some providers believe that more refractive services should be provided in the hospital setting (e.g. expand refraction clinics at the RVEEH) while others believe that this would be inappropriate and that these services should only be provided in community settings.

201 Providers and consumers believe that there should be improved access to low cost glasses. In their view, access to the VES could be improved through a range of strategies (some of which are contradictory to others):

201.1 Patient self-referral;

201.2 Provision of spectacles on prescription from an ophthalmologist, and in particular, patients who have undergone care in the hospital setting should be able to be provided with a glasses prescription from the hospital visit;

201.3 Subsidised glasses should be provided through the lowest cost, good quality provider as determined by open tender - currently this is the VES; and/or

201.4 Improving efficiency by:

201.4.1 Consolidating the VES at the VCO;

201.4.2 Allowing more competition for the provision of glasses; or

201.4.3 Providing the subsidy directly to the patient.

One provider said: "*The subsidy should go to individual patients, should only attach to a product that is below a set price and tiered according to banding of the patient needs. The VCO should remain an important source of glasses for this group*."

202 Many providers highlighted the need to provide high quality, dedicated equipment in all regional and major metropolitan hospitals, together with adequate theatre access and clear linkages to referral hospitals. Equipment needs suggested in the public sector include slit lamps and dedicated eye rooms in each emergency department, excimer laser equipment, equipment for retinal topography and equipment for imaging of the retinal vasculature.

203 Providers and consumers commented that support with community transport would assist some patients.

204 One provider suggested that consideration could be given to a rural incentive for optometrists, similar to general practitioners, in recognition of the higher costs of setting up practice.

Secondary and tertiary ophthalmology services

205 Providers suggested that efficiency would be improved if there are enough support staff (e.g. orthoptists). Registrars also have an important service role and aid efficient service provision.

206 Some providers believe that outpatient services at the RVEEH that are not required for training should be closed, to improve efficiency of service delivery.

207 There is strong but not unanimous support for the maintenance of a specialist tertiary hospital with a concentration of highly specialised services (for efficiency and quality reasons), either in the current form of the RVEEH or in a streamlined form, and possibly more closely co-located with St Vincent's Hospital.

208 Under this model, most providers also support substantial growth over time in secondary services already located in metropolitan general hospitals, and proposals were made for the number of surgical centres that are sustainable, whilst maintaining sufficient throughput to ensure efficiency and quality. With the current public/private mix, and taking into account population growth, a figure of 16 public surgical centres was proposed by one provider.

209 Some providers suggested, however, that it would be preferable for some or all general hospitals to provide emergency services only, with all other secondary and tertiary services being concentrated at the RVEEH. With respect to this model, one ophthalmologist suggested that: "*The most efficient in terms of time to have*

treatment completed and the total cost of providing emergency ophthalmic services is to have a centralised, ophthalmology registrar-run department. A second year eye registrar is better than any other non-ophthalmic specialist. Once safe working hours are properly implemented registrars called in after hours are required to have an 8-hour break before returning the next day, thus after hours on call will require very sub-specialised and centralised services to save money."

210 An alternative model proposed in the metropolitan area was for there to be no central specialist hospital, and three main ophthalmology centres (western, northern and southern), each with:

210.1 Highly active service profiles;

210.2 Active education and training roles; and

210.3 Research as appropriate.

211 There was support amongst providers for:

211.1 Reviewing the number of cataracts that are completed on 'registrar lists' with some support for the development of specialist, high volume, non-training service lists; and

211.2 Exploring the possibility of collaborating with the private sector in appropriate areas to utilise existing capital and infrastructure for high volume, efficient public operating.

The future role of the RVEEH

212 Most providers who supported continuation of the RVEEH as a specialist centre (the vast majority of all providers) suggested that it should:

212.1 Reduce its emphasis on routine care, and more actively triage primary care patients to more appropriate settings;

212.2 More actively discharge patients from both emergency and outpatients departments back to the community as appropriate, thereby creating additional capacity to manage new referrals more efficiently;

212.3 Maintain its focus on multi-disciplinary specialist clinics;

212.4 Provide a combination of teaching and service operating sessions;

212.5 With the RANZCO and the Department, lead the evaluation of new models of care;

212.6 Provide enhanced clinical support to other elements of the service system;

212.7 Actively participate in state-wide monitoring of the performance of the service system;

212.8 Assist to ensure equitable service provision across the state, through outreach services and other support; and

212.9 Continue an active teaching and research role.

213 The overall consensus amongst consumers was also for keeping the RVEEH as a centralised, specialty hospital. Nevertheless, Melbourne consumers and Consumer Representatives were highly conscious that regional and rural people did not have the same access to a facility such as the RVEEH as they did. Consumers in Melbourne spontaneously raised the issue of establishing hospital units with similar specialised services as those associated with the RVEEH outside of Melbourne – both in the outer suburbs and in regional Victoria: "*I would like to see that the eyes and ears hospital also branches out to some regional hospitals across the metropolitan and suburban area where older people don't have to go into town … like Dandenong has a branch I would like to see more of that" … "In a place like Victoria, you should be able to have quick and ready access to say an eye and ear hospital whether you live in Mildura or Ballarat or anywhere else*."

214 This generated considerable discussion, with some people being in favour of such a strategy, and others rationalising that there was insufficient volume of demand and resources (financial and professional) for this to be feasible. Some, although not all, appeared highly conscious of the limited public financial resources available and the wide range of demands it was required to satisfy. Thus, the following diversity of views were raised and disputed during discussion regarding desirable and practical alternatives:

214.1 With limited resources it was pointed out that more numerous individual units would only be able to provide a 'skeleton' of the wide range of services and expertise currently available at the RVEEH. Thus this did not really address the needs of the population base and increasing demand: "*You know it all comes down to finance doesn't it and if they're spreading all over the place you have little cells all struggling for money. I rather think that the eye and ear hospital essentially it's a unique hospital. I think it's the only hospital in the southern hemisphere that specialises in eye and ear problems the only one" … "I think it's a matter of finances and if money is not available …. If it was I'm sure we'd have those services. But I mean even given the waiting list for people who do need those services, if you had more centres set up that whole service is diluted. I can see that people are disadvantaged. But I think overall it's got to be for the benefit of the most people*";

214.2 By distributing resources and patients more widely the capacity for research and training would suffer and the RVEEH would no longer be the 'centre of excellence' and speciality it was currently perceived to be. Hence, there was a danger that the standard of services could deteriorate overall. The suggestion that training and research could feasibly be undertaken by an independent academic organisation was rejected by consumers. The perceived reputation of the RVEEH, together with the implications associated with the volume and variety of patients treated by such a specialist hospital endowed it with great authority and credibility as a specific resource for training and research. "*Yes the eye and ear hospital is where all the hands on things are happening. So it's relevant. I mean probably in theory you can do it at any other universities, but …" … "I somehow think that a centralised service will achieve more in research*."

Improving rural service delivery

215 There is extremely strong support amongst providers for the proposition that specialist medical and surgical ophthalmological services should be provided in each region, where affordable.

216 Some consumers do not believe it necessary for specialty services to be provided in the outer suburbs, or in areas within a reasonable proximity to Melbourne. However, they acknowledged the need to provide services for people throughout regional and rural Victoria by establishing specialist ophthalmology services in a few major regional centres: "*I don't see why you should really need places in Frankston and all those places because it's really not that far. But when you're in country Victoria you might have to travel over 100 kms and if you had something where a lot of the small country town can come say Ballarat or Bendigo or some place like that it's easier for them to do that than having to wait 6 months then go all the way to Melbourne just for an operation or whatever, it is that's much harder*."

217 There were mixed provider views on whether surgical services should continue to be provided in smaller sub-regional or rural hospitals. One view was that efficiency considerations required surgical work to be concentrated in larger regional centres, possibly with outreach medical consulting services provided closer to where people lived. Another view was that these services are enormously valuable to communities in small rural areas, help to sustain hospitals financially, and should be continued.

218 Some providers and consumers consider that a 'hub and spoke' model has potential to be extended further, with rural clinics attended by RVEEH senior staff and registrars run on an outreach basis, although it was noted that in some rural areas there is no major regional base. One suggestion was that 'some sort of enhanced rural spoking' will be necessary for the RVEEH to adequately address outpatient and elective surgery demand, and to increase the very limited rotating registrar positions sufficient to provide a level of 24-hour emergency care in selected locations.

219 The establishment of a working group to look at a system approach, similar to the trauma system, was suggested by a provider.

220 Other suggestions included a mobile service for people with special needs, or an outreach service where an eye health worker does the initial screening.

221 Hospitals would value much more active involvement of the Department in service planning and allocation of designated WIES and VACS, at a price that reflects actual prices in rural Victoria, and with quarantining of WIES and VACS to ophthalmology services. In particular, there was strong support for the Department taking a more active role in determining what services should be provided in each regional centre, in collaboration with local managers.

222 Most rural providers advised of the need for an enhanced WIES payment for cataract surgery, taking into account the higher cost of services in rural areas.

223 Some providers suggested that service provision may be improved by:

223.1 Competitive tender of cataract services, on a local, regional or state-wide basis;

223.2 Provision of WIES payments to eligible public patients in the form of vouchers, which could then be used to purchase public surgical services from their provider of choice;

223.3 Partnerships of major providers, public or private, with public metropolitan or rural health services;

223.4 Regional management of services, with distributed service centres; or

223.5 Consortia of public and/or private providers.

224 There is support for the provision of public funding to private providers to fund registrar services in the rural sector.

225 Other options proposed for rural service delivery were:

225.1 A hub and spoke regional model with a mobile facility regularly visiting smaller centres whilst procedures are made available from regional centres; and

225.2 Telemedicine linkages between smaller rural and regional/metropolitan centres, and between regional centres and metropolitan centres.

226 Consumers supported the ‘remote camera’ concept, whereby diagnosis and some forms of treatment may be made possible by a medical practitioner who is not an eye specialist. This was talked of in terms of reducing the need for the physical presence of an experienced ophthalmologist to the extent they are required at the moment. Some consumers, particularly those in Shepparton, saw this as reducing the need for specialist services spread throughout the community, and a definite benefit for people in rural and remote areas: “*But then again look at it from the other side. There is a technology that’s just come in recently, I believe it’s satellite consultations. You could be sitting up here in Shepparton with a specialist down in Melbourne. You go to the doctor here in Shepparton and he just sits you down in front of a blooming camera and the specialist in Melbourne he diagnoses what’s wrong with you and tells you what to do about it and you don’t have to go to Melbourne” … “It saves you going all the way to Melbourne you just come in here to your local one and the diagnosis is through television*.”

227 Some consumers thought that ophthalmologists should be more willing to be ‘on call’ for emergency cases in regional areas and air transport provided to service these areas: “*You know you might not have medical centres everywhere but you could have the medical specialists that are equipped to say look this is an emergency get on a plane and go*.”

228 There was a suggestion by consumers that, rather than establishing physical units of care, more money should be spent on 'outreach' services in regional and rural areas, and in servicing people who, because of age, physical incapacity or limited financial resources found it difficult to access traditional services: *"People living in aged care facilities and no way of getting to a service … no access to transport" … "The service providers were also saying they didn't know about services provided for low income earners, or where to refer them*."

229 Rather than wider distribution of specialist services, some consumers thought that more money should also be made available for providing access to metropolitan medical services in terms of transport (planes, trains and cars) for people living in regional and remote areas: "*I think the service should be provided not so much medically but travelling. You know it must be a hell of a voyage if you have a problem and you live in Mildura. But you should be able to get on the train or some form of transport that gets you there and back very quickly and efficiently. If it's an emergency you can fly from Mildura to Melbourne in an hou*r."

230 An outreach service from the Royal Children's Hospital for paediatric ophthalmology was also proposed.

231 The future regional service system was described by one provider as follows: "*Expansion of specialist eye day surgery units where staff is skilled, equipment is first class and specialists are happy. Regional day surgery units could be active enough to support registrars and therefore be part of a training program. Allied health workers could be more actively involved in post operation outpatient appointments*."

Appropriate public/private balance

232 Most hospitals in which private patients gain quicker access than public patients would prefer to treat more public patients, if resources were available.

233 Some providers suggested that there needs to be a more transparent relationship between treating public and private patients in the public sector.

234 Consumers and Consumer Advocates believe that it is the role of Government to ensure that there were sufficient resources to ensure a basic level of access in the public system. Most felt it was the responsibility of Government to impose certain requirements on ophthalmologists (and other medical specialists) to contribute to the public system. Some consumers and Consumer Representatives felt the ophthalmologists (common to other specialties) wielded too much power and this should, somehow, be reduced to improve the overall delivery of public health services: *"There are some groups in Australia that are so powerful among the surgeons …"*

Governance and leadership

235 There was general support amongst providers for a more transparent and active state-wide planning approach, with designation of ophthalmology WIES and VACS by the Department of Human Services.

236 In rural Victoria, there was some support for a regionally-based planning and leadership role, with the development of a regional governance committee structure.

237 There was strong support for the RVEEH, RANZCO and the Department taking a more collaborative, active leadership role in developing and evaluating service models, establishing service standards and monitoring ophthalmology outcomes.

238 Most ophthalmologists did not support the concept of the Department establishing ‘appropriateness’ standards for cataract surgery, but other providers had mixed views, with many supporting the need for greater transparency of decisions about access and priority.

239 Given that no consumers in the study had experienced a problem with waiting times, they did not appear to have very strong opinions regarding the value or need for prioritisation in a conceptual sense. However Consumer Representatives were strongly in agreement that a more formal and transparent process of prioritisation was required and that it should take into account both physical and emotive characteristics. That is it was not just the eye condition that should determine priority, but the implications it had on a persons overall lifestyle, or ability to be independent.

240 There was some support by providers for ophthalmology outcomes to be evaluated against agreed standards with the results to be available to providers and hospitals. Some providers, in particular hospital managers, thought that clinical outcomes should also be transparent to the Department and the community, if there were agreed, valid and reliable performance measures. There was also some provider support for more transparent waiting list management in rural areas.

241 It was suggested that a state-wide Ophthalmology Advisory Committee or equivalent could have a role overseeing system wide performance.

Conclusion

242 The Victorian ophthalmology service system is well-regarded by providers and consumers, who are particularly satisfied with its quality and, generally, its accessibility. Stakeholders consulted during this project, however, identified a range of opportunities to improve the service system.

243 Stakeholders believe that better utilisation of the range of health care professionals, in particular optometrists and orthoptists, in the provision of ophthalmology services would improve their quality, efficiency and accessibility.

244 The availability of affordable spectacles is considered to be very important, and various suggestions were made to improve the accessibility of subsidised spectacles through the VES.

245 The RVEEH is highly regarded by consumers and most providers, but opportunities were identified by many for refocussing its services on higher complexity clinical conditions. There is general support for the maintenance and development of higher volume service centres in major metropolitan and regional hospitals.

246 There are concerns about the accessibility of public outpatient services at the RVEEH and in other hospitals, and about the lack of service provision in some major regional centres. Those regional centres are seeking specific leadership and direction from the Department, particularly in relation to reasonable medical costs for ophthalmology services and the appropriate mix of services in regional hospitals. There are also some concerns about the developing practice of allocating specific theatre time for private patients, whose waiting times are often considerably less than those of pubic patients.

247 Smaller sub-regional and rural hospitals in which visiting ophthalmology services are provided are very satisfied with these services and believe they are important to their local communities. Others are concerned that the low utilisation of high cost equipment in these centres does not represent a good use of public funds.

248 There is a general, but not universal, view that there is little evidence of inappropriate service provision in the public sector, and there is no consensus on whether explicit intervention guidelines for the public sector should be developed. There is, however, support for more transparent management of waiting lists and more active evaluation of new models of care. Development of a systematic structure for governing the overall ophthalmology service system, with a focus at either a state or regional level, is supported by most stakeholders, as is more systematic data management and multi-disciplinary monitoring and disclosure of information about quality and clinical outcomes.

Attachments

Attachment 1: Respondents to the Department's discussion paper

Ms Maree Bowman	State Manager, Department of Health and Ageing
Ms Maxine Brockfield	Director of Clinical Services, Kyabram & District Health Services
Dr Anne Brooks	Ophthalmologist-in-Charge. General Eye Clinic 3, RVEEH
Dr Adrian Bruce	Senior Optometrist, Victorian College of Optometry
Ms Heather Byrne	Chief Executive Officer, Alexandra District Hospital
Dr W G Campbell	Head, Vitreo-Retinal Unit, RVEEH
Confidential	Ophthalmology Registrar
Confidential	Orthoptist
Confidential	Ophthalmologist
Confidential	Ophthalmologist
Dr Tony Cull	Executive Director Medical Services, Royal Children's Hospital
Dr John Elcock	Director of Medical Services, Northeast Health, Wangaratta
Assoc. Prof Ian Favilla	Head of Ophthalmology, Southern Health
Ms Nicole Feely	Chief Executive Officer, St Vincent's Health
Assoc Prof Kerry Fitzmaurice	Chair, Australian Orthoptic Board
Mr Jim Fletcher	Chief Executive Officer, Western District Health Service
Dr Michelle Gajus	Ophthalmology Registrar, RVEEH
Mr Zoran Georgievski	Orthoptic Association of Australia (Vic Branch)
Dr W E Gillies	Ophthalmologist
Dr Ken Gullifer	Director of Ophthalmology, Austin Health
Dr Anthony Hall	Chairman, QEC, RANZCO
Dr Anthony Hall	Head of Ophthalmology, Royal Melbourne Hospital
Dr Alex Harper	Ophthalmologist-in-Charge, Medical Retina Clinic, RVEEH
Mr Ben Harris	Executive Director, Optometrists' Association Australia (Vic Div)
Dr Trevor Hodson	Ophthalmologist, Mt Gambier
Mr Graeme Houghton	Chief Executive Officer, RVEEH
Dr Robert Hudson	General and Paediatric Ophthalmologist
Dr Nicholas Karunaratne	Ophthalmologist, Albury (Wodonga) Eye Clinic
Ms Serena Lillywhite	Manager Ethical Business, Brotherhood of St Laurence
Dr Patrick Lockie	Ophthalmologist, St John of God Hospital, Geelong
Dr David Mackey	Ophthalmologist

Dr John McKenzie	Chairman, Victorian Branch, RANZCO
Professor Neville McBrien	Director, Victorian College of Optometry
Ms Kathy Meleady	Director, Statewide Service Development Branch, NSW Health
Mr Michael Murphy	Director, Surgery and Surgical Services, St Vincent's Health
Ms Carly Nicholls	Chief Executive Officer, Vision 2020 Australia
Assoc Prof Justin O'Day	Ophthalmologist, St Vincent's Medical Centre
Ms Gillian Perriment	Chair, NorthEast Division of General Practice
Dr D Polya	RVEEH
Mr John Purvis	Acting Chief Executive, Bendigo Health Care Group
Ms Alex Rankin	Assistant Secretary, Acute Care Strategies Branch, Department of Health and Ageing
Dr Marc Sarossy	Ophthalmologist
Dr Mark Scott	Melbourne Specialist Imaging
Dr Richard Stawell	Head of Ocular Immunology Clinic, RVEEH
Professor Hugh Taylor AC	Professor of Ophthalmology, RVEEH
Mr John Turner	Chief Executive Officer, Bentleigh Bayside Community Health
Ms Pat Usher/Mr Tim Puyk	Australian Ophthalmic Nurses Association
Dr Arlene Wake	Executive Director, Medical Services, Western Health
Ms Robyn Wallace	Orthoptic Association of Australia (Vic Branch)
Dr Robert West	Ophthalmology Unit, Alfred Hospital

Attachment 2: Individuals and groups who participated in interviews

Assoc Prof Ian Favilla	Head of Ophthalmology, Southern Health
Dr Anthony Hall	Chairman, QEC, RANZCO
Mr Ben Harris	Executive Director, Optometrists' Association Australia (Vic Div)
Dr James LeNauze	Rural Ophthalmologist
Professor Neville McBrien	Director, Victorian College of Optometry
Dr Richard Stawell/Dr Robert West	Ophthalmology Unit, The Alfred Hospital
Professor Hugh Taylor	Centre for Eye Research Australia
Dr Michael Toohey	Regional Ophthalmologist
Members of Executive	Royal Victorian Eye and Ear Hospital
Regional Health Council	Victorian Healthcare Association
Rural Health Council	Victorian Healthcare Association
Victorian Branch Members	RANZCO

Attachment 3: Workshop attendees

Royal Australasian College of Surgeons, Monday 19 April 2004

Mr Mitchell Anjou	Clinical Director, Victorian College of Optometry
Dr Anne Brooks	Ophthalmologist, RVEEH
Ms Lynn Cheetham	Head of Treatment, Peter MacCallum Cancer Centre
Dr James Elder	Head of Department of Ophthalmology, Royal Children's Hospital
Assoc Prof Kerry Fitzmaurice	Chairman, Australian Orthoptic Board
Mr Zoran Georgievski	Chief Orthoptist, Northern Hospital
Dr John Gioulekas	Ophthalmologist, Berwick Ophthalmology Clinic
Assoc Prof Robin Gymer	Ophthalmologist, CERA
Dr Alex Harper	Head of Medical Retinal Clinic, RVEEH
Mr Ben Harris	Executive Officer, Optometrists Association Victoria
Dr Kim Hill	Executive Director Medical Services, Bayside Heatlh
Ms May Ho	Optometrist, Victorian College of Optometry
Mr Graeme Houghton	Chief Executive Officer, RVEEH
Dr Rob Hudson	Head of Clinic, RVEEH
Dr John McKenzie	Head of Ophthalmology, Western Health
Ms Annette Mercuri	Manager Strategic Planning and Development, Women's and Children's Health
Assoc Prof Michael Murphy	Director of Neurosurgery, St Vincent's Health
Ms Genevieve Napper	Manager Clinic Public Health Services, Victorian College of Optometry
Assoc Prof Justin O'Day	Ophthalmologist, St Vincent's Medical Centre
Ms Sandra Staffieri	Chief Orthoptist, Royal Children's Hospital
Dr David van der Straaten	Registrar, RVEEH
Ms Robyn Wallace	RVEEH
Dr Robert West	Ophthalmologist, Alfred Hospital
Dr Geoffrey Williamson	Director of Medical Services, Maroondah Hospital

Department of Human Services, Tuesday 20 April 2004

Ms Shirley Admans	Vision Australia Foundation
Mr Richard Clark	Vision 20-20 Australia
Ms Emer Diviney	Research and Policy Project Officer, Brotherhood of St Laurence
Ms Jane Gallo	General Manager Client Services, Vision Foundation Australia
Ms Kate Giles	President, Retina Australia
Mr Patrick Moore	President, Macular Vision Loss Support Society of Australia
Mr Richard Rigby	Vice President, Retina Australia
Ms Catia Sicari	Southern Australia Coordinator, Glaucoma Australia Inc.

The Gables, Tuesday 20 April 2004

Dr Andrew Atkins	Ophthalmologist
Ms Lin Cole	RVEEH
Ms Clare Douglas	Director of Surgical Services, RVEEH
Dr David Erlich	Ophthalmic Surgeon, Bass Coast Regional Health
Assoc Prof Ian Favilla	Head of Ophthalmology, Southern Health
Dr Ken Gullifer	Head of Ophthalmology, Austin Health
Dr Raj Pathmaraj	Ophthalmologist, RVEEH
Dr Julian Rait	Ophthalmologist, Cabrini
Ms Shelley Straw	RVEEH
Ms Malak Sukkar	Project Business Manager, St Vincent’s and Mercy Private Hospital
Dr Arlene Wake	Executive Director Medical Services, Western Health

Wangaratta Gateway, Monday 28 April 2004

Ms Heather Byrne	Chief Executive Officer/Director of Nursing, Alexandra District Hospital
Mr Steve Carroll	Department of Human Services
Dr Christopher Chesney	Ophthalmologist, Bayside Ophthalmology
Dr John Elcock	Director of Medical Services, Northeast Health
Dr Paul Giles	Ophthalmologist, Wodonga Regional Health Services
Dr Nicholas Karunaratne	Ophthalmologist, Albury Eye Clinic
Ms Nora Ley	Chief Executive Officer, Seymour District Memorial Hospital
Mr Andrew Watson	Chief Executive Officer, Wodonga Regional Health Services
Mr Dan Weeks	Director of Nursing, Benalla District Hospital
Ms Erica Williams	Rural Management Resident, Victorian Healthcare Association

Ballarat Lodge, Monday 3 May 2004

Ms Lisa Adair	Nurse Unit Manager, Barwon Health
Mr Damian Armour	General Manager Surgical Services, Barwon Health
Ms Rowena Clift	Ballarat Health Services
Mr Michael Delahunty	Chief Executive Officer, Stawell Regional Health
Dr John Ferguson	Executive Director Medical Services, Ballarat Health Services
Mr Hayden Lowe	Access Coordinator and manager Peri-operative Services, Geelong Hospital
Mr Alex Mactier	Director of Finance, Mt Alexander Hospital
Dr David McKnight	Ophthalmologist
Dr Peter O'Brien	Director of Medical Services, South West Health Care
Ms Nicola Reinders	Project Officer, Grampians Region
Dr Michael Toohey	Ophthalmologist, Ballarat Health Services
Dr Bruce Warton	Medical Director, Western District Health Service

Century Inn Traralgon, Thursday 6 May 2004

Mr Gary Gray	Chief Executive Officer, Bairnsdale Regional Health
Dr Robert Lazell	Ophthalmologist, LaTrobe Regional Hospital
Ms Janine Silvester	LaTrobe Regional Hospital
Mr John Warren	Optometrist

Attachment 4: Comprehensive report of consumer consultations

Attached as a separate volume.

Attachment 5: Quality Framework dimensions and key organisational elements

The following definitions are extracted from the Quality Framework (available at the time of writing this report at http://www.health.vic.gov.au/vqc/sqframe_execsumm.pdf), which describes the intersection between four critical organisational processes essential for quality improvement, and each of the six dimensions of quality, as well as describing related roles and responsibilities throughout the health system.

Dimensions of Quality

Dimension	Definition
Safety of health care	A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm arising from care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimised in care delivery processes
Effectiveness of health care	Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome
Appropriateness of health care	It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome for each patient. This means that the expected health benefit exceeds the expected negative consequences by a sufficiently wide margin that the procedure is worth doing. Essentially, the appropriateness of health care is about using evidence to do the right thing to the right patient, at the right time, avoiding over and under utilisation
Acceptability of health care	Opportunities must be provided for health consumers to participate collaboratively with health organisations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way. Consumer and community participation should enhance the level of acceptability of services, which is the degree to which a service meets or exceeds the expectations of informed consumers
Access to health services	Health services should offer equitable access to health services for the population they serve on the basis of need, irrespective of geography, socio-economic group, ethnicity, age or sex. This includes availability of services, such as waiting times for services and processes involved in accessing services, physical and information access. The Victorian public health system, like others in Australia and internationally, is experiencing unprecedented and sustained increases in demand. The issue of access to all health services is a critical one
Efficiency of health service provision	Health services must ensure that resources are utilised to achieve value for money. This can be achieved by focussing on minimising the cost combination of resource inputs in the production of a particular service as well as the allocation of resources to those services to provide the greatest benefit to consumers. Allocative efficiency informs decisions on what services or treatments to deliver, whereas technical efficiency is concerned with reducing costs and minimisation of waste

Key Organisational Elements

Governance, leadership and culture	Corporate governance describes the structures and processes put in place by boards to fulfil their strategic, statutory and financial obligations. Clinical governance is a critical element of the corporate governance of health services Clinical governance refers to boards' accountability for ensuring that a framework and rigorous systems are established so health care safety and quality is monitored and supported, evaluated and continuously improved
Consumer and community involvement	Consumer involvement in health care is critical to effective service planning and evaluation and to the achievement of optimum care outcomes. There are many differing definitions of 'consumers' in healthcare. For the purposes of this document, the term consumer refers to people who either directly or indirectly make use of health services. This includes individuals receiving, or who have received, health care services, whether individuals or in groups according to similar backgrounds or health states. It also includes family and carers of those receiving health care. Community is described in this framework as the population served by the health service, including future users and the wider community that benefits from health care services
Competence of, and education to support, health care providers	Competence is an overarching issue and a major priority for review and action in health services. This includes the competence of the organisation, the competence of multi-disciplinary care teams and the competence of the individuals who deliver care and services
Information management and reporting	Information management refers to the collection of data, the technology required to do so, including the software and hardware, the reliability and validity of the data and how data are reported and converted into information to be used in practice. To support these processes, data and information should be available, accurate, timely and relevant. Ensuring this includes review of coding accuracy, robust data definitions and collection systems, and transparent analysis and reporting processes

Attachment 6: Key performance indicators suggested by stakeholders

General

249 Many stakeholders supported:

249.1 Indicators already endorsed by the RANZCO;

249.2 "ACHS indicators relevant to ophthalmology"; or

249.3 Indicators "already collected by the RVEEH and reported to the DHS".

RANZCO indicators

250 Current RANZCO indicators are as follows:

- Wrong operation on correct eye;
- Operation on the wrong eye;
- Penetration or perforation of globe during periocular injections;
- Expulsive haemorrhage during surgery;
- Endophthalmitis following surgery;
- Patient collapse requiring resuscitation during surgery;
- Death;
- "Open" category for incidents causing concern among staff for whatever reason;
- Unplanned return to the operating theatre within 28 days of surgery for treatment of the same eye;
- Unplanned readmission to an eye unit within 28 days of surgery for treatment of the same eye;
- Unplanned transfer or referral of patients to other ophthalmic units within 28 days of surgery.

Other suggested indicators

Safety

- Posterior capsule rupture rates;
- Complications of surgery and anaesthetic;
- Postoperative infection;
- Unplanned overnight stays;
- Risk management strategies.

Effectiveness

- Audit of cataract surgical outcomes at designated periods;
- Functional measures of improved vision following procedures such as cataract;
- Refractive outcomes in cataract surgery;
- Change in VF-12 scores;
- Best corrected acuity;
- Variation in final refraction from predicted;
- Target pressure achievement in glaucoma follow up;
- Number of patients left in workforce.

Appropriateness

- Best corrected visual activity;
- VF-14 survey;
- SF12v2 survey;
- A-scan and predicted refraction;
- Co-morbidities ocular and general;
- Patients cancelled;
- Clinical pathway development for high volume procedures;
- Number of post-op visits following cataract surgery.

Acceptability

- Number of patients and families provided with appropriate information on diagnostic and treatment options;
- Patient satisfaction (general, or relating to service provision, client care, paperwork and bureaucracy for individuals with special needs and their carers);
- Complaints monitoring.

Access

- Capture rate for screening for diabetic retinopathy;
- Patient waiting lists for non-surgical appointments;
- Waiting time to first appointment in outpatients;
- Waiting time for procedures;
- Surgical waiting lists;
- Public/private care mix;
- Number of Culturally and Linguistically Diverse community members accessing both public and private ophthalmology services.

Efficiency

- Numbers of patients attending for various services;
- Patient activity, including casemix weighted activity and non-inpatient activity;
- Patient throughput and waiting times;
- Staffing;
- Same day surgery rates;
- Average length of stay;
- Cost per casemix weighted inpatient, cost per outpatient occasion of service;
- Operating theatre utilisation;
- "Fail to attend" rates;
- Discharge rates.