Online with Shickle

Optician publishes more questions and answers generated by the recent ABDO College online webinar

Earlier this year, ABDO College, in conjunction with Canterbury Christ Church University, broadcast its first webinar. The subject was 'Public eye health' and the session was led by Professor Darren Shickle. In his talk, Professor Shickle described the epidemiology of visual impairment and some developments in eye health services and policy. He also presented some of his research on why people do not attend for eye examinations. He proposed rethinking recommendations for frequency of eye exams and separation of exams from the dispensing of glasses and lenses. A recording of the webinar can be watched at www.abdocollege.org.uk.

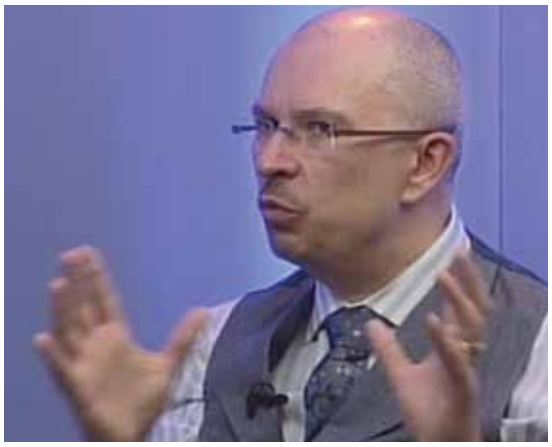
● When will the government and general public realise that sales of spectacles subsidise underfunding of eye care professionals?

In many ways the government and the NHS get a very good deal with the provision of an eye exam service subsidised by the sales of spectacles. However, the need to generate these sales can also be counter-productive to the public health if it means that the public only perceive opticians as somewhere to visit if they think that they need to purchase glasses.

The problem with totally separating the eye exam from the sale of specs is that the NHS funding for an eye exam is woefully low (£20.90) and I cannot see the NHS increasing this.

In effect, the middle classes, who buy the higher end product, subsidise the cost of the eye testing service (for both NHS and private patients). Thus, there is a disincentive for the Department of Health to renegotiate significant changes in the fee structure and delivery model. However, the introduction of the Public Health Outcomes Framework Indicator for preventable sight loss in England demonstrated that government recognises the public health implications of visual impairment. The key will be to demonstrate how earlier detection of sight threatening diseases, by better uptake of eye exams, can lead to better quality of life and economic outcomes.

● These days many optometrists are put under pressure to convert a patient's eye test into a dispense of spectacles. Their performance is often measured using 'conversion' rates. What do you think of this?



Professor Darren Shickle: keen to ensure preventable sight loss is identified

There is a challenge for the profession to recognise such behaviour as malpractice and to deal with it accordingly. The research that I have conducted demonstrated that the majority of the public, who do have their eyes examined, are happy with the service they receive. However, the research also identified that there are a number of people who have not received the standard of care that they should expect. Thus I agree that not all dispensing opticians are pushy, and indeed there will be a small number of rogues in all professions. The problem is that these stories of unprofessional practice circulate within the community and can lead to people not attending for regular eye exams.

● Why not have only registered opticians able to dispense prescription spectacles as before? Surely that would prevent the 'hard sell' and give patients more confidence. Targets for spectacle sales in multiples should be outlawed.

I believe that 'hard-selling' and in particular 'mis-selling' are grounds for professional misconduct that should be investigated by the GOC.

Separating clinical services from refractive correction would work only if the professional fees reflected the service. Too many rely on sale of product to survive because of a culture of 'free testing' planting the perception in many minds that the exam aspect is worthless.

I agree that one of the implications of a separation of eye exams from dispensing would be the need to assess the true economic cost of eye exams, and for optometrists conducting these tests to be paid accordingly. This would release those who specialise in dispensing from the need to build in the cost of this subsidy into the cost of glasses. The question arises as to what impact this would have on the cost of glasses and indeed how the industry would adapt without the attraction of a sight test to attract potential customers through the shop doors.

● Surely splitting the eye test and sale of spectacles supports the concept of 'customer choice' by removing 'the guilt factor' at not buying specs after an eye test that your research showed as a reason why some people do not attend for eye exams?

From a public health perspective I am keen to ensure that preventable sight loss is identified wherever practicable. Thus, I am considering options for service redesign to facilitate this. The delivery of optometry within a more explicit primary care model is one option. This could include ensuring that individuals at higher risk of eye disease on the basis of age, family history, ethnicity etc receive a reminder letter from the NHS rather than commercial practices and that eye exams are provided in settings which are less overtly oriented towards sales of glasses, and indeed may not dispense glasses at all. However, refractive error is still an important cause of visual impairment but I would hope that a market which

is not encumbered with the need to subsidise eye exams would develop to address all consumer budgets, as it has done in other sector such as supermarkets and fashion retail.

● Do you think legislation allowing dispensing opticians to refract would have a positive or negative effect on the public's perception as optical practices as a place for healthcare as opposed to just being glasses shops?

I am aware that the right of dispensing opticians to refract is a sensitive and controversial subject. From a public health perspective, my only concern is that the professional who administers specific investigations has the appropriate training with suitable equipment etc. The public are generally unaware of the terms optometrist and dispensing optician, let alone the difference in their training and what they are allowed to do. I am reminded of the shift that occurred in the 1990s with nurses taking on some of the roles that doctors used to do. This allowed doctors to use their training more appropriately. I can see an argument for optometrists taking on more of the routine work of the hospital eye service. If this is the case, then some optometrists may wish to specialise in local enhanced services rather than refraction. However, I am told that there is already an excess of optometrists for the posts available, and that salaries are falling as a consequence. I suggest that it would be prudent to conduct some workload planning to assess what numbers of

also be prudent to assess the curricula of courses to ensure that universities are training the right sort of staff according to the changing patterns of need. I have spent the last few years working closely with the optical sector at national and local levels. I observed early on that both optometrists and dispensing opticians are a highly trained resource and indeed that for much of the day-to-day workload within a practice, many of these skills are not utilised. This must impact on job satisfaction, but also on the need to maintain such skills for the occasions when they are required.

The separation of the 'medical' and the 'dispensing' sides of optics would make things much clearer for patients and what it actually costs to produce spectacles without having to fund the cost of the sight tests within them, I'm sure it would be a great move for the future.

I recognise that redesign and restructuring of healthcare services is not without its problems and will have implications for some eye care professionals. However, I think that it will provide some clarity as to what is offered by optometrists and opticians and what are the different elements of the services cost.

● Surely separating the eye exam from the supply of spectacles would open a huge can of worms with regards responsibility of treatment, which is already a headache with online retailers?

There is also an issue in terms of professional responsibility when a

practice to be dispensed by another, and then makes a complaint about the glasses not helping their vision or even making it worse. The dispensing of glasses is an important solution for addressing visual impairment for many people. Thus I recognise that there is a risk that many people who would benefit from glasses may choose not to have their prescription to be dispensed.

● How can online dispensing be 'safe'? This will reduce the number of patients visiting practices. Independent practices will close. The skilled professionals will be redundant and the NHS will be further stretched beyond what is sustainable.

Online sales of books, CDs, DVDs etc have certainly had an impact on high street retailers for these products. Online sales of glasses and in particular contact lenses are likely to have a similar effect within optics. The optical sector will need to adapt its business model. My focus is on the public health not directly on the livelihood of the sector. However, it is important to have a widespread network of optometrists and opticians to deliver the healthcare services as part of this public health agenda. Thus the commercial pressures to adapt may be an opportunity to reflect on the model needed in the future and the mix of skills and professions required to deliver this model.

● Do you not think that this would cause more problems with an increase in visual problems if there is a separa-

eye exam history, record taking is just as important as treatment dispensed?

I recognise this as an issue, and something that would need to be considered within any recommendations for service redesign. Patients already have the option of taking a prescription elsewhere and so the dispensing opticians would not have access to any additional information obtained from the eye exam or medical history. I think that the key decision is whether refraction is performed as part of the eye exam, or whether the exam ends with an assessment of visual acuity and a recommendation to seek refraction as part of the dispensing process. I recently visited optometrists and ophthalmologists in Hong Kong. The set-up there is similar to many countries and has many weaknesses compared to that in the UK. Optometry in Hong Kong is focused almost exclusively on the sale of glasses and a basic refraction, usually based on autorefraction is all that is offered. Thus, if this is all that people receive, there is a risk that other preventable sight loss will be missed. Therefore, ensuring that people can access an eye exam by other routes will be crucial, either as part of a formalised NHS screening programme or via the primary care team.

● **With regards to changes to the proposed frequency of eye exams, how has the evidence base for this proposal been produced?**

At present, I am only suggesting that we ought to explore a change in recommended test frequencies as a way of targeting the available NHS budget to maximise health outcomes. Of course, there is a separate argument to be made about whether the NHS budget should be bigger. However, there may be a better return from ensuring that people at higher risk of preventable sight loss are screened, than funding tests for those at lower risk. I suspect that opticians and optometrists would also prefer not to offer subsidised tests to people who are unlikely to need glasses. An attempt was made a few years ago in Canada to review the evidence base for sight test frequency; however, their final recommendations were still largely based on consensus rather than evidence. As part of our research in Leeds, we are currently scoping the evidence that we would need to inform evidence-based guidance. We are hoping to establish a database to look at changes in vision over time, and what would be the impact of extending the test interval for low risk groups. We are looking at the epidemiology of the common diseases to model the predictive value of tests at different ages.

● **It seems hypocritical to say that on the one hand patients do not attend exams because they don't feel anything wrong, but on the other hand we should see patients every five years?**

The majority of people who do not attend because they do not feel anything is wrong will be low risk and hence would not have anything detected during an eye exam. However, some of these people may be at higher risk, and may, for example, have field loss due to glaucoma that they are not aware of. The key is to develop a screening policy that targets screening on subgroups of the population which are at higher risk, for example, on the basis of age or ethnicity.

● **If the uptake of eye tests can often be seen to be less in deprived areas, would increasing the time between tests possibly reinforce the message not to bother having a test?**

I can see why increasing the recommended interval between eye exams for low risk individuals could be perceived as reinforcing a perception that eye exams are not important. However, the epidemiology of the major cause of sight loss means that frequent eye exams, for younger adults for example, are probably not that important, because such individuals are low risk. Indeed, while they do not think in terms of age-specific incidence of disease, they probably realise that they are highly unlikely to be diagnosed with cataract etc in their 20s or 30s. Thus having the same recommendation for eye exam frequency for a 25-year-old as for a 65-year-old sends the wrong message in relation to the importance of eye exam to people in middle and older age groups. If the NHS were to establish a formal eye screening programme for higher risk individuals, this would actually send a very clear signal that eye health is very important.

● **Who would fund the annual vision screening of the elderl, given GOS issues/budgets?**

The elderly currently have an eye exam funded by the GOS budget, and this would not change. The addition that would need to be funded would be invitations for screening to be sent by the NHS rather than commercial practices as usually happens at present. The logic is that the public may be more likely to act on the basis of an NHS letter, and that non-attendance could be flagged with the GP. While there is a case for new funding for this, I am speculating whether we could generate the funding needed by disinvesting in frequent tests for lower risk individuals.

● **If we are to be seen to be further promoting eye health, surely testing certain age groups only every five years would mean a higher number of problems would go undetected?**

Screening tests (as with diagnostic tests for that matter) are not perfect. People without the disease may have a false positive test result, and people without the disease may be missed by a false negative test result. When establishing a screening programme we consider what combination of factors will give the best outcomes in terms of picking up people with a disease, versus not causing anxiety or unnecessary burden for those who do not. We also consider what might be the most cost-effective option per case detected. Yes, increasing the test interval may mean that a few cases of preventable sight loss might be missed, but I propose only increasing the interval for low risk individuals. The money saved could be reinvested and hopefully lead to the detection of far more people with the capacity to benefit from further investigations and treatments.

● **Is there a danger with increased screening for disease, such as increasing access to eye tests, that increased numbers of detected disease might swamp an already over stretched eye health service?**

It will be important to have guidelines in place so that patients are referred with greatest need and most capacity to benefit from further investigation by ophthalmology. Glaucoma referral refinement pathways have shown the value of doing repeat contact tonometry by optometrists in reducing unnecessary referrals to secondary care, while ensuring that those patients with consistently raised intraocular pressures and/or optic disc changes are referred for further investigations.

● **Professor Darren Shickle** is professor of public health at the University of Leeds