RANZCO
The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

VISION 2030 and beyond

RANZCO's Australia-Focused Advocacy Strategy

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Vision 2030 and beyond – Six Pillars

Workforce and Training

Service delivery

Closing the Gap

Preventative Health

Sustainability

Global Eye Health

Aims in drafting Vision 2030 & beyond Australia

- To develop a repository of current **evidence** & recommended changes relevant in the Australian context with a **focus on patient-centred care**
- **Clear, consistent messaging:**
  - What eye healthcare is
  - The importance of eye healthcare
  - Current challenges in service delivery & recommended changes
- **An ask for improved governance – not more money**
- **Clearly define RANZCO's agency and sphere of influence:**
  - What can we do ourselves to get our own house in order
  - What can we do with others
  - What can we influence – either alone or with other organisations

Aims in drafting V2030 Australia continued

- **Unify RANZCO's and the Fellows' approach to advocacy**
  - Engage the membership – active involvement of ≈150 Fellows
  - **Speak with one voice**
- **Unify the eye healthcare sector**
  - Strengthen relationships
  - **Establish our common ground**
- **Position ourselves to collaborate** with other craft groups and NGOs in the advocacy space
  - **Stronger together**

Universal Contemporary Challenges in Healthcare

- The demand for healthcare is growing
  - Ageing and growing population
  - Increased burden of disease – e.g., the obesity epidemic
  - New technologies and treatments
- Healthcare costs are increasing faster than the broader economy
- An historical focus on the treatment of acute presentations
  - Poor coordination & funding of chronic disease
  - Inadequate and ineffective funding of preventative health
- Siloed government funding = Return on Investment muddied

Poverty gap highlights depth of financial hardship

The poverty gap shows how far people's incomes fall short of the poverty line — the bigger the gap, the further they are from making ends meet.

	50% of median*	60% of median*
	Percentages	
People below the poverty line	14.2	21.6
Children below the poverty line	15.6	23.9
	Numbers	
People below the poverty line	3,706,244	5,614,616
Children below the poverty line	756,734	1,159,833
	Poverty Gap	
Average poverty gap ($ per week)	$390	$399
Average poverty gap (% of poverty line)	47%	39%
Average poverty gap for families with children ($ per week)	$464	$479
Average poverty gap for families with children (% of poverty line)	44%	38%

*Median income poverty lines (minus housing costs).
Source: Poverty in Australia 2025, ACOSS and UNSW Sydney

- Widing income gap in Australia
- Cost-of-living crisis
- Population below the poverty line in Australia in 2025:
  - 3.7 million people
  - 750,000 children

Australian Universal Health Care

- Aim: Affordable healthcare for all Australians
- Public Hospital Services: Free treatment guaranteed
- Medicare: Covers all or part of the costs for GP & specialist services and tests performed outside of public hospitals.
- Pharmaceutical Benefits Scheme: Subsidized prescription medications
- Funding: Australian taxpayer

Private Health Insurance

- ≈ 45% of the population – but membership falling
- In part tax-payer funded
- Covers inpatient (but not outpatient) specialist services

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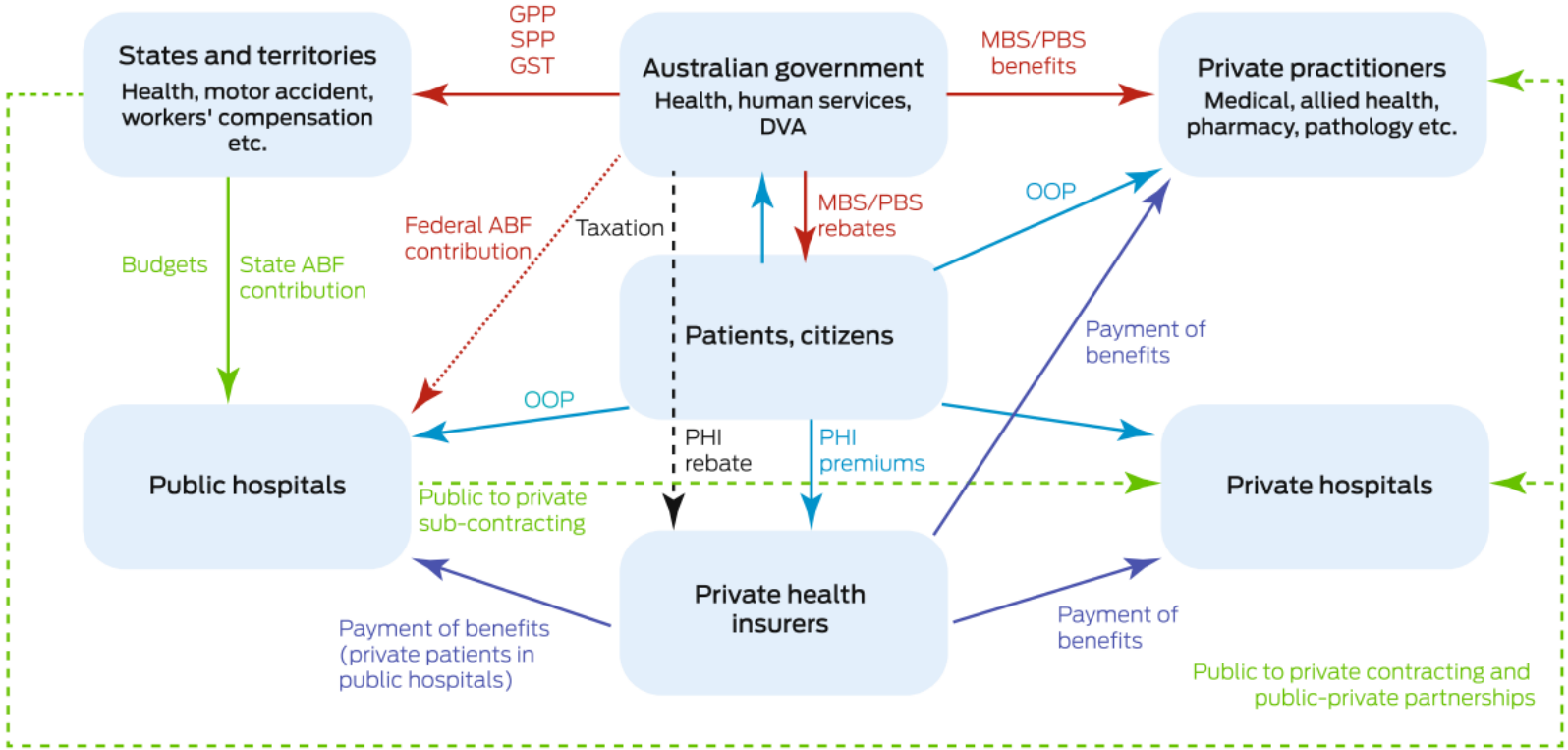
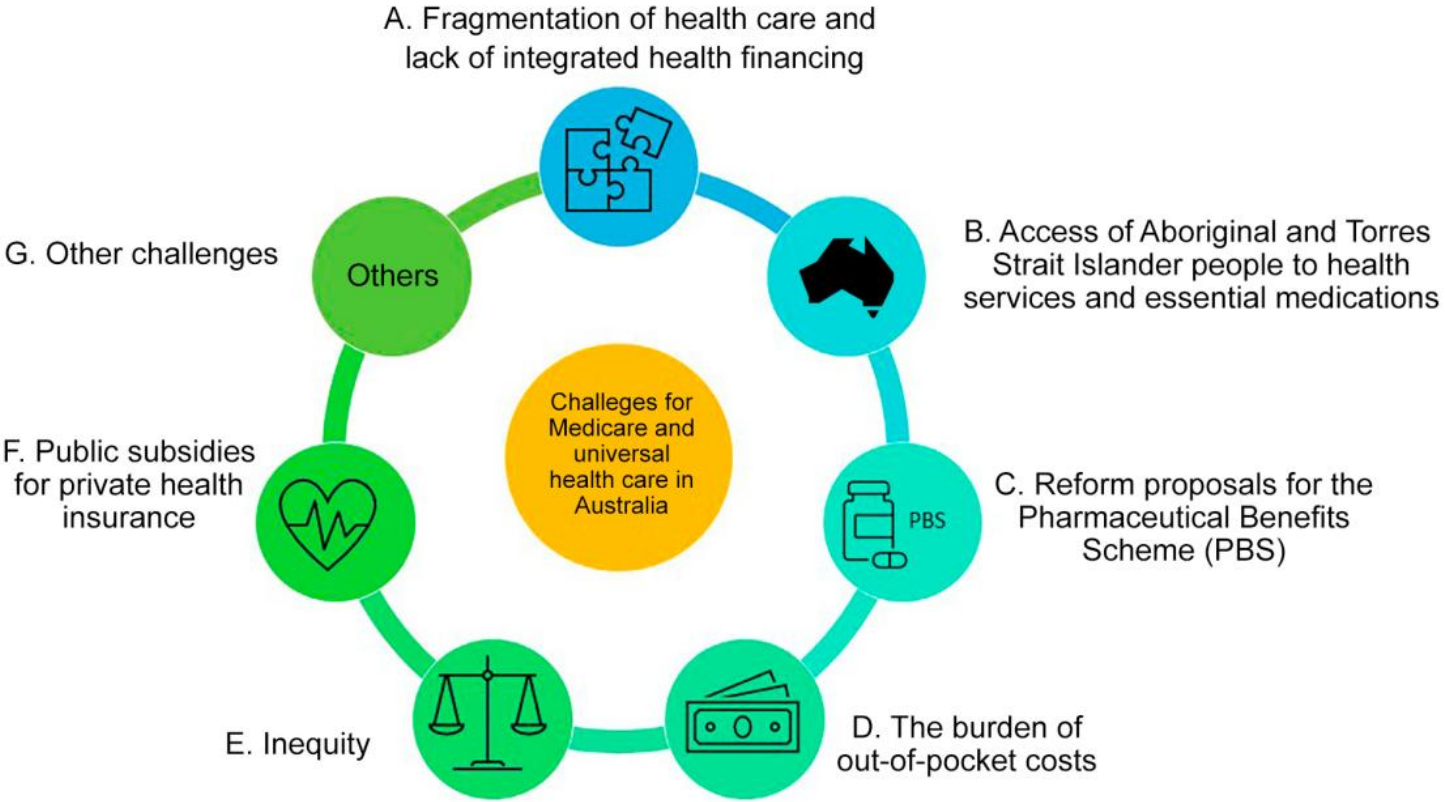
1 Simplified schematic depiction of health care financing in Australia



ABF = activity-based funding; GPP = general purpose payments; GST = goods and services tax; MBS = Medicare Benefits Schedule; OOP = out-of-pocket expenses; PBS = Pharmaceutical Benefits Scheme; PHI = private health insurance; SPP = specific purpose payments. ◆

Angeles, M. R., Crosland, P., & Hensher, M. (2023). Challenges for Medicare and universal health care in Australia since 2000. *Medical Journal of Australia*, *218*(7), 322-329. https://doi.org/10.5694/mja2.51844

3 The seven major themes identified in 76 articles on universal health care in Australia



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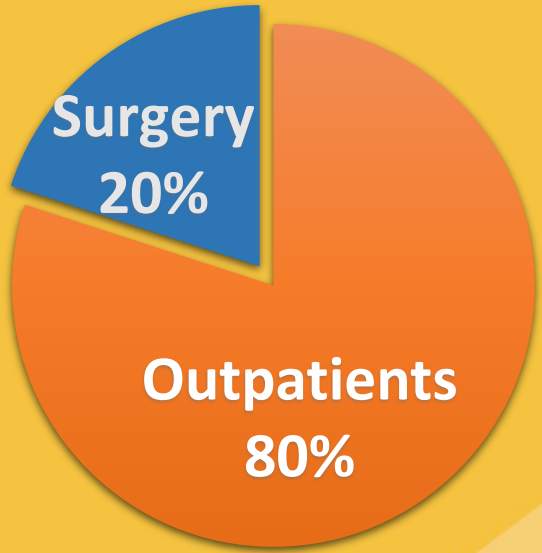
Eye healthcare service delivery snapshot

- Cataract – commonest operation
- Common chronic blinding diseases
  - Diabetic retinopathy
  - Age-related macular degeneration
  - Glaucoma
    - ➢ Very common in our ageing and highly comorbid population
    - ➢ Can cause permanent visual impairment and blindness without timely care
- Acute care is typically ambulatory



Eye Healthcare Services = High-Value Healthcare

The true cost of hidden waiting times for cataract surgery in Australia

Jessie Huang-Lung, Blake Angell, Anna Palagyi, Hugh R Taylor, Andrew White, Peter McCluskey, Lisa Keay

Association Between Cataract Extraction and Development of Dementia

Cecilia S. Lee, MD, MS[1,2]; Laura E. Gibbons, PhD[3]; Aaron Y. Lee, MD, MSCI[1,2]; et al

Author Affiliations | Article Information

JAMA Intern Med. Published online December 6, 2021. doi:10.1001/jamainternmed.2021.6990

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Global economic productivity losses from vision impairment and blindness

bie Muirhead •

Br J Ophthalmol. 2006 Mar; 90(3): 272–275. PMCID: PMC1856946
doi: 10.1136/bjo.2005.080986 PMID: 16488942

The economic impact and cost of visual impairment in Australia

H R Taylor, M L Pezzullo, and J E Keeffe

The Economic Impact of Vision Loss in Australia in 2009

A report prepared for Vision 2020 Australia by Access Economics Pty Limited

https://www.vision2020australia.org.au/wp-content/uploads/2019/06/Access_Economics_Clear_Focus_Full_Report.pdf

The *Lancet Global Health* Commission on Global Eye Health: vision beyond 2020

Prof Matthew J Burton, PhD • Jacqueline Ramke, PhD • Ana Patri

Prof Rupert R A Bourne, MD • Prof Nathan Congdon, MD • Iain Jones, MS

Open Access • Published: February 16, 2021 • DOI: https://doi.org/10.10

BURDEN OF DIABETES IN AUSTRALIA: IT'S TIME FOR MORE ACTION

Preliminary Report

July 2018

https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-medicine-and-health/research/centres-institutes-groups/burden-of-diabetes-its-time-for-more-action-report.pdf

Access to Public Hospital Eye Healthcare in Australia

- Stagnant funding of eye healthcare in the public hospital sector
  - **Public hospital funding = 13% of service delivery in Australia**
  - Most adult & paediatric public eye services overwhelmed
  - **Outpatients waitlists non-reportable**
- > 50% of existing **services are not comprehensive**
- Public hospital eye departments under threat of closure
- New hospitals built without eye services
- **Maldistribution of outpatient services** – typically not delivered in:
  - Outer urban areas
  - Much of regional Australia - even when workforce present

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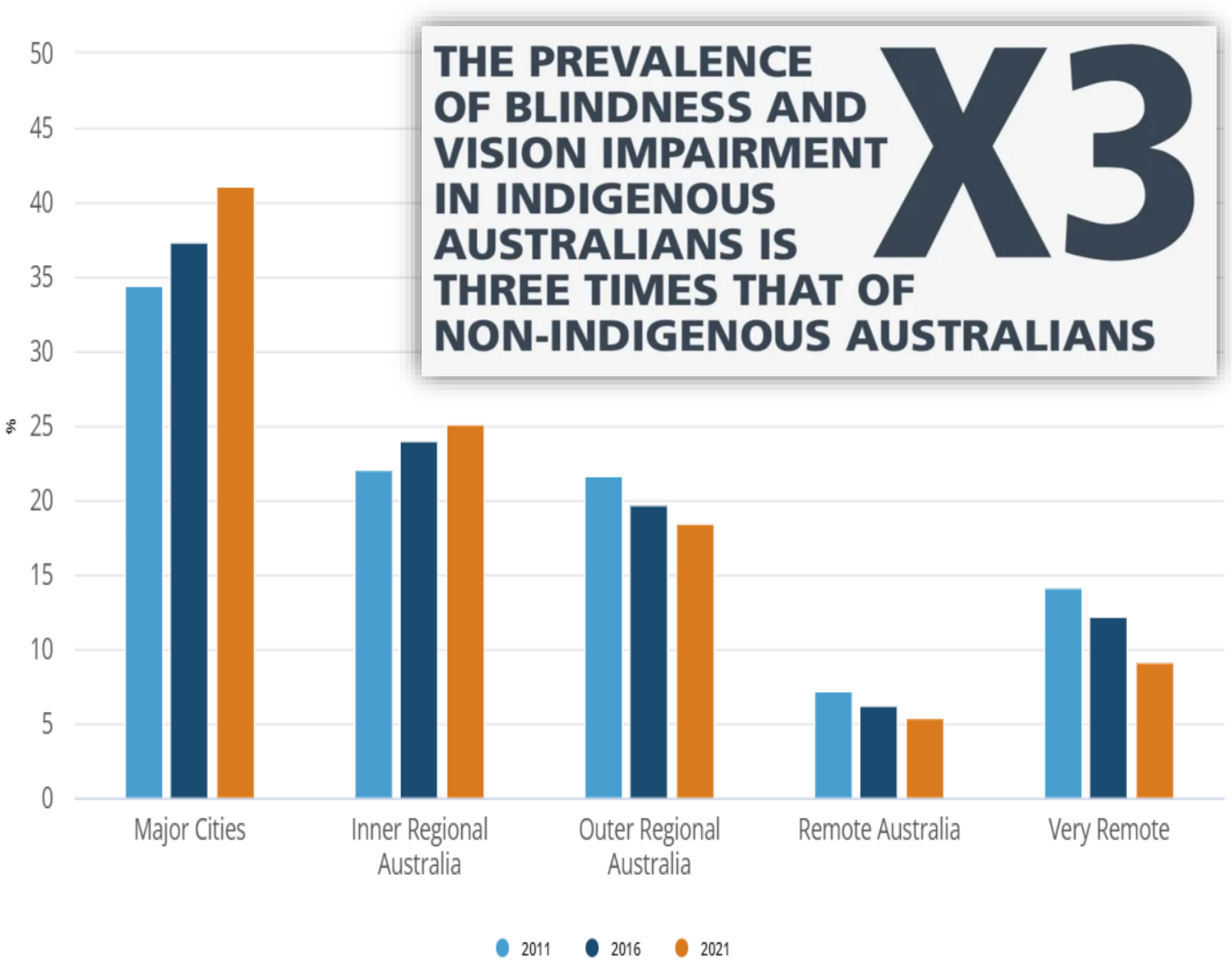
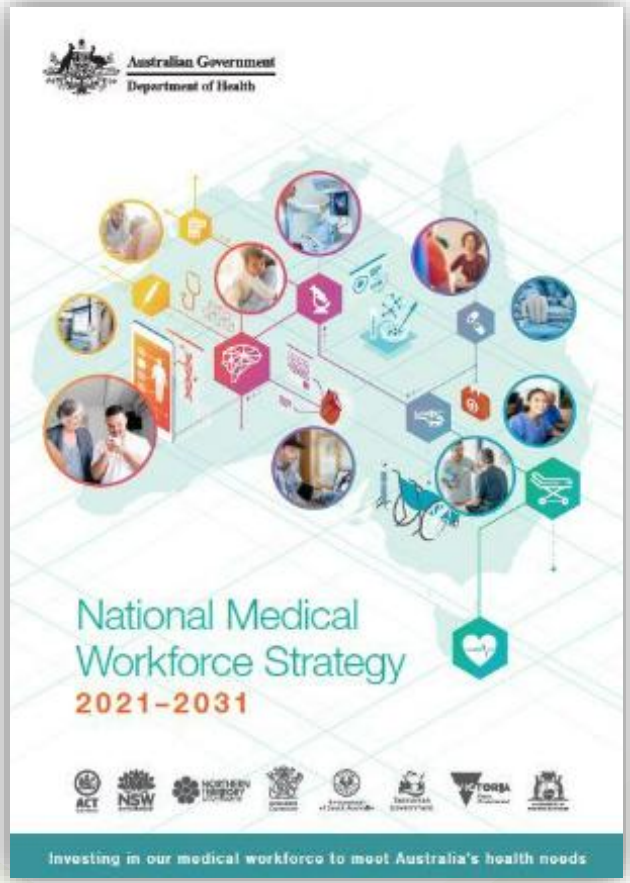
Distribution of Aboriginal and Torres Strait Islander persons by Remoteness Areas, 2011-2021 (ABS)

Population 59% regionally-based



Geographic workforce distribution – 16% regional

- 28% of population regional
- 16% of ophthalmic workforce regionally-based
- Regional background (RB) is a strong independent predictor of future regional practice (FRP) – Odds Ratio ≈ 2.7 for ophthalmology
- Current tracking - return rates to FRP of RB doctors ≈ 30%.
- For urban origin doctors ≈ 10% → FRP



What we know

- 25% of commencing Australian medical students have a RB (2002)
- Rural Clinic School (RCS) attendance is a strong independent predictor of FRP in both GPs and specialists.
- RCS Students lose rural interest as they move back to the city for specialty training.
- RB + RCS attendance = additive as predictors of FRP
- Regionally enhanced specialist training strongly increases the likelihood of future regional practice
- Regional training terms < 1 year don't result in 'connection to place'


The rural pipeline to longer-term rural practice: General practitioners and specialists

Marcella M S Kwan [1], Srinivas Kondalsamy-Chennakesavan [1], Geetha Ranmuthugala [1 2], Maree R Toombs [1], Geoffrey C Nicholson [1]

Affiliations + expand

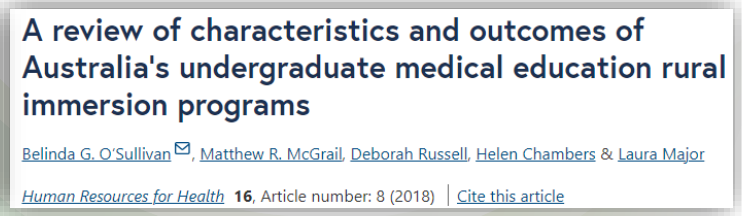
PMID: 28686628 PMCID: PMC5501522 DOI: 10.1371/journal.pone.0180394


Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 doctors

David Wilkinson [1], Gillian Laven, Nicole Pratt, Justin Beilby

Affiliations + expand

PMID: 12950945 DOI: 10.1046/j.1365-2923.2003.01596.x


A review of characteristics and outcomes of Australia's undergraduate medical education rural immersion programs

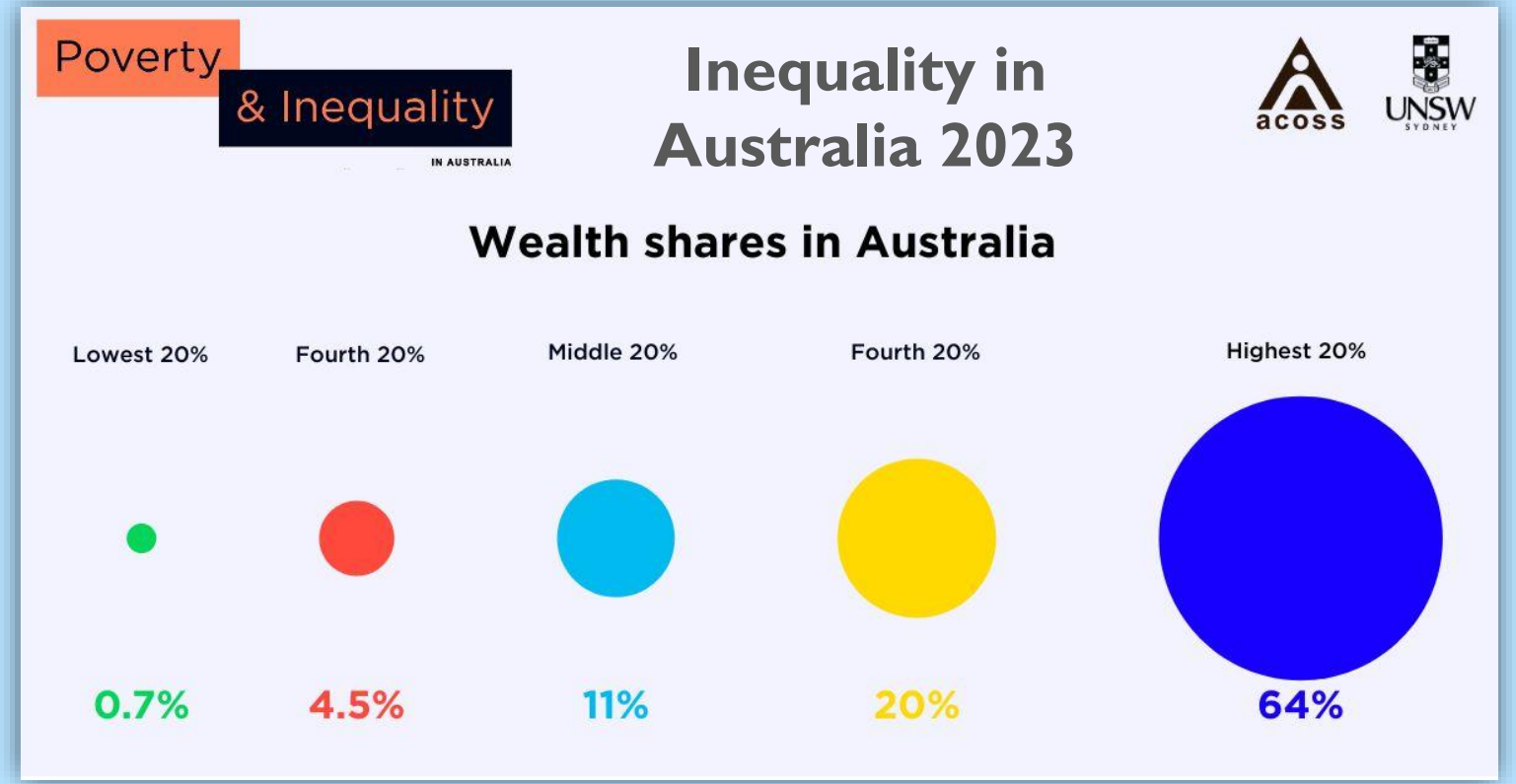
Belinda G. O'Sullivan, Matthew R. McGrail, Deborah Russell, Helen Chambers & Laura Major

Human Resources for Health **16**, Article number: 8 (2018) | Cite this article

Public Hospital Services and Ophthalmology Workforce Sustainability & Maldistribution

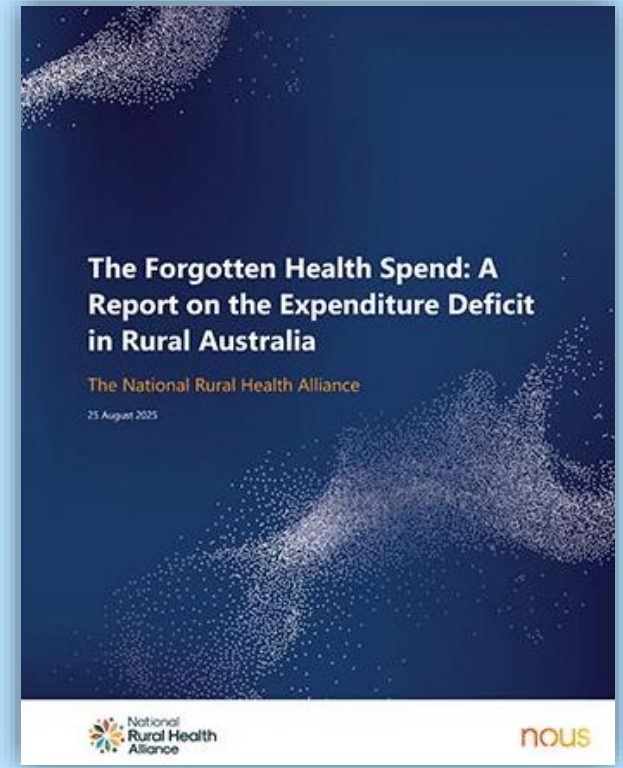
- **Most specialist training occurs in the public hospital sector**
  - Hence public hospital funding is a direct rate limiter to future overall specialist workforce numbers
  - Maldistribution of public hospital services results in training post maldistribution exacerbating future workforce maldistribution
- **87% of ophthalmology service delivery in Australia is in the private sector = 13% of specialist time spent in public sector**
  - A limitation in training enough ophthalmologists to service 100% of the population = projected workforce shortage
  - Public-private maldistribution of the workforce is the biggest single barrier to meeting community needs

Widening wealth gap: The poorest 60% of the population share just 16% of the wealth



What determines which services are delivered where?

- There is no governance under the National Health Reform Agreement over what public hospital services are delivered where
  - ➢ Maldistribution in the funding of public hospital services
  - ➢ High healthcare variation
  - ➢ Most training opportunities are based centrally in major urban teaching hospitals
  - ➢ Uneven public hospital service distribution is a driver of future workforce maldistribution



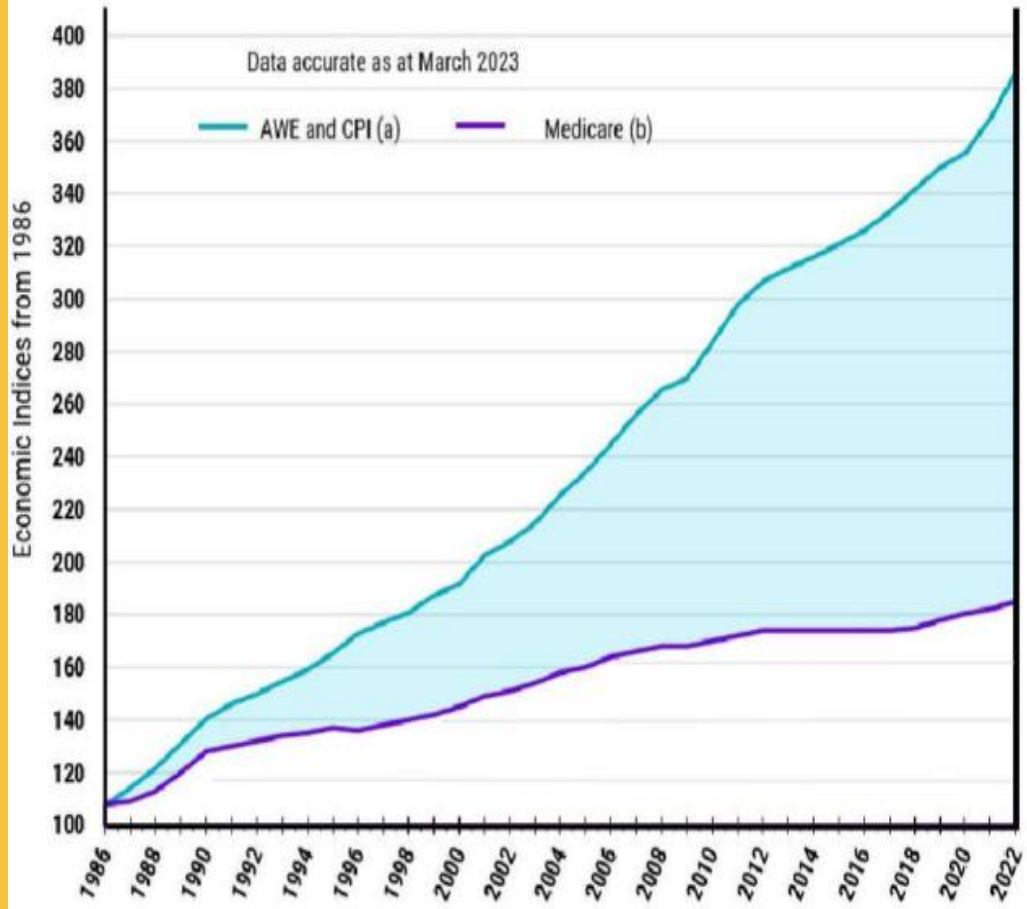
$8.35b Total gap in expenditure *(expanded base)*

$1,090.47 Expenditure per person, per year

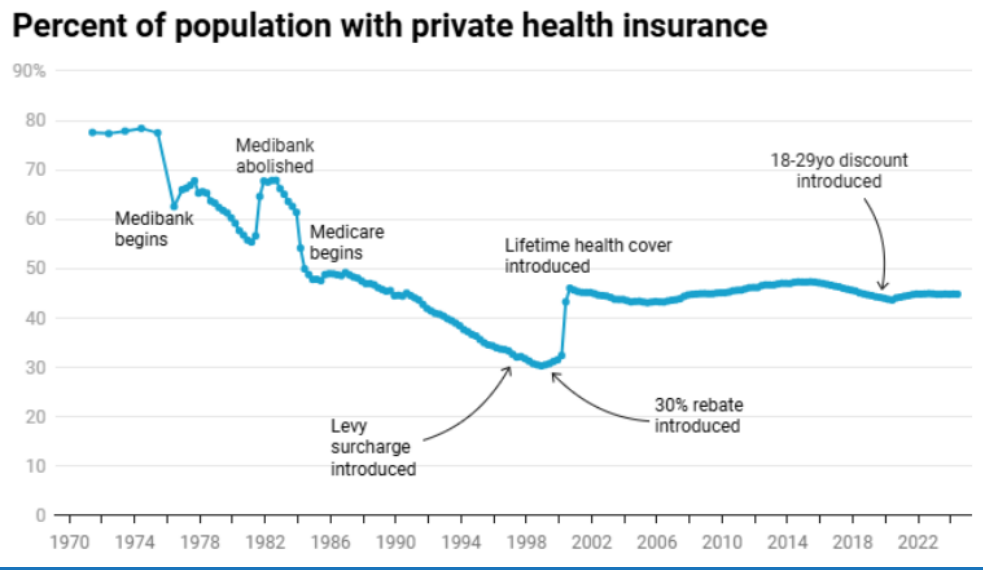
The Gap = **out-of-pocket expense** consumers may be asked to pay for Medicare services

Government indexation of rebates has not kept up with economic indices

- increasing gap between rebates and the cost of medical service delivery



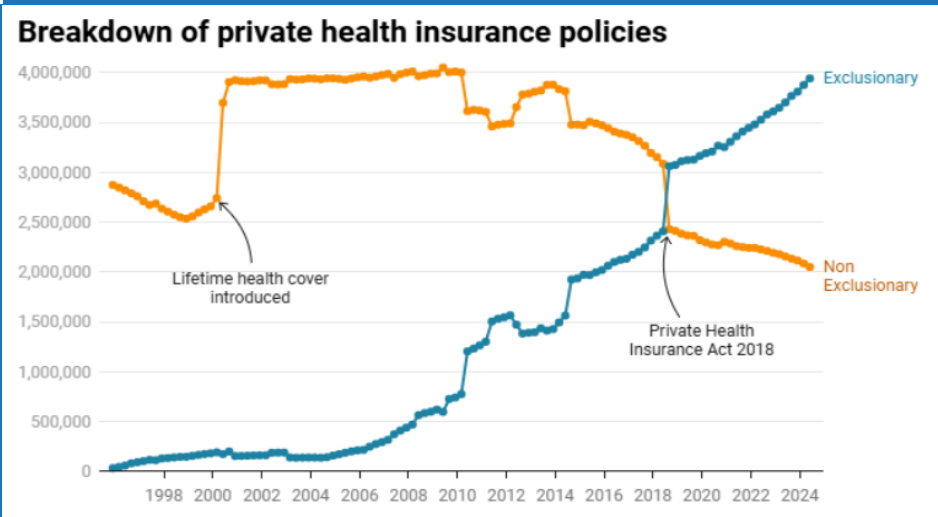
(a) Index comprising of Average Weekly Earnings and Consumer Price Index (70:30) reflecting the average cost structures in medical practices.
(b) Index of Medicare fees as determined by the Commonwealth Government.



Private health insurance is a dud. That's why a majority of Australians don't have it

November 12, 2024 *by* Greg Jericho *in* The Guardian

- Increasingly unaffordable
- Covers inpatient (but not outpatient) specialist services
- Increasing exclusions: cataract = gold level cover
- Private hospitals under pressure



Workforce strategy – Implemented Actions

- RANZCO's vocational curriculum reinforced to ensure we graduate generalist ophthalmologists
- Binational Selection points for:
  - Regional attributes: > 30% of new entrants to training have RB
  - First Nations doctors: 4% of new entrants identify as First Nations
- Implemented our Regionally Enhanced Training Network (RETN) across Australia
- Collaborative care engagement

Vision 2030 also looks to strengthen Collaboration across the Eye Health Sector& Collaborative Models of Care

- RANZCO has delivered eight Collaborative Care Workshops
  - Strengthen relationships across the eye and broader healthcare sector & with NGOs
  - Reach a consensus on the roles of each craft group
  - Document existing & build additional patient-centred, high-value, cost-efficient models of collaborative care
- United voice to government

The Regionally Enhanced Training Network

- An Australian-wide network of regionally enhanced ophthalmology training pathways
- Each RETN training pathway:
  - End-to-end specialist ophthalmology training designed to graduate an excellent comprehensive ophthalmologist
  - ≥ 60% regional
  - Positive regional training experiences essential

RANZCO Vision 2030 & beyond advocates for improved governance and accountability

1. **Atlas of Healthcare Delivery Standards calibrated** by specialty, patient demographics and geographic area for all health care.
   - Embed in the NHRA to address unacceptable healthcare delivery variation across Australia
2. **Include Tier 2 (outpatient) waitlists in the reportable data set** (NHRA) to ensure visibility at a national level of these services
3. **Introduce jurisdictional KPIs for all specialty training Full Time Equivalents**
   - to be calibrated by population served and delivered at the level of the Local Hospital Network


thank you
al warren