What's fair in vision care? Potential approaches for equitable access to spectacles

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Background and introduction

We all value our vision. Good vision is vital for mobility, independence, work, study, driving and social interactions; reduced vision impedes our quality of life and everyday function. Vision problems are one of the leading self-reported health complaints by Indigenous Australians, reported by 30% of people.(1,2) This reflects a higher prevalence of visual problems experienced by Aboriginal and Torres Strait Islander people, who are three and six times more likely to have low vision or blindness compared with the non-Indigenous population.(3) Whilst pathological causes such as cataract, diabetic retinopathy & trachoma contribute to these statistics, uncorrected refractive error (correctable with spectacles) is the predominant cause of low vision among Indigenous populations.(3-5)

Refractive error is the easiest and cheapest cause of vision impairment to correct. In the National Indigenous Eye Health Survey (NIEHS), those who had the appropriate spectacles to restore their vision were as satisfied with their vision as those who had normal vision without glasses. This shows the importance of correcting uncorrected refractive error (URE) for Indigenous adults.(1)

According to the NIEHS, 5.3% (about 1 in 19) Indigenous Australians are visually impaired simply because they do not have spectacles. The results indicate that, with a prevalence of blindness of 2.79 for Indigenous adults, 14% of which is due to uncorrected refractive error, 0.4% of Indigenous adults (4 per 1000) have vision classified as ‘blind’ simply because they do not have spectacles, compared with 0.02% for non-Indigenous adults. In other words, Indigenous adults are 20 times more likely to be ‘essentially blind’ (have vision at a level that equates with being legally blind) due to uncorrected refractive error, than their non-Indigenous counterparts. Furthermore, prevalence of vision loss among Indigenous Australians does not vary significantly across regions and remoteness areas in Australia; prevalence of uncorrected refractive error is also relatively unvarying.(3)

Clearly, there are reasons for the disparity between Indigenous and non-Indigenous rates of URE. Basically, correction of refractive error requires two things:

- access to refractive services (optometry)
- accessible prescription spectacles.

Access to refractive care

The ‘Roadmap to Close the Gap for Vision’ has identified a series of required approaches for improved eye care access and outcomes for Indigenous Australians.(6) Given that just over 1 in 3 Indigenous adults have never had an eye exam, enhanced provision of optometric care for Indigenous Australians is vital, particularly within settings that are accessible such as Aboriginal Community Controlled Health Organisations (ACCHOs). (7-10) However, an optimal provision of eye care examinations without vision correction that is accessible will fail to address the unnecessarily high rates of vision impairment due to refractive error. A prescription from an optometrist means nothing to a person who faces barriers to accessing spectacles.

Accessible spectacles

Although the overall prevalence of refractive error is relatively lower for Indigenous people (compared to the wider Australian population),(11) rates of uncorrected refractive error are higher. Additionally, glasses are worn less commonly by Indigenous adults compared to non-Indigenous, for both distance and near vision.(6) Evidently, there are factors which are limiting access to vision correction for Indigenous people. The socioeconomic disadvantage faced by many Indigenous Australians would mean
the costs of spectacles through regular channels are often prohibitive. Anecdotal reports from practitioners who provide services to remote communities indicate that some of the current spectacle subsidy schemes are inappropriate for access by Indigenous communities. (This seems to be more pronounced in some jurisdictions than others). Success of some programs of low cost spectacle options for Aboriginal people has shown that, when more affordable options for spectacles are available, particularly when accessible through ACCHOs, there is increased use and uptake of glasses.(12)

Spectacle schemes

Currently, each jurisdiction (State/Territory) in Australia provides a subsidised spectacle scheme to people who meet certain eligibility criteria (e.g. senior, pensioner). These schemes are available to Indigenous Australians meeting pensioner/concessioner criteria, and some also enable access for all Indigenous people who access the scheme via an ACCHO. Yet, higher rates of uncorrected refractive error (URE) in this population suggest that such schemes may be underutilised, or are currently not accessible for Indigenous people who require vision correction. Given that these schemes are funded/run by different state governments, there is a great deal of variability between schemes, in terms of the way that the schemes are accessed, the way systems are administered, the costs and the amounts that people are entitled to and the choice people have in the styles of frames and types of lenses.(13) For example, in Western Australia (WA), subsidy is provided in the form of a cheque mailed to the eligible applicant, after they have paid the full price for their spectacles. Apart from the problem of affordability of the initial cost, and the currently meagre subsidy offered, the infeasibility of obtaining a reimbursement via cheque for Aboriginal people living in very remote communities and/or with no fixed postal address systematically limits their potential to benefit from the scheme.

Given the distinct disadvantage faced by Indigenous Australians, specific approaches and targeted investment to improve health outcomes for this population are being taken, via ‘Close the Gap’ initiatives of Australian governments.(14) Other specific approaches for Indigenous Australians to overcome cost and access barriers for health care include: improving access to Pharmaceutical Benefits Scheme (PBS) medicines for chronic disease,(15), enhanced access to Medicare Australia programs,(16) and chronic disease care coordination.(17) The disparity in visual health for Indigenous Australians, due largely to URE, indicates potential value of a targeted method for provision of accessible, affordable spectacles.

National Spectacle Scheme

Australia’s optometry sector—represented by the Aboriginal & Torres Strait Islander Eye Health Working Group of Optometrists Association Australia (OAA)—has recognised and articulated the need for improved access to subsidised spectacles for Indigenous Australians.(13) One potential approach to overcome barriers to correction of refractive error is a National Spectacle Scheme, specifically for Indigenous Australians. Indeed, a nationally consistent Indigenous subsidised spectacle scheme has been proposed in concept,(13) and supported by other proponents in the Indigenous eye care sector,(18) including as a recommendation in the ‘Roadmap to Close the Gap for Vision’, (6) and supported by the peak body for Australia’s eye care sector, Vision 2020 Australia. Such a targeted approach may align with similar ‘close the gap’ measures to overcome the ‘gap in vision’ for Indigenous Australians.

As an alternative to the National Scheme, it has been suggested that existing state/territory schemes meet nationally consistent ‘best minimum practice’ criteria. However, an additional scheme that targets access to spectacles for Indigenous Australians might still be needed to address the distinct disadvantage faced by Indigenous Australians which often requires distinct and targeted approaches in order to ‘close the gap’: this is a key concept of equity.
Methods

- A survey of Australian optometrists was conducted to establish the variability in existing spectacle schemes in each state and territory and to ascertain the general level of support for a national Indigenous spectacle scheme.

- Australian optometrists and associated dispensing personnel were invited to respond to the questionnaire, administered in October 2011 and again in September 2012. The online survey was sent to members of the OAA with email addresses, with a reminder email two weeks after the initial notification. Optometrists were also asked to invite their practice colleagues involved in the dispensing or delivery of spectacles to complete the survey.

Results

- An email inviting potential participants was sent to 3976 people. Of these, 1849 (46.5%) opened the email and 570 people (30.8% of those who opened the invite email, 14% of total invitees) indicated consent to participate in the survey. Of those who agreed to participate, 361 (19.5% of those who opened the invite email, 9% of total invitees) completed the survey in its entirety.

- Most (98%) of survey respondents were optometrists; from NSW (40%), QLD (25%), VIC, (16%), WA (8%), SA (7%) and NT (4%). Of the 427 who responded to the question, 285 (67%) indicated that they were involved in providing eye care services to Indigenous Australians, primarily through private practice and through a range of other methods (outreach clinics and within Aboriginal Medical Services). This included 90 optometrists who provide services through the Department of Health and Ageing funded Visiting Optometrists Scheme.

Rating of existing subsidised spectacle schemes

- When asked to rate the schemes on a 1-5 scale according to a range of criterion, it was clear that there was perceived variability between the state-based schemes, particularly in the areas of quality and range of frames. Range of lenses available and repair or warranty for damage also showed variability across the schemes, and simplicity and ease of paperwork rated rather poorly for all schemes. Interestingly, the mean rating for patient satisfaction with spectacles was “good” for all schemes.

Support for a National Spectacle Scheme

- The majority (80%) of respondents indicated their support for the general proposed concept of a national spectacle supply scheme for Indigenous Australians.

- 88% indicated they would make use of such a scheme for their Indigenous patients.

Several themes arose from respondents’ general comments and considerations regarding the prospect of a proposed national spectacle scheme, relating to eligibility criteria (Indigenous specific versus broader scheme for all disadvantaged Australians), national versus local administration, adequacy of existing schemes, the need for active promotion of available schemes to Aboriginal and Torres strait islander people and communities, and logistical/administrative and financial considerations relating to the introduction of an additional scheme.

Discussion

It is likely that the variation in existing subsidised spectacle schemes, and other cost-related barriers to accessing spectacles for Indigenous Australians, mean that access to refractive correction is not currently entirely equitable and fair. There is need for “a fair go” for disadvantaged Australians who require spectacles, and concerted approaches to reduce barriers to accessing spectacles for these groups. A fundamental concept of equity in health care is that specific/targeted approaches may be (indeed often are) required in order to achieve more equality in outcomes between disadvantaged and advantaged groups.(19) Such is the agenda of ‘Close the Gap’ initiatives.
Indigenous Spectacle Scheme to ‘Close the Gap’ for vision

As a scheme intended to specifically address higher rates of uncorrected refractive error amongst Aboriginal and Torres Strait Islander Australians, a National Spectacle Scheme may possibly represent an opportunity, within the ‘Close the Gap’ agenda for tangible improvement in wellbeing for Indigenous people. In addition to alleviating vision impairment, improving spectacle access may have additional benefits to improving the eye health of indigenous Australians generally. The prospect of obtaining a pair of spectacles may act as a powerful incentive for people to present for an eye examination. Regular eye exams are important for the early detection and prevention of other conditions that may not be apparent until eye damage is irreparable. This is particularly pertinent to a population for whom diabetic eye disease is highly prevalent.

The National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss also identifies the need for cost barriers to accessing spectacles to be addressed, and specifically notes the need to address cost barriers with “disadvantaged groups, particularly Aboriginal and Torres Strait Islander peoples who reside in remote locations”.(20) There is a clear need for approaches to contribute to overcoming existing obstacles to access and use of spectacles by Indigenous Australians, which are likely to be contributing to higher rates of URE in this population. Improved schemes for the provision of affordable glasses are one such approach, which may have enhanced impact when combined with health promotion regarding spectacle correction and the potential for improved vision for the majority of Indigenous Australians with vision impairment.

In line with current targeted ‘Close the Gap’ approaches, the notion of a dedicated spectacle scheme for Indigenous Australians, designed with features to facilitate uptake of spectacles by this population, may hold merit. Concurrently, ensuring existing state-run general pensioner/concession schemes align with essential nationally consistent criteria—in the areas of: eligibility, patient co-payment, frequency, cost certainty, quality, product range, timely supply and accessibility could help to address the current systematic inequity in access to affordable spectacles for people who are economically disadvantaged. The OAA has outlined the required core principles of subsidised spectacle schemes for Aboriginal and Torres Strait Islander Australians.(13) These Guidelines, currently in the final stages of development by the OAA Aboriginal and Torres Strait Islander Eye Health Working Group, identify key best practice principles for subsidised spectacle schemes, to facilitate improved accessibility of vision correction for Aboriginal and Torres Strait Islander people.

Conclusion

This survey has revealed high variability in the practitioner-rated performance of existing spectacle schemes, according to a range of criteria. This agrees with anecdotal evidence and suggests that such variation may contribute to inequitable levels of access. Survey respondents also indicated a general majority support for the concept of a national spectacle scheme for Aboriginal & Torres Strait Islander Australians, with some conditions around administration, eligibility criteria, and several other key aspects identified by respondents. Potential approaches to overcome existing barriers to vision correction for Indigenous Australians may include a national scheme, and/or efforts to align existing schemes with recommended criteria for consistency. The most relevant or feasible approach will depend on the political environment, funding opportunities, and what is most operationally feasible. Clearly, outcomes in vision care will be suboptimal if the patient does not have access to affordable spectacle correction. Analogous to other initiatives designed to improve the access of Indigenous Australians to health care reducing the cost of spectacles and thereby reducing barriers to accessing spectacles specifically for this population has potential to contribute to ‘closing the gap’ in vision.
Key policy recommendation
That the distinct barriers to accessing affordable spectacles and therefore correcting refractive error for Aboriginal and Torres Strait Islander Australians is addressed by:

- ensuring jurisdictional subsidised spectacle schemes align with nationally consistent ‘best practice’ criteria and principles, as outlined by OAA and endorsed by Vision 2020 Australia and

- considering the feasibility of a national spectacle scheme specifically for Aboriginal and Torres Strait Islander Australians.

References


13. OAA. Proposed Spectacle Scheme for Aboriginal and Torres Strait Islander Australians. In: Australia) OOA, editor. Canberra: OAA (Optometrists Association Australia); 2010.


