



A social action project by the Brotherhood of St Laurence

Seeing clearly Access to affordable eyecare for low-income Victorians

“Because of her circumstance she didn’t want to access the [eyecare] service because she was scared in case it cost her money because she was in debt with regard to accommodation and a few other things.” Welfare worker

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What factors limit Victorians’ access to affordable eyecare?

What choices are there for low-income Victorians needing affordable spectacles?

What place do ‘ready-made’ spectacles have as a low-cost option?

What needs to be done to improve eyecare for disadvantaged Victorians?

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Specific groups of low-income people in Victoria face unnecessary vision impairment and vision loss. The cost of eyewear and the appearance of subsidised glasses, along with lack of information, cause some people not to have their eyes examined or not to purchase the glasses prescribed, and others to experience financial hardship. Because of limited public eye surgery facilities, some patients face considerable inconvenience and cost.

This report identifies the barriers low-income and vulnerable people face in accessing appropriate eyecare. Generic difficulties, which also affect other health services, include awareness levels and inadequate promotion, access and equity issues, rural disadvantage and waiting lists. Barriers specific to the eyecare industry include the cost and appearance of frames and the disparate views of ophthalmologists and optometrists on issues such as initial screening and ready-made glasses.

While Victoria has extensive eyecare services, individuals who may miss out include those living in supported residential services or aged care facilities, homeless people and culturally and linguistically diverse (CALD) communities, particularly newly arrived migrants and refugees.

This research especially confirms the value of increasing outreach services for the most marginalised Victorians. There is also

clearly a need to increase promotion of eye health, address the cost and choice of eyewear and increase access to public eye surgery in regional Victoria.

This bulletin

We asked 117 people living on low incomes and 58 community and welfare workers about the barriers to accessing eyecare services. We also asked them to suggest how services could be improved. Focus groups included people over 50 years of age, young people and parents with school-aged children, in both rural and metropolitan Victoria. They also included members of Indigenous and culturally and linguistically diverse communities as well as people living with disabilities.

The Brotherhood of St Laurence interest in eyecare

The Brotherhood of St Laurence (BSL) has an interest in the provision of affordable and appropriate eyecare services in Victoria, because of both its work to ensure low-income earners are not disadvantaged, and its acquisition of a wholesale optical frame business, Mod-Style, in 2000. Mod-Style is a supplier of frames to the Victorian College of Optometry Low Cost Optometry Service in Melbourne and the Victorian Eyecare Service in rural Victoria. In addition to identifying limitations in existing eyecare provision for low-income Victorians, the present research will inform the development of Mod-Style as a social enterprise.

Eye health and people on low incomes

Over 150,000 Victorians have poor sight or significant vision loss (Taylor 2000). According to the Centre for Eye Research Australia Visual Impairment Project (VIP), in Australia over 80 per cent of vision impairment is caused by five conditions (refractive error, macular degeneration, glaucoma, cataract, diabetes) (CERA 2000); but half is correctable and one-quarter is preventable.

The VIP also found that:

- Half of visual impairment is due to refractive error (vision loss corrected through the provision of spectacles).
- One person in ten will develop glaucoma, with half not knowing they have it. If treated, loss of vision can be prevented or delayed.
- By 90 years of age, everybody will have developed cataract and half will have cataract surgery.
- Australians with diagnosed or undiagnosed diabetes risk developing eye disease. With early treatment up to 98 per cent of severe vision loss can be prevented, but only half of people with diabetes have the recommended regular eye test.

These findings show the importance of eye care. According to Taylor, it is vital to:

Make sure we have regular screening for those groups of people at risk, particularly school children and the elderly. We need health promotion activities to encourage people to have their eyes checked if they notice a change or decrease in their vision, and we need the provision of accessible and affordable spectacles. (Taylor 2000)

Important to this study are the links between low socio-economic status and eye disease. The Blue Mountains Study, a NSW study of 3654 older Australians, found that people with lower educational attainment or receiving a government pension are more likely to have uncorrected refractive error (Thiagalingam et al. 2002). The VIP researchers found that the correlation between visual impairment and lack of private health insurance approached statistical significance. They recommended further investigation to ascertain the barriers to use of eyecare services by sub-population groups (Livingston, McCarty & Taylor 1997).

Economic and social cost of vision loss

In Australia, the cost of vision loss is substantial: the cost to government in 1999 was \$2.1 billion, not including indirect costs (Vision 2020, 2003, p.13). Implications for the community, include increased falls, diminished independence, health consequences such as depression and increased demands on other services (CERA 2000).

For people living on low incomes, vision loss strains already stretched resources and may increase social exclusion. Vision problems can affect capacity to work and to carry out daily activities. Children may experience delayed educational, physical and social development.

Eyecare services in Victoria

This research considered the role of ophthalmologists, optometrists, general practitioners and others including maternal and child health nurses, school nurses and Indigenous health workers. Low-vision and rehabilitation services were outside the scope of the study.

Ophthalmology services

Ophthalmologists are medical doctors registered to provide total care of the eyes, from performing comprehensive eye examinations to prescribing corrective lenses, diagnosing diseases and disorders, and carrying out medical and surgical procedures. There are 168 practising ophthalmologists in Victoria (150 metropolitan and 18 rural) (DHS 2004). Public ophthalmological services are

available at select public hospitals. For visits to a private ophthalmologist, Medicare refunds 85 per cent of the scheduled fee; bulk billing is at the doctor's discretion.

Optometry services

Optometrists are non-medical practitioners trained to assess the eye and the visual system, and diagnose refractive disorders. They prescribe and dispense corrective lenses and ensure that patients are referred appropriately to other eyecare professionals for further diagnosis and treatment. Optometrists also prescribe certain drugs and monitor long-term eye conditions.

The number of optometrists per 100,000 of population increased by 10.3% between 1992–93 and 1998–99 and is expected to be

adequate for the next decade (AIHW 2000, pp.13,15).

Private optometry services

In general, there are no out-of-pocket expenses for an eye examination by an optometrist, as 95.8 per cent of optometry services in Victoria are bulk billed (HIC 2004). Optometrists are restricted from charging more than \$55.75 for a full eye examination and the Medicare rebate is \$48.95.

However, glasses are not covered in the rebate and are sold at market prices. Brotherhood of St Laurence research has confirmed that 90 per cent of the world's optical frames are made in China (Lillywhite 2002). Comparison of the landed and retail costs of spectacle frames sourced from

Eyecare services in Victoria

China and sold in Australia shows at least a 1000 per cent mark-up. HCF Health Insurance (2002) reports these retail charges:

- bifocal lenses only – \$143.10 (average)
- single vision lenses only – \$91.05 (average)
- top end (highest 5 per cent) designer frames only – \$284.46 or more
- bottom end (lowest 5 per cent) frames only – \$90.00 or less.

However, these figures need to be put into context. According to the Australian Bureau of Statistics (1998), the optometry industry recorded an operating profit in 1997–98 of 10.9 per cent, with 80 per cent of income generated by the sale of optical goods and 18 per cent by fees for optometry services.

Victorian Eyecare Service (VES)

The Victorian Eyecare Service (VES), funded by the Department of Human Services and run by the Victorian College of Optometry (VCO), provides eye tests and glasses at a nominal cost (see Table 1) for Victorians who hold a pensioner concession card or have a health care card for at least six months, and their dependants under the age of 18 years. The College promotes the Service through the information booklet issued with pension or health care cards, fliers (in English) and information sessions for key community organisations and health providers.

VES metropolitan clinics are located in Carlton (with a children's clinic), Darebin, Broadmeadows, Doveton-Hallam, Braybrook and Frankston. Rural patients can visit participating private optometrists and ophthalmologists in more than 70 towns. Some 3000 people known to have difficulty accessing mainstream services received VES services in 2003 (VCO unpublished data).

In 2002–03 the VES received \$3.4 million to provide 67,000 people with subsidised glasses. It provided 35,256 services in Melbourne and 29,180 in country Victoria. A budget of \$3.5 million has been allocated for 2003–04.

Table 1 Out-of-pocket cost of eyewear through the Victorian Eyecare Service

	Reading or distance lenses	Bifocal lenses
Standard frames	\$28.50	\$41.00
Customer's own previously used frames	\$12.00	\$23.50
Non-standard frames of choice	\$28.50 plus frames cost	\$41.00 plus frames cost
Contact lenses (available for certain conditions)	\$40	

Outreach services

The metropolitan VES and participating private rural optometrists have instigated some outreach to aged care facilities, Indigenous health services, day centres for disabled people and services for homeless people. According to the VCO, 719 services were provided to such specially disadvantaged patients in 2003. These local initiatives, however, are constrained by finance.

Promotion and information

Several professional and private organisations offer information about eye health and vision impairment, with varying focus on low-cost services. Examples include:

- the Optometrists Association Australia, whose website includes information about common eye diseases and treatment and (for Victoria) a services directory identifying optometrists who speak languages other than English
- Vision Australia, whose national phone and e-mail service answers queries about vision loss and helps people locate services.

There are also many organisations which offer programs, support or information related to specific eye conditions.

Other sources of subsidised glasses

The Royal Victorian Eye and Ear Hospital (RVEEH) provides subsidised glasses to eligible patients through a contract with the Victorian Eyecare Network (VECN); however, this service is due for re-tender. The Royal Children's Hospital provides vouchers for discount glasses for children of pensioners and health care card holders.

The Department of Veterans Affairs provides comprehensive optical services, including a wide range of frames and lenses at no cost, for veterans and war widows; most optometrists are registered as providers.

Eyecare service delivery

Consumers and community workers described several difficulties related to the channels through which eyecare services are provided.

General practitioners as a referral pathway

People in both rural and urban areas were confused about whether a referral from a doctor was needed to visit an optometrist. In reality, a referral is not generally required, with the exception of some rural areas (e.g. Mildura) where optometry services face heavy demand. However the misunderstanding may deter people from having their eyes tested, especially in places where there are not enough general practitioners, and even fewer who bulk bill:

Nearly all GPs in Shepparton have closed their books and aren't taking new patients and none bulk bill, or advertise that they bulk bill, so people... often don't have a doctor who can refer. Community worker

Private optometry services

A number of consumers and community service providers expressed concern about Medicare-subsidised eye testing being available to most people through private providers who also sell spectacles.

There was a widespread perception that private optometrists took advantage of the subsidised eye-testing to market more expensive eyewear. Many felt that low-cost options including budget-priced frames and the VES arrangements were not actively promoted:

They never show you the cheapest pair. Aged pensioner

Optometrists commented that because optometry fees are fixed below the actual cost, the sale of glasses enabled them to defray consultation costs and earn an adequate return.

Some people on low incomes, more familiar with community health settings, felt uncomfortable and intimidated in a private

optometry service and others were wary of extra expenses:

Some will only go to the health centre and they won't go anywhere else ... That is a big barrier, isn't it? Indigenous parent

I always think that they will tell me I need new glasses just to make a sale. Parent

Visiting an optometrist is more cost and time effective than seeing a private ophthalmologist for an initial eye examination. This is due to a larger optometry workforce, shorter waiting time (see Table 2) and lower out-of-pocket expenses due to widespread bulk billing and the fees for optometry being capped.

State government funded optometry services

Most participants who had used the VES through metropolitan or rural providers were satisfied with the clinical care. However some people felt that the waiting time for appointments and spectacles was too long. Interestingly, many people expected a 6–8 month waiting period for the VES, whereas the actual waiting period averages 8 weeks.

Many participants raised concerns about the VES being provided through private optometrists in rural areas due to a potential conflict of interest:

It is a big issue having a non profit-making service within a profit-making machine. CALD worker, rural

Some optometrists participating in the VES were concerned about its impact on their business viability. They said they took part out of a sense of civic responsibility to those with limited means, rather than for profit:

You couldn't run your practice on the basis of the VES provision. It is a nice private/public balance that we look for to balance the two together ... If the public work [VES] ... got out of balance and was the major percentage of our work, then it would be very difficult to maintain the type of consulting work that we do. Optometrist, rural

In the La Trobe Valley, an area with many low-income households, a major VES provider has withdrawn from the scheme, leaving no VES provision between Melbourne and Traralgon. The provider cited as reasons for withdrawal the large increase in the number of people eligible for the scheme due to an ageing population and changed criteria for health care cards and pensions. In 1985, when the VES was introduced, 24 per cent of their clients were eligible; by 2002, these numbers had grown to 50 per cent of patients in Warragul, 60 per cent in Drouin and almost 70 per cent in Moe (provider letter 2004).

The present VES scheme depends on the willingness of rural optometrists to participate. There is concern, however, that optometrists withdrawing could lead to further gaps in services for people on low incomes.

Public ophthalmological services

Access to affordable ophthalmological services was identified as a significant barrier for low-income earners in both metropolitan and rural Victoria. Within Melbourne, consumers and service providers identified waiting periods of 6–8 months for an initial consultation in the public system (see Table 2). In regional towns such as Bairnsdale, consumers expected to wait more than 6 months. However, in areas such as Shepparton, with no public provision for eye surgery, patients must travel to Melbourne or another regional centre. Health care providers and users pointed to difficulties including:

- stress and inconvenience
- cost of transport and accommodation
- lack of carers in Melbourne after discharge
- having to rely on family members for transport and post-operative care
- awkward appointment times (early morning and late afternoon), compounded by the limited train and bus schedules, making a one-day round trip very difficult.

Difficult decisions have to be made between travel to Melbourne, paying for private surgery—\$1500 in the case of cataracts—or

going without treatment. This leads to financial hardship or risks to eye health:

It's not an option for me to have private surgery and it's not an option for me to go to Melbourne, so I will just live with it.

Aged pensioner

An ophthalmologist in Shepparton said he had a patient considering using money saved for a grave plot to pay for private surgery. He also commented that there were private ophthalmologists working in Shepparton who would be prepared to offer services at the public hospital.

Table 2 Waiting times for eye health services

Optometry – for initial eye examination	
• Victorian College of Optometry (VES)	8 weeks
• Private optometrist	within 2–3 days
Public hospital (RVEEH)	
• Initial consultation for testing (outpatient)	within 8 months
• Urgent surgery Category 1	within 30 days
• Semi-urgent surgery Category 2	30 days
• Routine surgery Category 3	within 90 days

Sources: Victorian College of Optometry, Optometrists Association Australia; Royal Victorian Eye & Ear Hospital (RVEEH).

Access and outreach

Eligibility for eyecare services

The VES appeared to work well, especially in terms of clinical care, for those on health care or pension cards who had the confidence and skills to access the service.

Many people, however, wanted the service made more accessible to those most excluded from receiving eyecare. Some health care providers stated that having a health care card or a pension card was unachievable for their most vulnerable clients:

Quite often the homeless people I work with don't even have a healthcare card because they don't have the skills to apply for it, or it has been misplaced. This causes huge problems accessing the service.

Health provider

Another commented that because people had to hold a health care card for 6 months, newly arrived refugees did not have access

to VES eyecare as part of their initial health screening. The College of Optometry waives this criterion for refugees referred by one health provider; however the worker felt the waiver needed to be formalised so that refugees accessing other health services would not miss out.

Of concern was the optometrists' view that the high number of Victorians eligible for health care or pension cards meant that people who could afford other options were more likely to use the VES:

We have got a flawed service delivery mechanism as we are dependent on people having pension cards and health care cards. You have got people who live in million-dollar homes that have got pension cards and \$28 dollars for them is just a spare pair of glasses and knowing how to manipulate the system ... whereas there are some people who can't even fill out the form to get the pension card.

VES optometrist

VES optometrists also asserted that the level of funding and funding arrangements based on number of clients do not allow for services for people with high needs, as such services cost more to conduct.

Consumers who were not eligible for a health care or pension card, but identified themselves as 'the working poor', also talked about struggling to pay for eyewear. This was partly due to their only option being to visit a private optometrist and pay the full cost of frames. One woman whose income was just \$1000 over the cut-off for a health care card commented:

It is very expensive to have glasses. My partner got some glasses a couple of years ago. We were pretty stretched at that stage on one wage. I was shopping at the supermarket [and] he came out and said 'I have just spent \$500'... I left the trolley at the supermarket.

Parent

Access and outreach

Administrative practices

Some community workers believed that the paperwork and appointment scheduling for public eyecare services were barriers. Those working with homeless, transient, CALD and disabled clients were concerned that many lacked the skills to seek out the service, keep appointments, remember to bring their concession card and send back forms; the language or literacy skills to read the paperwork; or a permanent address to receive correspondence.

As one person remembered:

We nagged our neighbour Peter to get new glasses: his were as old as the hills and held together with string, he was having trouble watching the telly. We organised some glasses through the scheme. They sent him a letter which he couldn't read. We filled it in and sent it back, then they sent it back to us saying 'Do not post this to this date' (which was about two months away). I would have forgotten if I hadn't put it in my diary. It was a pain in the neck. I don't know what Peter would have done if we weren't there to help.

Aged pensioner, rural

Service providers commented:

Many of the parents who use our service don't have the ability to follow through with things.

Childcare worker

Filling in forms and sending back letters can be a barrier to people who are in crisis.

Aged care worker

Some optometrists also found the VES administration time-consuming and a disincentive to serving too many VES clients:

Within our practices it takes six processes to supply a non-VES patient with glasses, whilst it takes a further six to supply glasses through the scheme.

Optometrist, rural

Unfamiliar services

Many community workers believed clients are reticent to access unfamiliar services and that existing eyecare services do not always cater for certain groups. People may be anxious about:

- being looked down upon for being poor or 'different' (especially a concern for rural Victorians accessing the VES through private optometrists)
- being unable to afford the service
- the health professional using terminology that they won't understand.

Disability advocates were concerned about:

- providers lacking the sensitivity or training to work with clients with special needs
- wheelchair access and the size of the consulting chair
- long waiting times at public services causing distress for disabled clients and their carers.

CALD community members and workers mentioned:

- being unable to understand the health professional due to language barriers
- fear of health professionals and clinical procedures due to experiences in their country of origin—especially of torture or trauma
- lacking experience of services in their country of origin
- needing to see a female (or male) eyecare professional, due to cultural beliefs.

Indigenous participants also described:

- reticence to use services outside the local community, staffed by strangers
- not wanting to be put into a position where they will not understand 'big language'
- not feeling comfortable in institutional settings.

In communities like ours they are really ashamed to walk into a place ... I was thinking if they could get down to the Co-op for eye checks you probably have more of their people getting checked, instead of sending them up to the hospital where they wouldn't go and they dodge their appointments, where[as] down at the health service they would go because it's their own people.

Indigenous health worker, rural

Travel and transport to services

Workers in aged care and supported residential services were concerned for clients who are frail or disabled or have complex social issues, since staffing levels rarely allow staff to accompany clients to appointments:

SRSs are not supposed to (and not funded to) provide transport to appointments. They have a staff to resident ratio of 1 to 30. Some of them will have more than that, but legally that's all they're required to provide ... and the other thing is the residents are so disabled in other ways that expecting them to go to an appointment in a strange place with a strange person is unrealistic. A lot of them are what we call psychiatrically house-bound.

Health worker

Staff indicated that some of their clients had never had their eyes tested due to access issues. Some services had private optometrists conduct eye clinics on site; however, they felt that some residents did not follow up with commercially priced glasses prescribed, due to the cost.

Individuals, aged care workers and Indigenous workers in smaller rural communities also talked of problems getting to regional centres to see an optometrist:

Many people don't own vehicles at all and depend on others for transport, so making appointments is difficult and there is not public transport outside the internal area of the town. And just the general distance, it is too far to walk.

Indigenous health worker

Interpreters and translation services

Shortage of interpreting and translation services was a major barrier, especially for newly arrived migrants and refugees. Of people who had accessed eyecare services, many had been unable either to make themselves understood or to understand enough to proceed with treatment:

Access and outreach

I can express my problem (in my language) and had no trouble with examinations in my home country. I can't explain my problem with my retina in English though. I have just let it go instead of misrepresenting myself.

CALD participant

I went to an ophthalmologist. From my basic understanding I was told that I need glasses, but I was not happy to take the risk as I don't fully understand what is being proposed.

As a result I have not followed through with any action.

CALD participant

Particularly for emerging communities there are often few providers who speak their native language. For example, the Optometrists Association Australia lists only three Arabic-speaking optometrists in Victoria, all in north-western Melbourne.

Two community workers advised that waiting times at VES clinics were significantly longer if their client needed an interpreter. A VES optometrist confirmed:

The more unique requests for languages can wait quite a long time ... there was some African language and they were waiting a year.

VES optometrist, metropolitan

In rural Victoria, there was no provision for private VES optometrists to access interpreters.

I asked the receptionist [at the VES Optometrist] whether I could get an interpreter for my client. She told me to contact the council. When I contacted the council they said they didn't organise interpreting services.

CALD service provider, rural

Optometrists and ophthalmologists felt the patient should organise an interpreter, and using family members was appropriate. However, both community members and support workers asserted the individual's right to interpreting services and said relying on family was unacceptable, because of the medical terms involved and for reasons of confidentiality and culture.

One eye health professional suggested it was the patient's responsibility to learn English:

I am sure the [community] will assimilate very nicely but they are going to have to do it by speaking English rather than getting interpreters in repeatedly—that is not going to happen, it is not a big enough town to have the sort of interpreter services that you have in the city ...

Ophthalmologist

Current VES funding provisions appear to fall short of the Victorian Office of Multicultural Affairs (VOMA) guidelines which stipulate that:

... clients should have access to professional interpreting and translating services when required to make significant decisions concerning their lives, or where essential information needs to be communicated to inform decision making. (VOMA 2003)

The federal Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) funds a fee-free Doctors Priority Line (telephone service) which is available to enable doctors to communicate with patients who do not speak English. Ophthalmologists are eligible for the Doctors Priority Line; however those interviewed appeared unaware of it. Optometrists are ineligible, because they are not classed as medical practitioners.

Outreach services

The Vision 2020 The Right to Sight Australia Vision initiative (2003) recommends that messages about eye health and initial vision screening should occur in multiple community settings, including schools, health services and shopping centres. It does not, however, specify the most appropriate people to conduct such screening.

People consistently told us that outreach services would overcome some barriers for the most disadvantaged groups. Community workers whose clients use the outreach services instigated by the metropolitan VES and participating private optometrists have seen major improvements:

The outcome has been terrific because they can see and they can watch telly and they haven't watched telly for years or for a number

of months; or their glasses went missing whilst they were transient and you've enabled for them to get their glasses back and they can read and do their paper work and whatever ... Perhaps having a practitioner like [name of VES optometrist] as well actually in the clinics has made it much more accessible to the clients.

Health worker

However these are initiatives of individual optometrists responding to gaps in services. Without separate funding, outreach must be fitted in with regular services under the present VES arrangements. Staffing these programs is also a challenge:

We have problems getting optometrists involved in the service. It takes a special kind of person to be prepared to work outside the comfort zone as well. It is reasonably difficult to do this work as there is a lot of equipment that you need to carry. VES optometrist

This raises the question of whether other people could be trained to deliver satisfactory initial screening in various settings.

Preschool and school-age vision testing

Parents, teachers, health workers and children's services workers were concerned by what they perceived as drastically reduced service screening in preschools and schools:

I mean, it is the children who are missing out ... I reckon eye testing should be done through school no matter what, because then everyone is going to be tested. Parent

There used to be sight screening in kindergartens, colour blindness tests for grade 4 boys and eye tests for students at the beginning of secondary school, but these were scrapped. Now we do eye screening for students in prep. School nurse

Some people's responses also suggested limited awareness of the screening which does occur through the School Nursing Program. Only one parent with a school-age child (of 32 who participated in our consultation) knew that eye screening was included; another had been advised by the school to take their child to an optometrist before starting the prep year.

Community workers and teachers also raised concerns regarding eye screening being incorporated into the 3½ year Maternal & Child Health appointment, as this is the worst attended in the program (49 per cent participation rate, compared with 95 per cent soon after birth) (DHS 2002).

Significantly, maternal and child health nurses interviewed did not know about the VES and some were referring low-income families to public hospital clinics with long waiting lists.

The Optometrists Association acknowledges the role played by maternal and child health and primary school nursing programs in 'detecting some of the more severe categories of visual disorder and referring children to an optometrist or ophthalmologist for a full examination' but cautions that some children and some categories of visual disorder are missed (OAA Vic. Div. 2003, unpub.).

Some mothers with young children were not confident of maternal and child health nurses' ability to do a thorough eye examination. One suggested compulsory examinations performed by an optometrist at the MCH clinic. Given the limits to current outreach by optometrists, it seems desirable to strengthen the capacity of other services to conduct screening and identify cases requiring further attention.

Cost and choice of spectacles

Cost of spectacles from private providers

Most consumers and service providers said the price of eyewear was a significant barrier. Moreover, cost was a major deterrent to having regular eye examinations. Many consumers asked why glasses cost so much:

I just want to know why they cost so much, why you pay \$250 or \$240 for a frame like that. They would be making at least 300 per cent profit.

Parent

Many low-income consumers we spoke to had no prior knowledge of subsidised eyecare services such as the VES and believed that they could only access glasses through private optometrists. One said she had an examination, received the prescription, but had not had it filled because it would cost around \$290. Others did not get that far:

Because of her circumstance she didn't want to access the [eyecare] service because she was scared in case it cost her money because she was in debt with regard to accommodation and a few other things.

Welfare worker

In regional Victoria, three of the 34 pensioner participants aged over 50 years said they had purchased glasses through private optometrists participating in the VES but had not been made aware of the service. One pensioner had worn glasses since age 55;

now 90 she had always paid retail price for her glasses, less a seniors' discount of \$30 and a pensioners' discount of \$30. She had been told there would be a two-year wait if she wanted 'the cheap glasses'. Another older participant, told about the VES, commented:

I paid too much for my glasses: I paid \$200.

Service providers highlighted the lack of information about options. An emergency support worker said:

I suppose our biggest problem is finding places across Victoria where people can get low cost eyecare ... A lot of clients will go to the local optometrist to get their free eye test and then automatically get led into purchasing spectacles. They don't realise how much it is going to cost in the long run, thinking that if they have had their eyes tested there [private optometrist] they have to buy their glasses there and that causes a lot of distress. I don't think they are very often shown the cheapest range that they have. If the clients aren't aware of subsidised services they will end up with huge bills. I find that in regional Victoria and metropolitan Melbourne the same thing happens.

Many staff, including emergency support workers, workers in aged care facilities, maternal and child health nurses and youth workers were unaware of the VES and were referring people to private optometrists. Some consumers thought that public

hospitals were the only places they could go to receive eyecare services without out-of-pocket expenses. Most participants recommended better promotion of the VES, the bulk billing practices of private optometrists and Medicare benefits for eye examinations performed by optometrists.

The College of Optometry communicated reluctance to promote the VES broadly, due to the risk of creating a demand for services exceeding the level of DHS funding.

Cost of VES spectacles

For vulnerable groups, including people living in boarding houses, pensioners in supported residential services and Indigenous community members, even the out-of-pocket cost of basic VES spectacles (\$28.50 for standard lenses and \$42.00 for bifocals) was seen as a major obstacle:

Most residents have \$84 a fortnight left after they pay for their accommodation. Out of this money they have to pay for their medication. On average they are left with \$40 per fortnight. For those who smoke or drink that doesn't leave much money. Aged care manager

Especially people who are living in SRSs [supported residential services] and housing commission. Because of the financial side of things they will say, '\$28.50 is too much and no I would prefer not to have them'.

Welfare worker

Community service providers consistently stated that they sought funds to pay for VES glasses for their clients. Two organisations providing emergency relief said that payment for glasses was a common request.

More often than not with people that we take to get glasses through the VES we will actually try and find the money to pay for their glasses, even the reduced cost frames. Even \$28 is beyond a lot of people's budget and some would prefer to put up with broken frames.

Health worker

Appearance and quality of subsidised spectacles

Consumers under 50 years of age were disappointed with the selection of VES glasses. This particularly applied to parents purchasing glasses for their children:

The eye testing side was fine, it was just the choice of glasses. I actually bought glasses for both of my children through this scheme and they just wouldn't wear them. Six months later I had to buy them a different pair of glasses. And I don't think my kids are that fussy.

Parent

Two young mothers said even if they had known about the VES, they still would not have purchased standard VES issue frames due to the appearance. One commented, 'It's got a lot to do with confidence.'

Young adults were unanimous that the VES glasses were unsuitable, and consistently described them as ugly and undesirable:

Some glasses are really nice—the frames and everything—but these are not that nice.

Young person, rural

If I turned up in these I would get bashed.

Young person, metropolitan

There was general agreement that frames needed to be:

- more fashionable (hence less conspicuous)
- metal (not plastic).

An optometrist saw things differently:

You can't go and get metal frames, but it is not meant to be a service that provides that. It is a basic provision of eyecare for those in need.

Some VES users said they rejected the standard frames. Some had purchased non-standard VES frames on lay-by, which resulted in a long delay while the glasses were paid off. Others sought financial support to purchase glasses that were more appealing:

When you are on a pension, you get a bit of discount but you are battling to pay the glasses off because they (children) don't want that frame that the government wants to give them.

Indigenous parent

Likewise, optometrists working with Indigenous communities found:

Most people in the younger age group would go, 'Well I am not going to wear the plastic frames, I want to go for a metal one and I will pay it off', but then other things crop up in between and it will be a year or so down the track and they haven't got around to picking up their glasses.

By contrast, people over 50 years of age seemed quite satisfied with the appearance of standard VES glasses they were shown in the focus group. Those who had previously used the VES noted an improvement in the styles. The main concerns were about poor quality and durability of the plastic frames and the lack of trifocals and photochromatic lenses.

Concern about appearance seemed more pronounced in rural areas where the VES was offered through private optometrists. Many community workers said how disheartening it was for clients to see all the attractive frames on display and then to be shown the small VES range:

Part of the problem is having a two-tiered service in the optometrist. I have seen them do the service ... they have lovely glasses all over the wall and then they come out with this little wooden case full of 'nice frames not'.

It definitely segregates our clients.

Health worker, rural

People in rural Victoria were suspicious that private optometrists participating in the VES took advantage of the limited appeal of VES frames to 'up-sell' to more stylish, and expensive, frames. Some believed that

the glasses were purposely unattractive to increase this commercial opportunity.

Ready-made glasses

Ready-made glasses, bought without a prescription, are another option for low-income earners. The Vision Impairment Project found that 20 per cent of the Victorian population in the age range 40–60 years would be suitable candidates for refractive correction using 'off the shelf' spectacles (Maini et al. 2001).

Some consumers and eyewear providers were concerned about the effectiveness and potential risk of people self-prescribing by purchasing 'ready-wear' glasses.

Optometrists and ophthalmologists expressed different views regarding the appropriateness of ready-made glasses, and whether people other than eyecare professionals should be allowed to screen for eye conditions, including refractive error.

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) endorses the view of US colleagues that:

Ready-to-wear reading glasses are effective, safe, and economical. Self-selection and over-the-counter purchase of these glasses appear to be medically acceptable, cost-effective and in the best overall interest of the public. (RANZCO 2004)

Ophthalmologists we spoke to said that screening for refractive error was relatively simple and could be done by providers other than eyecare professionals. It could also identify people who needed to be referred to an expert for a full examination. The Centre for Eye Research Australia has developed: *simple screening tools to assess vision and visual function under a variety of circumstances. Using the pinhole test [staff] can go some way in sorting out those who have undercorrected refractive error from those who have other causes of vision loss. Having developed the visual testing kit for the World Health Organization, they have developed material for use in home testing and also for the assessment of the elderly.* (Taylor 2000)

Ophthalmologists said they commonly recommended 'ready-mades' to low-income earners needing reading glasses. However one ophthalmologist cautioned:

People who just need reading glasses I send along to the chemist or petrol station for a pair of the chemist glasses, which is a fantastic innovation for providing good low-cost reading glasses, readily accessible. It is OK for those that come to see me because they get an eye examination. But, the ones that just walk in off the street and get them, 5 per cent are going to get glaucoma and we are not going to know. So I think in 15 years we are going to see a large group of undiagnosed glaucoma patients appearing—which never happened before because they had to go along to an eyecare provider, and they would get a check in passing.

The Optometrists Association Australia does not endorse the use of ready-mades, asserting that they are a poor optical choice:

They have the same prescription in each lens but 75 per cent of people requiring a vision correction require lenses with different powers in each eye. They do not have any correction for astigmatism [which] 80 per cent of people require ... Ready-made spectacles make no allowances for the different distance between people's eyes, and can cause some strange optical effects and discomfort and headaches if worn for extended periods. (OAA 2003)

It warns that buying ready-made glasses without a professional eye examination could result in serious eye conditions including glaucoma and cataracts going unnoticed.

Vision 2020 and the Pharmaceutical Society of Australia (Victoria) have recently developed an education program on vision and loss of sight for pharmacists who had asked for advice to assist their customers. This may go some way to addressing concerns about people purchasing spectacles without any screening.

While health professionals commented on ready-made spectacles available in pharmacies and other shops, people living on low incomes also talked about buying glasses secondhand, for example at opportunity shops. As one woman explained:

You can go into Clints [bargain centre] and get a ready pair—or op shops because this is cheaper and you can just go in and grab them.

Parent

It appears that differing professional views on ready-made glasses and necessary appropriate screening may be preventing the development of affordable eyecare choices for people living on low incomes.

Promotion of eye health and services

Eyecare was not seen as a priority by many low-income earners. Community workers also felt clients often had more immediate needs:

There are many people living in the community who are just surviving. There are so many major issues or barriers to just existence that I think it (eyecare) would be very low on the chain of priorities. Family services worker

It is a bad thing to say, but I think that if I walked into my staff meeting this afternoon and said, 'OK, when was the last time you asked a family about their eyecare?', they would probably look at me blankly because they tend to look at the other things.

Children and family services worker

Moreover, if disadvantaged families did not value education highly, that could impact their view of eyecare. This was identified as a particular problem when families had literacy difficulties.

Of more concern was the fact that some community workers took eye health for granted or did not regard it as affecting clients' quality of life:

Usually at this age eyes are pretty good aren't they? Youth worker

Many low-income earners were unaware of the benefits of regular eye examinations:

I mean, you are always told to get your teeth checked and your eyes are so important [but] you don't realise that so many things could be wrong. Parent

Participants aged over 50 and aged care providers were, in general, more aware of the importance of eye examinations as a preventative health strategy. People who had a family member with an eye condition were more likely to have regular examinations.

However, parents with young children, young people and service providers working

with them mostly only considered eye examinations if they noticed changes in vision or other symptoms such as squinting and headaches:

No, I think it is only important if it is affecting their grades at school or things like that.

Parent

Participants felt that the low level of awareness was due in part to the absence of a major eye health promotion campaign:

You actually don't see a lot of health information focussing on your eyes, only if it is advertising glasses or something like that. No-one tells you about the dangers ... if something has happened to your eyes. It is not advertised enough. It doesn't get the focus that other health issues do. Aged care worker

The advertising is not there telling people, 'Look, it is important to go and have your eyes checked once a year' or whatever. Parent

Community workers also said that health providers did not always circulate information about eyecare services and health issues through community networks. Many were unsure about the most appropriate professional to attend to clients' eyecare needs. They recommended including services contact information as part of eye health promotion.

Members of CALD and Indigenous communities and some community workers pointed to the lack of eye health messages and services information that:

- are designed for diverse communities
- are available in different languages
- are not text-based
- are distributed more broadly in the community, not just through health services.

People suggested ways to communicate including:

- radio and newspapers
- pamphlets distributed through health centres, community centres and GPs
- information that links health messages with ways of accessing services

- posters targeting different communities
- public presentations.

Another concern was that some children, youth and younger adults did not like wearing glasses at all as they were perceived as 'uncool'. Examples were given of children 'deliberately' losing or destroying their glasses or simply not wearing them at school. Participants favoured a campaign to make glasses 'cool', using role models who wear glasses.

Recommendations

Our research shows that current eyecare services have limitations for some low-income Victorians. These require policy responses from governments and increased flexibility, sensitivity and outreach from eyecare providers.

Access to eyecare services

The Victorian Department of Human Services needs to:

- consider multi-disciplinary eyecare services which enable a wider range of health professionals and other trained staff to participate in initial eye screening
- actively promote optometrists as providers of comprehensive eye testing with a Medicare rebate and with no referral required, and the Victorian Eyecare Service as a channel for low-cost eyewear for pensioners and health care card holders
- explore ways to provide post-operative eyecare for patients from rural areas through regional health professionals, to reduce cost and inconvenience to families.

Administrative practices

The Victorian Eyecare Service and public ophthalmological services should:

- simplify the paperwork for patients, and make translations available to providers via the Internet for use with patients from non-English speaking backgrounds

- provide for patients without a permanent address or with special needs to name an organisation or case manager to receive correspondence on their behalf.

Interpreting services

The Victorian Department of Human Services should:

- define eye examinations as a situation where professional interpreting and translating services must be provided
- ensure contracts between eyecare providers and the Department include funding for interpreting and translating services.

The federal Department of Immigration and Multicultural and Indigenous Affairs should

- extend eligibility to optometrists to use the fee-free Doctors Priority Line
- promote the Doctors Priority Line to all eligible providers.

Professional development

Optometry and ophthalmology students and professionals should:

- undertake training to sensitise them to the needs of people on low incomes and from diverse cultural and language backgrounds. Training should develop competencies in understanding access and equity issues and communicating cross-culturally.

- undertake training in the use of interpreters and translating services.

Health education and promotion of services

Governments in partnership with the industry need to:

- introduce targeted eye health education programs outlining risk factors, prevention strategies and services for diverse groups living on low incomes including parents, disabled people, young people, Indigenous Australians and those from non-English speaking backgrounds
- direct an eye health awareness-raising campaign at welfare agencies, emergency support programs and referral services working with people living on low incomes
- promote the Medicare rebate, bulk billing practices and the capacity to access optometrists without a referral as part of eye health campaigns
- ensure all VES contracts require targeted promotion and publicity about the existence of the VES, eligibility criteria and provider access
- develop a campaign targeted at school-age children and young people to improve attitudes to wearing glasses.

Outreach services

The Victorian Department of Human Services in partnership with the industry needs to:

- encourage and financially support eyecare service initiatives which reach out to the most vulnerable people including those in remote rural communities, CALD communities, people with disabilities, pre-school and school aged children, homeless people and people living in supported residential services and aged care
- assess the appropriateness, risks and benefits of trained service providers other than eyecare professionals conducting eye screening and making referrals, as a means to reach disadvantaged groups

- fund mobile or visiting services for groups with significant transport difficulties, including frail aged people and people living with disabilities or mental illness.

Eye testing for pre-school and school-age children

State and federal governments should:

- review the current eye testing for pre-school and school-age children and consider linking the testing to other public health programs such as the National Immunisation Program.

Cost and choice of spectacles

The Department of Human Services in partnership with the industry should review

the current provision of low-cost eyewear in Victoria. This would include considering:

- increasing the range of contemporary eyewear available as standard frames through the VES, to recognise different age-groups' tastes and prevent stigmatising the wearers
- introducing a voucher system for the most vulnerable people who are unable to afford the cost even of subsidised glasses
- exploring ways to provide affordable eyecare for low-income Victorians who do not qualify for the VES
- assessing the appropriateness, benefits and risks of ready-made glasses as an affordable eyewear option.

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