



**SUBMISSION IN RESPONSE TO GREEN PAPER
NATIONAL HEALTH INSURANCE IN SOUTH AFRICA**

December 2011

ABBREVIATIONS

AIDS:	Acquired Immuno-Deficiency Syndrome
DHS:	District Health System
DOH:	Department of Health
HIV:	Human Immunodeficiency Virus
HPCSA:	Health Professions Council of South Africa
IOP:	Intra Ocular Pressure
ISQua:	International Society for Quality in Health Care
MCC:	Medicines Control Council
NDOH:	National Department of Health
NHI:	National Health Insurance
OSC:	Office of Standards Compliance
PBODO:	Professional Board for Optometry and Dispensing Opticians
PHC:	Primary Health Care
SAOA:	South African Optometric Association.
STI:	Sexually Transmitted Infections
TB:	Tuberculosis
WCO:	World Council of Optometry
WHO:	World Health Organization

EXECUTIVE SUMMARY

1. Historical Background

THE South African Optometric Association (SAOA) is a non-profit organization established in 1924. It is the only professional body in South Africa representing the aspirations of the optometry profession. Significant changes in the board of directors and management of the organization has seen at least the last four black presidents including vice-presidents and most recently the first black CEO being appointed. It currently has about 1630 members out of an estimated total of about 2300 practising optometrists. Optometry was made accessible to blacks as a profession in 1976 with the first degree qualification at the then University of the North. Since then, about 550 black optometrists make up this total mostly from the University of Limpopo as well the Kwa-Zulu Natal, University of Johannesburg and most recently the University of the Free State.

2. Introduction

The SAOA submission on the NHI Green Paper has deliberately refrained from making any statements about the economic and financial viability of the proposed National Health Insurance (NHI). It is our view that this competence lies in the relevant arms of government and shall therefore not be commented upon beyond this sentence. Our concerns have been limited to the role of optometry under the NHI as well as integrating this largely hitherto private service into the health system for better access to the South African population. The premise upon which our position is founded can be summarised as follows:

- a. Visual disability is the second leading cause of disability after movement disability in South Africa. Refractive blindness is a leading cause of blindness in developing countries and the second highest cause of blindness after cataracts. The global economic costs of blindness are estimated at an annual figure of US\$270 billion in productivity only. We are mindful that Sub-Sahara Africa carries 60% of the global burden of preventable blindness and South Africa has at least twice the burden of disease of an average developing country. We submit that successes in eye care have been inadequate despite good programmatic intentions. The partnership between role players in this sector is a precondition for meaningful prevention and management of the affected population.
- b. Optometry services by design were reserved for the few privileged people who historically are white and hence the confinement of the service to the private sector and shopping malls. The scarce eye care medical services were dispensed by a few white ophthalmologists catering for this privileged class of people. With the new dispensation, optometry has continued to be limited to the shopping malls, accessible only to those who can pay and the costs of the service are out of reach for the majority of the population. The NHI intervention is key towards making optometry services affordable through multi-pronged strategies.
- c. Despite recognition of optometry as public resource post-1994, its incorporation into provincial health departments has been slow. Medical schemes do not remunerate the expanded scope of the profession which is a disincentive to provide the full scope of

professional services. The generous remuneration by medical schemes of the optical goods provided by the profession and disregard for professional services has led to the artificial high cost of spectacles. This loaded price of optical goods can be seen as a means to meet the high operating costs of the shopping malls. The healthcare funders through this model of remunerating optical goods have disregarded the burden of disease, access, affordability and appropriateness of optometry services.

- d. Clinical training has been geared towards the corner-shop practice to some extent, resulting in limited clinically progressive training outside of the public health training platform. The traditional professional turf battles with the medical profession have also not assisted the assimilation of optometry from the periphery of the healthcare system to mainstream services. There are discussions with ophthalmology to remedy this impasse for the benefit of the greater population in preparation for the NHI.

3. Synopsis of Core Submissions to the NHI

The SAOA therefore submits the following proposals in preparation for the era of the NHI.

- a. Optometry must be integrated into the mainstream health services alongside nursing, ophthalmology and other health care professions. Given the burden of disease, the scope of the profession should be determined by population needs and not the preferences of the limited number of all the eye care professionals.
- b. The training of optometrists should be based on the public health platforms where the bulk of the burden of disease presents and not the shopping malls which distort the relevance of the profession. The scope of practice should support the specialist service of ophthalmology and prevent wasting this scarce resource on routine primary health cases and other functions such as biometric measurements of the eye which can be competently managed by optometrists. This calls for a revision of the current model to a more innovative joint task shifting process between all role players to increase efficiency and effectiveness of eye care services.
- c. Optometrist should provide services in the public sector within the District Health System, where nurses and other designated professionals can refer to optometry after screening. Optometry will in turn refer cases upwards depending on the nature of intervention required. All general and common eye conditions should be handled at this level. All services that cannot be provided at this level will be referred to the next level of care where appropriate technology and expertise is available for the safe management of those patients. The screening of conditions with ocular complications such as diabetes should be an integral part of optometry service provision.
- d. An Optometry Clinical Quality Assurance process should be implemented to ensure consistent quality of care, appropriate care packages, clinical protocol adoption and other necessary processes for a successful NHI. Satisfying the norms and standards of this process will enable practitioners to be accredited to provide services under the NHI. The remuneration models under the NHI should include incentives to provide services in rural

and other under-served areas. Accredited private practitioners should be compensated for input operating costs and the level of care that is provided. The public should still access branded products if they are able to make the necessary out of pocket payments or have additional cover required beyond the capped NHI payments due to the psychosocial considerations of wearing optical devices.

- e. The affordability of goods for optometry services should be enhanced by the full remuneration of the scope of professional practice in the NHI. This will also be made possible by the availability of generic lenses, frames and other goods at a cost that is affordable for the NHI. The separation of goods and services is not recommended by the SAOA. This is due to the high variability of products supplied that are custom made per patient and can thus not be easily swapped from one user to the next. This can also complicate practitioner accountability in view of the implications of the Consumer Protection Act. As much of the existing supply chain should be utilised under the NHI and stricter BEE compliance mechanisms should be put in place to prevent the continued domination of white companies of this industry space still not transforming to BEE ideals.
- f. The remuneration of optometrists employed within the public sector has equated optometrists to technicians which resulted in payments that prevent reasonable practitioner migration to the public sector. The SAOA is of the view that the public sector remuneration scales for optometrists should be reviewed. More posts for optometrists should be available in the public sector and not only in Limpopo. The career ladder and vertical progression possibilities for optometrists should be just as attractive as it is for other health professionals.

4. Conclusion

The SAOA is committed to the NHI and is available for further consultation with the DOH on any aspect of the detailed proposal. An effort has been made to summarize the contents of the submission as accurately as possible in this short version. There are already processes in place for professional coding, quality assurance, education and other areas where our contribution can improve the state of readiness of the profession to function very efficiently with other professions under the NHI. The association is preparing the profession to engage very constructively with the National Department of Health to prepare for the implementation of the NHI. There is willingness and capability given the support of the NHI to develop and implement some of the requirements ahead of the full roll-out of the NHI. We are willing to make the transition smooth and minimize the shocks to the current model when the NHI is finally fully implemented.

The SAOA trusts that the NDOH finds these inputs valuable and constructive.

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"Everywhere, blind people live difficult lives. But in Africa, where social support services are non-existent, blindness and extremely low vision, first and foremost, spell humiliation. Begging becomes the only way for those affected to survive"

Dr Ebrahim Malick Samba, WHO's Regional Director for Africa (2000)

1. INTRODUCTION

- 1.1. The services of the profession of optometry in South Africa have been offered mainly by the private sector and non-governmental organizations outside the health care system mainly in commercial settings such as shopping malls (Maharaj, Dabideen, Naidoo and Ramson, 2011: 62-63). This is a historical result of viewing optometry as an optical/technical profession that offered visual aids without the responsibility of contributing to the overall health and wellness of the public (Kriel, 2003:3). This latter responsibility was largely seen as the domain of the medical profession as represented by the profession of ophthalmology and documented around the world in legal battles that were not focussed on patient needs but professional turf battles (Taylor, 2001)
- 1.2. Under the system of apartheid, restricting optometry to private providers catered for the needs of the privileged minority population who could afford out of pocket payments for optometry goods and service (Kriel, 2003:3). At the same time, the number of ophthalmologists was inadequate for the entire population; it was adequate to cater for the needs of the privileged minority. Many South Africans were denied the benefits of eye care services resulting in the dual burden of preventable refractive and pathological blindness. Whilst this lack of access was not immediately fatal, it had devastating social, economic and educational consequences. According to Maharaj et al (2011:62), the global economy loses 270 billion dollars annually in productivity due to uncorrected refractive errors and uncorrected errors of vision result in serious learning impediments.
- 1.3. Access and affordability of services are not the only important factors to the utilization of eye care services. There are other considerations such as level of educations, social class, gender, age, race, need and psychosocial factors which underpin usage (Ntsoane & Oduntan, 2010:189). The majority of South Africans were therefore disadvantaged not only in terms of legislation at the time but all the other cited compounding factors.
- 1.4. The introduction of the Primary Health Care approach by the democratic government post-1994 confirmed health care as a right (RSA Constitution, 1996). The principles of accessibility, affordability, acceptability and relevance proved to be massive hurdles to the profession of optometry to overcome. This has been shown by the different levels of implementation of optometry services integration into the public health system (Maharaj et al, 2011:63). The following impacts continue to manifest in the profession of optometry

with important implications for the envisaged National Health Insurance system.

- 1.4.1. The scope of practice of optometry is limited by amongst other factors a lack of access to public health facilities for experiential clinical training. The practice of optometry is further limited by the non-remuneration of professional of the scope of optometry such as diagnostic procedures which have traditionally fell in the domain of ophthalmology. International experience has shown that non-remuneration of professional services tends to limit professional acts to only those that get remunerated (Barnard, 2008) This makes optometry services inappropriate for the burden of disease, unaffordable for the masses in its present form and inaccessible to the majority through its confinement to shopping centres and malls. The remuneration restriction on what is considered acts within the scope of the profession of ophthalmology despite the expanded scope of the profession of optometry (Tshabalala-Msimang, 2006; GG29174) needs to be reviewed under the NHI.
- 1.4.2. The high cost of optical goods is a result of non-remuneration for professional acts leading practitioners to find the means of meeting the high costs of operating from commercial facilities. The goods peddling corner-shop mentality for fashionable optical goods remain the predominant form of professional practice with untold damage to clinical practice norms and standards. This explains the advent of franchising and other forms of business models that are unique to the profession. The healthcare responsibilities of the profession have been muted whilst reinforcing the commoditization of clinical practice for profit maximization (Morgan, 2008) It has yet to be shown how franchising has benefitted the clinical side of the professions against the professional networks or group practices.
- 1.4.3. The profession remains an undergraduate qualification without any post-graduate clinical training for vertical progression (Kriel, 2003). The commercial nature of the profession has resulted in aggressive drives for lay ownership of optometry practices. This can be seen with corporate groups preferring deregulation and multinational companies who pursue agendas in foreign countries different to their own countries. No clinical development is supported by corporate owners if it does not result in the sale of an optical appliance (Kokkinakis, 2011)
- 1.5. The case for a franchise business model under the NHI and the changing face of ethical regulations such as the ban on the use of practice names makes this model difficult to imagine under the NHI. Whilst many practitioners find

comfort in the security provided by belonging to such a corporate structure, it would appear that some adjustment may be necessary for operating under the NHI. The Office of Standards Compliance may well impose other regulations on this business model that would result in fundamental changes to corporate ownership.

- 1.6. The benefits of each business model can best be assessed on its own merits and against accepted quality standards as to whether or not they fall within or outside of expected norms.
- 1.7. The South African Optical Industry like other industries is largely white owned. There are no visible attempts to comply with BEE regulations which may pose a serious challenge especially with the new 2012 BEE requirements. The industry is geared to cater for a restricted market of those who can pay and whether there will be sufficient capacity under the NHI remains to be seen.
- 1.8. Procurement under the NHI should address black economic empowerment ideals. If owners of current in-practice laboratories and stand alone laboratories are excluded from the supply chain system, some critical balance may be lost in procurement. By overlooking these objectives, the NHI may benefit only those who are already enjoying economic surpluses accrued from a race based advantage of the apartheid era.

2. PROBLEM STATEMENTS

- 2.1. The public health system has functioned without optometry services in the main. This has resulted in a lack of systems for procurement for a mass market, industry productive capacity limitations, no clinical service packages, poor access to technology, variable job profiling and career progression within the public health system. The number of optometrists employed in the public sector averages 150 professionals with most of them in the Limpopo province. The total number of practicing optometrists is about 2500 resulting in less than 3% of optometrists in the public sector (Maharaj et al, 2011:63)
- 2.2. The standards of optometry care vary enormously from practice to practice. The Professional Board for Optometry and Dispensing Opticians (PBODO) has minimum standards of care but there is no capacity or systems to monitor and ensure compliance. There is also significant variability in the skills of qualifying graduates. This has led to the HPCSA considering the introduction

of a national board examination after a year of community service (HPCSA; 2008) There is therefore no guarantee of the type of service that the public can expect from one professional to the next. It is against this background that the professional association proposes the introduction of an accreditation system for optometry and the industry in preparation for the NHI.

- 2.3. The scope of the profession has undergone changes under the democratic government. This was aimed at addressing the human resource challenges in order to make eye care available to the majority of the population (RSA 1997). Health care funders do not remunerate the full scope of professional acts which limits practitioners from exercising their rights to practice the full scope of the profession.
- 2.4. Post graduate clinical training and development of the profession has been limited by the parachuting of international experts for short courses which are skills based and not necessarily qualification based. The absence of supervised training platforms within the public sector has also added to the challenges of post graduate training. Most optometrists with formal clinical post graduate training have obtained such qualification by training overseas and at prohibitive costs. This group of optometrists with post graduate training are very few; in fact they may not exceed ten in number.
- 2.5. There are clinical areas of possible specialization which are not receiving attention such as low vision, paediatric vision, binocular vision and occupational vision amongst others (Ntsoane & Oduntan, 2011:). This has resulted in gross under servicing of large sections of the population requiring these services with long term negative consequences limiting many people to a life of disability when care could have reduced dependence on the state for survival.

3. THE BURDEN OF DISEASE

- 3.1. South Africa's burden of disease is on average four times larger than that of developed countries, and in most instances almost double that of developing countries (Econex, 2009/2)
- 3.2. There were about 153million people impaired due to refractive error additionally, 410 million people are prevented from doing near tasks. About 25% of people over 40 years require a spectacle correction and 40% of those

above 20years require visual correction. (Crosby, 2008). The number of visually impaired people globally is 314 million (Maharaj et al, 2011:63)

- 3.3. Refractive errors make up a large portion of the burden of disease (Maharaj et al, 2011:62) and they are the leading cause of refractive blindness in developing countries (WHO,2000). There are other functional disorders of the visual system that can coexist with or without refractive errors. These are disorders of accommodation, motor functions or a combination of both accommodative and motor functions of the eyes.
- 3.4. The greatest impact of there can be seen at an occupational level and could determine the educational or occupational outcomes of those afflicted. No statistics are available on the prevalence of these conditions in South Africa due to limitations in the research capacity and associated funding within industry.
- 3.5. Pathological conditions also make up an important cause of preventable blindness. Amongst this group, cataracts remain the leading cause of pathological blindness as well as conditions such as glaucoma, trachoma, onchocerciasis, diabetic retinopathy amongst others. Due to limitations in the number of eye care medical specialists for the majority of the population, optometrists by virtue of their numbers are an important resource that can be used through targeted task shifting and precedent training to improve access to eye care. This was already envisaged by the White Paper for the Transformation of the Health System in South Africa (Dlamini-Zuma: 1997).
- 3.6. Optometrists have been adequately trained to manage the burden of disease however; the lack of access to clinical training platforms within the public health sector has impacted negatively on the requisite skills. This peripheral role of optometry has affected access to eye care and compounded the burden of disease with devastating consequences for the poor. The exclusion of optometry from the main stream healthcare system is a known international trend which has not backed by any scientific evidence in terms of how it benefits the health care system. (Challenor, 1978:325). On the contrary the reverse has been proven time and time again.

4. OPTOMETRY EDUCATIONAL CHALLENGES

- 4.1. There are numerous clinical conditions of an acute and chronic nature which impact on visual functions such upper respiratory tract infections, paranasal

sinuses and ear infections. There are other systemic conditions such as HIV and AIDS infections, Tuberculosis and Sexually Transmitted Infections which are common within our health system. An understanding of the relationships of these conditions whether direct or indirect to the visual and ocular system by optometrists is vital for the provision of a high standard of overall clinical care. Such an understanding can increase the number of referrals to other health professional to manage or co-manage these conditions and prevent suboptimal case finding competence in the new system.

- 4.2. The downplayed but compromised clinical effectiveness in optometry and ophthalmology has impacted negatively on occupational and educational competence of many poor people. Vision in South Africa ranks as the second highest cause of disabilities after movement disabilities (HST, 2003:168). This has untold negative social and economic impacts across the population. The failure to aggressively pursue the involvement of optometrists manifests in suboptimal care. This leads to occupational injuries with permanent total or partial disability, fatal consequences from trauma or other misdiagnosed medical emergencies such as undiagnosed diabetes and precursors of strokes. This lack of efficiency and effectiveness in eye care has serious economic consequences especially for a developing country who resources have many competing priorities. The seriousness of the economic consequences has already been explained above. (Maharaj et al, 2011, 63).
- 4.3. The above statements can create an impression that optometrists have substandard training for the professional acts they are obliged to perform. On the contrary, there are international studies which confirm the competence of optometry training. The post operative management of cataract patients was found to be on par with that of medical specialists in separate studies in the USA (1996) and Britain (1994). Another study in Britain (2000) concluded that post operative cataract patients without complications can be referred to optometric management after day 1 (Webb, 2008:1)
- 4.4. The Royal College of Ophthalmology guidelines for cataract surgery recommends a day1 post cataract surgery follow up which can be provided by an ophthalmologist, optometrist or ophthalmic nurse (Webb, 2008:1). This supports the assertion that given an appropriate training platform, optometrist can contribute more to the health system than is currently the case. It has been recognized that the training of doctors/ophthalmologists in not any easier than the training of optometrists (Taylor, 2001:769).

- 4.5. Whilst the optometrist is not the last provider of services in this regard, they can constitute an important link for the public to access ophthalmological and other specialist medical services in urban, peri-urban and rural areas if afforded appropriate patient contact platforms within the public sector with strategic collaboration with ophthalmology and nursing.
- 4.6. The introduction of community service for optometrists has been on the cards for a while. Due to other competing priorities and pressures on provincial and national budgets, community service by optometry has been delayed. The reasons have not only been around personnel budgets for optometry but the capital costs involved with structural requirements, procurement, distribution and dispensing of optical goods.
- 4.7. There are only 120 dispensing opticians in the country. This has very serious implications on accessibility and training for additional personnel. The number of required optometrists and dispensing opticians is provided in a separate annexure. In addition, many optical goods are not on the list of procurable items within the public sector which further denies patients access to services such as prosthetic eyes, contact lenses and low vision aides.

5. OPTOMETRY IN THE HEALTH CARE SYSTEM

- 5.1. Optometry is a primary health care profession which is practised differently internationally according to the politics of that specific country between the medical profession and optometry (Grit, 2010). Where the medical profession reigns supreme, optometry is practiced in its rudimentary form. Optical technicians/dispensers make spectacles from prescriptions received from ophthalmologists or auto-refractors used by trained and lay persons. There are different levels of optometry practice recognised by the World Council of Optometry (WCO) as shown in the table below.
- 5.2. The development of optometry in South Africa within the health system was delayed by professional politics. In 1938, British Optometrists were granted authority by the Courts to use drugs in the examination of eyes (Barnard 2008). In South Africa, this same development started late in the 1990's and properly legislated after 2005 (HPCSA, 2007)

5.3. Despite numerous outcries, optometrists have been using both diagnostic and therapeutic drugs in the UK, which compares favourably in training with South Africa without any adverse incidents being reported from 1968 to the Fitness to Practice Disciplinary Committee (Barnard, 2008). No cases have been reported to the Professional Conduct Committee of the Health Professions Council of South Africa after the change in legislation which gave therapeutic diagnostic privileges to South African Optometry. (HPCSA: 2010)

Scope of profession	Dispensing	Refraction Prescription Dispensing	Refraction Prescription Dispensing Screening for Eye Diseases	Refraction Prescription Dispensing Diagnosis of Eye Diseases	Refraction Prescription Dispensing Diagnosis and Treatment of Eye Disease
Designation	Dispensing Optician	Refracting Optician	Optometrist	Optometrist	Doctor of Optometry
Countries	Turkey	Belgium France Iceland Italy	Austria Czech Republic Denmark Germany Spain Switzerland	Finland Ireland Norway Netherlands South Africa Sweden?	Australia Canada New Zealand Nigeria UK USA
Levels of Care	Level 0	Level 1	Level 2	Level 3	Level 4

Adaptation of diagram by Feike Grit (2010) WCO Document October 2011 GB Item 18.1

5.4. The South African situation with a history of social and economic deprivation is suited for level 4 practices in terms of the table above. This will assist with increasing access and reducing costs to the National Health Insurance system through early interventions. Vision 2020, which is a WHO programme to combat preventable blindness, first listed its major priorities as cataracts, trachoma, onchocerciasis, childhood blindness, refractive error and low vision (WHO/2000).

5.5. Recently uncorrected refractive error was recognised as an important cause of functional blindness. This was due to landmark population based studies in adults, children and post-cataract patients (Holden & Reskinoff, 2002; 33 – 36)

- 5.6. Optometry has made some in-roads into the public health system and is just receiving recognition as a scarce skill in South Africa. The profession was still not recognised as a key healthcare provider as early as 2003/04 (HST, 2004: 305). With the four-fold burden of disease in South Africa, the case for the continued exclusion of optometry from the mainstream healthcare system is very weak. The WHO in recognizing blindness as a major public health problem confirms the disproportionate burden of Africa where 60% of blindness in developing countries is found mostly in Sub-Saharan Africa (WHO/2000).
- 5.7. There is irrefutable proof from studies in the USA, UK, Australia and New Zealand that optometry has a significant role in the healthcare system where political will has been demonstrated. Legislation has risen above professional concerns and put patient care at the central focal point. (Reid, 2010: 1 – 7; Taylor, 2001: 769; Cohen et al, 1986:431)

6. OPTOMETRY IN THE PUBLIC SECTOR UNDER THE NHI

- 6.1. The following submission refers to optometrists employed within the public health system or those optometrists that provide services within the public health system as part-time employees of the state.
- 6.2. The SAOA supports the notion that the nursing profession should be involved with screening for visual and ocular disorders at school and clinic levels. This team can include dispensing opticians however; the number of available opticians makes this option non-viable for the public health sector.
- 6.3. There is a need to set an eye test schedule from infancy to adulthood. This is very important in the developmental and preschool years where problems can be detected early and treated accordingly. According to Maharaj et al (2011:62) the Hall Report in Britain recommends screening at 21 months, 39 months and then at 5, 8 and 11 years.
- 6.4. Optometrists should be available in designated PHC facilities such as the clinics, community health centres and district hospitals. Nurses refer patients for refraction, dispensing and the co-management of common eye conditions such as allergies, bacterial infections and other functional visual conditions.
- 6.5. Optometrists can screen for other conditions such as diabetes, hypertension, and refer suspected cases of TB, STI's and other public health problems

such as obesity to other health professionals within the DHS. International studies confirm that optometrists are better positioned to screen for conditions such as diabetes and glaucoma, and diagnose associated ocular and non-ocular risks and complications (Barnes et al, 2005:575 – 579; Ewbank, 1997:100 – 101) Optometrists as PHC providers are an important source of referral within the DHS.

- 6.6. Optometrists can operate with ophthalmologists at DHS level II services. At regional hospital level, optometrists can sort referrals requiring further optometric care such as contact lenses, orthoptics and low vision care. Follow up of patients under ophthalmologic care requiring routine measurements such as IOP, visual fields and other measurements can be handled competently by an optometrist. Such patients can be managed by an appropriately trained optometrist or referred to ophthalmology for further management. Such relationships have been proven to have enormous benefits to eye care services in international studies (Cohen et al, 1986: 429 – 432; Riise, Arnestad & Saestrom, 2000: 2113-4; Barnes et al, 2005: 575 – 9).
- 6.7. The advantage of this approach is the release of scarce ophthalmology personnel from routine screening of referrals and PHC cases that should have been managed at lower levels within the DHS. Ophthalmologists can spend more time in theatre and managing medical cases instead of conducting routine measurements that optometrists are competent to perform.
- 6.8. In rural areas where no ophthalmologists are present, inducted optometrists can practice the profession at WCO level 4 according to the table provided above. Any expanded scope privileges for optometrists must be preceded by training and supervision, as well as the needs of the local population (Kriel, 2003, Wett and Sorimatti, 2011).

7. ROLE OF PRIVATE OPTOMETRISTS UNDER THE NHI

- 7.1. Optometrists can form group practices or solo practices. These optometrists will undergo an accreditation process that is addressed later in this document. The group is accredited singly or in combination with other health professionals in a one-stop service type of arrangement. This accreditation is necessitated by need to support clinical care and to detect and act against poor clinical performance (Wood, 2006:1)

- 7.2. A similar type of accreditation will be applied to solo practitioners and these will be registered under the NHI as providers if they meet the criteria. Patients visit these preapproved practitioners at their professional practices and offer packages of care according to contracts concluded with the NHI scheme. The same accreditation standards will also apply to facilities within the public health sector.
- 7.3. Depending on the location of these services and proximity to other health facilities, the packages of care provided will be customised according to relevance of the needs of the local population. All practitioners will provide services within the confines of the District Health System according to the relevant levels of care. Location differences between practitioners should be incentivised in favour of the more rural providers to ensure the redistribution of professionals towards the needy areas.

8. SUBMISSION ON QUALITY ASSURANCE OF OPTOMETRIC CARE

- 8.1. The SAOA proposes the establishment of an Optometric Clinical Standards Accreditation Council in preparation for services under the NHI. The council must comprise of members of the profession, related health professionals, community representatives and representatives from the NHI and DOH and other relevant statutory bodies such as the MCC.
- 8.2. The SAOA accepts the principles and support quality assurance, improvement and accreditation in health care and optometry in particular. The SAOA will develop a system that is aligned with accepted norms by the WHO, ISQua, and NDoH. The system developed can be progressively modified with the Office of Standards Compliance (OSC) over the implementation period of the NHI to its full development and incorporation by the OSC.
- 8.3. An accreditation system for optometry clinical quality assurance does not exist in South Africa. Given the variability in services as indicated in the submission above, the council will standardise clinical protocols and ensure adherence of members to desired quality norms and standards for practising members of the profession (Wett & Sorimatti, 2011)
- 8.4. The system will comprise a self-review stage as the initial stage. The second stage will comprise a self-review validation process by a selected group of peers who will investigate the different quality domains, the associated standards and specific quality measures. Domains refer to groups of

standards pertaining to a broad group of public health services whilst standards are the required level of achievement that providers are expected to meet. Measures refer to the parameters used to assess standards (PHAB, 2011:2)

- 8.5. The quality clinical care domains for assessment may comprise the following:
- 8.5.1. Practice Administration Systems
 - 8.5.2. Internal Quality Assurance Systems
 - 8.5.3. Batho Pele Compliance
 - 8.5.4. Packages of Care and Clinical Protocols
 - 8.5.5. Practice Location, Facilities and Technology
 - 8.5.6. Patient Records
 - 8.5.7. Public Health Information
 - 8.5.8. Continued Professional Development.
- 8.6. The results of the above quality assurance process will entitle practitioners to an accredited or non-accredited provider status. A process to develop or rehabilitate practitioners to meet the accreditation standards will be available at practitioner's cost for the next round of accreditation.
- 8.7. Accreditation can be self-funding by practitioners paying the fees for the accreditation process on a cost recovery basis. The professional association aims to complete this quality assurance mechanism and implement prior to the NHI. A partnership with the Office of Standards Compliance (OSC) or a delegated mandate to perform this function will be welcomed by the professional association in preparation for its adoption by the NHI.

9. MEETING THE PRINCIPLES OF THE NHI

9.1. Right to Access:

- 9.1.1. To make optometry accessible without crowding available public health facilities, and to reduce the initial set up costs of optometry services and the procurement of products and related logistics, the SAOA believes that accredited private providers have a significant role to play with specific conditions.
- 9.1.2. Providers should be accredited according to areas of need in order to ensure an equitable distribution of personnel. The SAOA submits that an incentive-based model would assist to resolve provider concentration in major towns

and cities. Under the NHI practitioners should have the right to choose between available localities for accreditation according to needs and a non-accredited status according to their will. The non-accreditation status will have negative consequences for remuneration under the NHI.

9.1.3. Where local public facilities are equipped to provide the services, private providers could render services within the public health facility or in different circumstances, the public could access the accredited provider from their own premises. Practitioners operating within the public health system should be remunerated a fee commensurate to the services offered and the scarcity of skills should be taken into account. Optometrists within the public sector are remunerated like technicians instead of a scarce skill that it is.

9.2. Effectiveness:

9.2.1. The profession of optometry can contribute to an effective eye care service through case finding and early intervention strategies. This would imply a system where children entering development education are tested for possible refractive and other functional problems.

9.2.2. Each milestone of the education career should have visual examination conducted in order prevent some learning difficulties associated with visual dysfunction. Cases of amblyopia or subnormal vision can be managed by optometrists with an interest in paediatric optometry early on prior to entering school and where there are underlying medical causes, patients can be referred timeously.

9.2.3. With appropriate integration into the health system, the multi-disciplinary team comprising ophthalmologists, optometrists and nurses can contribute to combating the overall burden of disease through case finding using appropriate screening methods. The education of the public by optometrists on healthy lifestyles should be included as a public health obligation in order to contribute to combating drug abuse, teenage pregnancy and other public health ills for which optometrists currently feel distant.

9.3. Appropriateness:

9.3.1. The full scope of professional services by optometrists should be recognised under the NHI for remuneration. This includes visual rehabilitation services, orthoptics, non surgical management of strabismus and pre and post surgical rehabilitation of patients.

9.3.2. It is important to note in countries where optometry has privileges to diagnose and treat; only 25% in the UK and Australia are involved with that form of practice according to patient needs. The sudden mass usage of pharmacological agents in South Africa is thus also highly unlikely since education and training will precede the expanded scope. The remuneration of professional services will also encourage professionalism and reduce dependence on the provision of goods.

9.4. Affordability

9.4.1. The remuneration of the full scope of optometry will prevent the recovery of costs by loading the costs of optical products. The non-remuneration of optometry professional services has led to the artificial high costs of optical products in the form of spectacles, branded frames and lenses. The SAOA is currently in negotiation with suppliers of ophthalmic lenses and frames to make available high quality generic lenses, frames and contact lenses to enable to NHI to cater for the needs of a larger population. Such a cost reduction will be compensated by increase in the volume of patients.

9.4.2. By innovative adaptation to the use of optometry services, costs of health care provision can be contained by appropriate timely referrals, reduced productive losses from absenteeism, transport costs and the complications of delayed treatment. The elimination of middleman services and direct dealings with practitioners can also help to contain costs.

9.5. Equity:

9.5.1. The standardization of optometry packages of care together with a needs based accreditation process will ensure that an equitable service is provided irrespective on the geographic location where the public receives the service.

9.5.2. The equity in service is however preceded by equitable training opportunities for optometrist to support a greater role within the public health system. Opportunities for experiential training within the public health system should become available on an equitable basis with other health professionals. This will ensure that eye care services under the NHI benefit the majority of the population and not only those with geographic advantages that offer proximity to scarce specialist services.

10. OPTOMETRY IN THE DISTRICT HEALTH TEAM

- 10.1. The SAOA believes that the preventative nature of services required under the NHI means that the optometrists must become part of district health teams in order to ensure that optometric care is available and integrated into the district health system.
- 10.2. This implies that the district health teams headed by any health professional to lead school health services should have options to refer patients to optometrists present within the district. These optometrists can be positioned at community health care centres to ensure that different municipal wards have access to an optometrist within the public health referral system. Such optometrists will render agreed packages of care that are commensurate with the needs of the target population up to grade 12 and beyond.
- 10.3. Access to an optometrist within the district is important for the numerous diabetic patients who currently have no access to an eye care practitioner with the technology to make diagnosis of the presence or absence of retinopathy which could lead to serious complications. The role of optometrists in the general health care system has already been explained in preceding discussions.
- 10.4. A different package of care for hospital based optometrists will be formulated based on evidence in other countries. The optometrist working closest to the ophthalmologists will have different needs and skills to ensure effective cooperation and organization of workflow streams.

11. OPTOMETRIC CARE CODING SYSTEMS AND REIMBURSEMENT

- 11.1. The South African Optometric Association has been involved with the designing and formulation of coding systems for more than 20 years. These codes have been used by the optometric industry to claim for services rendered and products supplied as well as the health funders to link professional services and products. Some of these codes have been given to fellow professionals such as ophthalmology to facilitate their remuneration by health funders.
- 11.2. New codes are constantly being developed and all the professional services that are not being remunerated by health funders are having codes developed for them. This will allow for motivations to be submitted for a payment model that is fair and cost effective.
- 11.3. All products supplied in the industry are also coded, which includes both generic and branded products from different suppliers. The Association is

currently working on standardizing the linkages of ICD-10 codes and the optometric services and product codes in order to meet public health information requirements of the NHI.

- 11.4. The SAOA can contribute immensely to the establishment of the coding system under the NHI. Depending on the requirements, some modifications can be made to existing systems to comply with the demands of the NHI without any financial motives.

12. PAYMENT OF PROVIDERS UNDER THE NHI

- 12.1. The SAOA strongly believes that the remuneration of optometrists under the NHI should be customised according to the packages and levels of care as well as the geographic location of providers.
- 12.2. At the primary health care level, private providers should be remunerated a consultation fee which takes into account the skills, technology and costs that practitioners incur in the process of providing services to NHI beneficiaries from their own premises. A capitation system for a registered section of the population should take into account the population dynamics and burden of disease in the area. These population dynamics will dictate the number of accredited providers desired per area.
- 12.3. In specific instances and according to the accreditation system, providers could be remunerated according to procedures or an intervention based model which is linked to the level of care and facilities within which the provider is operating. Where specialist services are in great need and more is required from providers to cater for population needs, the remuneration packages have to be adjusted accordingly.
- 12.4. Where providers offer services to the public within state facilities, the remuneration of practitioners should be reconsidered for upgrading because of the professional demand placed on optometrists and the scarcity of the skill within the public health sector. This will help to attract providers to the public service, especially when linked to a clear career path and progression within the public sector.

13. COPAYMENTS FOR OPTOMETRY SERVICES UNDER THE NHI

- 13.1. The SAOA acknowledges the inextricable link between the provision of optometry services and the right of individuals to look and feel good about themselves. This is a psychosocial need that is recognised as an important part of health care. The WHO defines health not only the absence of disease but also the absence of other compounded factors amongst which is psychological wellbeing (WHO/ 1978).
- 13.2. This implies that users of the NHI may wish to upgrade the generic products provided to branded products which can be sourced from accredited or non-accredited providers according to their ability to make out-of-pocket payments.
- 13.3. The SAOA submits that private sector optometrists have a vital role to play in addressing the needs of those members of the population who wish to exercise their rights to a particular look that suites their psychological profile. (Ntsoane & Oduntan, 2011:62) The satisfaction of these psychosocial needs can be guided by professionals but cannot be dictated to the user.
- 13.4. The SAOA submits that members of the population can address these psychosocial needs by accessing products not provided for within the pool of generic products of the NHI, by making co-payments in addition to the limited amount that the NHI system would cater for under capitation or non-accredited providers.

14. SEPARATION OF OPTOMETRIC SERVICES FROM THE PROVISION OF OPTICAL GOODS

- 14.1. Whilst the separation of goods and services has been successful in other health professions to manage perverse incentives, there are challenges of accountability and responsibility in optometry if the final product supplied to the recipient does not perform according to expectations.
- 14.2. The products are made to order by the suppliers. Two problems can arise with the recipient which are that;
 - 14.2.1. The order could be erroneous due to practitioner failures or,
 - 14.2.2. The final product could be erroneous due to dispensing problems.
- 14.3. Therefore, unlike pharmaceutical products that are standard from person to person which makes it possible to separate the prescriber and the dispenser,

the product performance variability in optometry can be a result of the prescriber or the dispenser. The challenge of separating the two value chain activities is the dichotomy of which provider takes the responsibility for service failure. Is it the dispenser or the prescriber? The SAOA submits that one area of accountability will resolve any possible challenges in this regard. The implications of the NCPA should be taken into account with such a divided system

- 14.4. This matter can be more complex with contact lenses where several trial lenses may be used prior to a final order. Even after the final order, adjustments may be necessary on the part of the prescriber which can undermine the role of the prescriber if that dispenser is not linked with the prescriber.
- 14.5. There are many providers who have in-house laboratories who can be disadvantaged by this separation. This can also disadvantage service users who may be residing in areas far from laboratories and an abundance of practitioners.
- 14.6. There should also be an accreditation of goods provided within the service. This will ensure that that the standards of goods do not vary to the extent of disadvantaging users.
- 14.7. The SAOA therefore submits that the services and products should not be separated unless both the dispenser and prescriber are within the same practice. Even then, the limitation is that there are much fewer optical dispensers compared to optometrists. If optometrists were to select dispensing this would reduce the number of existing optometrists. Therefore such a system would contribute to the depletion of an already restricted number of optometrists.

15. INTERGRATING OPTOMETRIC SERVICES INTO THE NATIONAL HEALTH SYSTEM

- 15.1. The integration of optometry services into the National Health System has already begun in provinces such as Limpopo, Free State, Eastern Cape, KwaZulu-Natal, with the Limpopo leading the group by the number of employed optometrists and coverage of the service.
- 15.2. One of the biggest challenges of the health system, which is not unique to optometry services is the procurement of goods and technology. Unlike pharmaceutical agents, the unit variability in optometry is very high making the

transfer of unit between recipients limited if the principle of clear comfortable vision is to be followed to the letter. This differs from pharmaceutical agents that are manufactured to identical specifications per product line.

- 15.3. It can be argued that the extent to which goods can be supplied could be standardized and materials manufactured in bulk to fixed specifications and a selection or the nearest appropriate unit is supplied to the service recipient. There is no danger to the visual system when using such an approach. It however defeats the purpose of clear comfortable vision, without which the efficiency of the visual system deteriorates progressively and without set predictability. A small error for one patient could result in significant compromise of visual efficiency when another person with a large error could wander about undeterred due to compensatory reserves.
- 15.4. The implications of exposure of many optometrists to the public health system have already been discussed. Without belabouring the point, familiarization to referral protocols, clinical protocols and co-management approaches requires some preparation for many private sector optometrists. An induction programme for optometrists into the health system is necessary to entrench the use of clinical protocols, referral systems, norms and standards as well as the range of clinical presentations which differs from the shopping mall profile of patients who can afford the corner-shop services.
- 15.5. This skills variability is further exacerbated by the highly varied conditions from training institution to institution. There are institutions with limited access to the public system and the trainees are prepared differently. There are others with access to public sector clinics which results in a different calibre of optometry clinician. It would thus be important to narrow this gap arising from historical imbalances.
- 15.6. Critical to the success of an effective eye care system, is the unavoidable task shifting process that must take place between the related professionals. As it has been explained earlier in this document, optometrist with the appropriate support of ophthalmologists could perform many tasks which ophthalmologists are currently performing resulting in operational inefficiencies. In the same breadth, optometrists can also shift certain tasks such as vision screening to other categories.
- 15.7. Routine follow up patients requiring maintenance treatment can be referred to optometrists for follow up. These patients can be referred back if there is a need for treatment regimen changes or other complications arising from time to time. The current task allocation is proving inefficient with the current

patient volumes as evident in the extended waiting lists. A fivefold increase in patient numbers will spell disaster for eye care if task shifting, personnel redistribution and operations remodelling is not considered.

- 15.8. The training and induction of optometrist, task shifting and closer collaboration with nursing and ophthalmology requires the participation of the entire team to revise both the training and clinical protocols. Discussion between the professional associations of optometry and ophthalmology has been initiated, a task team is in place and education, training and access to hospital facilities for supervised rotations is receiving attention.

16. OPTOMETRY HUMAN RESOURCES: (Quantitative and Qualitative Analysis)

- 16.1. The current number of practising optometrists is estimated at 2300 in total. The association will conduct a survey in 2012 to confirm scientifically these figures. The SAOA estimates the number of optometrist requirements on the following assumptions.

- 16.1.1.1. A population estimated at 50million registered South Africans.
- 16.1.1.2. Estimated population usage of 1.3 consultations annually taking into account the burden of disease and access issues.
- 16.1.1.3. Percentage of consulting population is 40%
- 16.1.1.4. No limits on the number of consultations per annum.
- 16.1.1.5. Usage rate balances out the percentage of non-consulting population per annum population growth and natural attrition amongst optometrists.
- 16.1.1.6. An average consultation period of 30minutes.

a) Consulting Population: 25 million per annum

= 50 million total population X 0.40 consulting population

= 25 000 000 of total population p.a.

b) Consultation Weeks: 46 weeks

= 52 weeks – 2weeks public holidays – 4weeks normal leave

= 46 weeks

c) Consultations per Week: 434 782.6

= 25 000 000 population/46 consultation weeks

= 543 478 Consultations

d) Usage Rate Based Consultation per week: 706 521.8

= (Consultations per week X usage rate) /2years

= (543 478.3 X 1.3)/1 years

= 706 521.8 Consultations weekly

e) Optometry Work Rate: 2 Consultations/hr

= 1 Hour / Consultation time

= 60minutes/30 minutes per consultation

= 2 Consultations per hour

f) Consultations per 40 Hour Week: 80 Weekly Consultations per Optometrist

= Work Rate X Week

= 2 X 40 = 80 Consultations weekly per Optometrist.

g) Number of Optometrists Required: 8 831

= Consultations per Week/Consultations per optometrist

= 706 521.8 Consultations per week/80 Weekly consultations per Optometrist

= 8 831 Optometrists Required.

16.2. We expect a single dispensing optician to serve about 4 optometrists with their daily workload very effectively. We thus extrapolate from the above calculations based that the number of required dispensers is $8831/4 = 2208$ dispensers. This assumption is based on dispensers not getting involved in other work such as screening and limited refractions. A different optical dispenser requirement would be calculated with these additional tasks. This omission is done for ease of estimation.

16.3. The optometry and dispensing human resource challenges will remain with the country for some time. Not all qualified optometrists go into clinical practice and the attrition rate is also compounded when the childhood bearing years of the young population is taken into account. Given the current output rate of 120 optometry graduates, the deficit of about 5000 optometrists cannot be addressed in the near future. To address the deficit in 10 years, an output of 500 qualifying students will have to be met in the near term.

16.4. The SAOA confirms that given the output challenges of training, the burden of disease and possible increase in access, there is a need to manipulate more than just the numerical component. . The proposed further clinical training as well as task shifting is an important aspect to be considered together with streamlining work processes at facility level.

- 16.5. The training of optical dispensers is taking place in one institution which produces about 30 graduates annually. With the conservative estimate of 2208 dispensers, it will take about 73 years at the present output rates to reach the conservative target. The training of optical dispensers should receive priority if a meaningful role is to be made possible under the NHI.

17. CONCLUSION

- 17.1. The SAOA welcomes the NHI initiative as a necessary intervention to address the needs of the majority of the population. Through this submission, the SAOA has limited itself to addressing professional concerns of a historic and structural nature. There are numerous technical and quality issues to be considered and detailed. We believe that the Association can make positive contributions towards formulating and piloting their usage prior to adoption in the NHI system.
- 17.2. We are not unaware of the little impact that the BEE initiative and preferential procurement has had in this insulated industry. We firmly believe that these matters will be addressed when procurement considerations are focussed on as the operational model details are tabled.
- 17.3. There are education and training issues of importance as we have demonstrated in the human resource exercise above. We submit that the training platform should accommodate the majority of practitioners in practice. Other solutions are needed for the challenges of undergraduate training.
- 17.4. We are putting systems and solutions in place with immediate effect to ensure that the incorporation of optometry into the broader health system is less challenging. This will be done by ensuring that the profession conforms to norms and standards that are commensurate with expectations under NHI system. In this interim phase, we believe that a partnership needs to be forged with the National Department of Health around the introduction of an accreditation system for professionals. This is the system that the NHI can incorporate or mandate the association to assist in its implementation, together with other stakeholders.
- 17.5. We are prepared to engage in further discussions and consultations with the Department of Health on any aspect of this submission. We trust that our input will receive particular attention given the hitherto peripheral existence of optometry in relation to the entire health system.

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