EVALUATION REPORT

The Victorian Aboriginal Spectacles Subsidy Scheme

July 2012
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation</td>
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<tr>
<td>ACO</td>
<td>Australian College of Optometry</td>
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<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
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<td>VACKH</td>
<td>Victorian Advisory Council on Koori Health</td>
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<td>VAHS</td>
<td>Victorian Aboriginal Health Service</td>
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<td>VES</td>
<td>Victorian Eyecare Service</td>
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<tr>
<td>VOS</td>
<td>Visiting Optometrists Scheme</td>
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</tbody>
</table>
Introduction

The Victorian Aboriginal Spectacles Subsidy Scheme (the Scheme) provides subsidised visual aids (spectacles) to Aboriginal and Torres Strait Islander (Aboriginal) Victorians. It is funded by the Victorian Department of Health (DH) and delivered by the Australian College of Optometry (ACO), an organisation experienced in delivering eye care services to disadvantaged Victorians. The Scheme builds upon the infrastructure of two pre-existing programs: the State Government’s Victorian Eyecare Service (VES) and the Commonwealth Government’s Visiting Optometrists Scheme (VOS). Medicare Australia contributes funding to subsidise the cost of optometry consultations.

The Scheme was introduced in July 2010 to provide 1,800 subsidised visual aids to Aboriginal Victorians over three years. Since commencement of the Scheme, DH has approved provision of additional funding to deliver a further 1,879 subsidised visual aids to Aboriginal Victorians; 1,509 of these to be available through services in rural and regional Victoria.

Development of the Scheme was overseen by the Eye Health Subcommittee of the Victorian Advisory Council on Koori Health (the VACKH Subcommittee). At commencement of the Scheme, the VACKH Subcommittee recommended a future evaluation to assess the effects of the Scheme against its intended objectives and to understand the benefits of different models and strategies employed to deliver the Scheme. The information gathered could form the basis of future service improvement and development.

The Aboriginal Health Branch within DH identified an opportunity to resource the evaluation internally. This report presents the evaluator’s findings based on:

- A review of service delivery data available from ACO’s existing clinical data collection systems.
- Telephone interviews conducted with seven service providers (six private optometrists working in rural and regional areas and one ACO-employed optometrist).
- Analysis of patient change stories collected by ACO-employed optometrists on the anticipated benefits for patients accessing the Scheme.

The availability of service delivery data (including baseline data) is acknowledged as a key limitation of the evaluation, in particular on determining the extent to which the Scheme is achieving some of its intended outcomes such as earlier identification of vision-threatening eye disease and engaging clients who have not previously accessed services. Data is limited to a subset of providers of the Scheme, and within these only certain data items are collected.

Despite the data limitations, there is evidence of good uptake of the subsidised spectacles by eligible clients and anecdotal evidence that the Scheme is being successfully delivered to and accepted by community members. By December 2011, 1,787 visual aids had been administered through a range of service providers including ACO-operated clinics, outreach services and VOS trips as well as through a network of private optometrists in rural and regional areas. This evaluation report provides a summary of the successful strategies employed by providers to deliver the Scheme and offers some suggestions for future opportunities for the Scheme.

The evaluator acknowledges the input of key stakeholders into the evaluation, including representatives from ACO, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), the University of Melbourne and DH.
Background

The Victorian Eyecare Service (VES)

The early detection, monitoring and treatment of eye disease and other vision impairment can improve a person’s quality of life, education and employment opportunities and decrease overall medical costs. Ensuring low cost (accessible) eye care services is a key part of public health, as people experiencing financial disadvantage often experience poorer health care than the general population.

The VES commenced in 1985 to provide subsidised eye care services to people experiencing financial disadvantage. Eligibility for the VES is limited to Victorians who hold a Pensioner Concession or Health Care Card.

The VES is delivered by ACO’s Clinical Services Division in four main streams, being:

- **VES Metro** – ACO-operated clinics. The main clinic is located in Carlton and five subsidiary metropolitan clinics are co-located with community health services in Broadmeadows, Braybrook, East Preston, Doveton and Frankston. ACO also works in collaboration with Vision Australia to deliver rehabilitative services for people with permanently impaired vision.
- **VES Outreach** – a program that delivers mobile optometry services throughout metropolitan Melbourne to facilities providing homeless, aged, residential and disabled care and to other services for disadvantaged groups.
- **VES Rural** – supporting a group of private optometrists in rural and regional areas of Victoria to offer subsidised eyecare services to disadvantaged Victorians.
- **Visiting Optometrists Scheme (VOS) trips** (see below).

When the Victorian Aboriginal Spectacles Scheme was introduced in 2010, ACO identified six sites where services were already being delivered specifically to Aboriginal people (in addition to VOS trips – see below). These are:

- The Victorian Aboriginal Health Service (VAHS) (ACO-operated optometry clinic established in 1998)
- Western Suburbs Indigenous Gathering Place, Maribyrnong (Outreach)
- Bunurong Health Service, Dandenong (Outreach)
- Billabong BBQ, Collingwood (Outreach)
- Rainbow Place, St Kilda (Outreach)
- Eastern Access Community Health (Outreach with specific referrals from Mullum Mullum Indigenous Gathering Place).

The Visiting Optometrists Scheme (VOS)

VOS supports optometrists to deliver outreach optometric services to remote and very remote locations, which would not otherwise have ready access to primary eye care. It was established in 1975 and is funded through the Commonwealth Department of Health and Ageing.

VOS addresses some of the financial disincentives incurred by optometrists providing outreach services, with funding provided for costs that include:

- travel, accommodation and meals
- facility fees and administrative support at the outreach location
- external locum support at the home practice
- lease and transport of equipment.

In addition, an absence from practice allowance may be payable to compensate participating optometrists for the ‘loss of business opportunity’ due to time spent travelling to and from an outreach location to deliver VOS supported services\(^1\).

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\(^1\) Department of Health and Ageing, Program Guidelines for the Visiting Optometrists Scheme, July 2011
ACO is one fund holder for the VOS in Victoria. When the Victorian Aboriginal Spectacles Subsidy Scheme was introduced in 2010, VOS was already being delivered by ACO specifically to Aboriginal people at:

- Lake Tyers Health and Children’s Services; and
- Moogji Aboriginal Council, Orbost.

In 2010, at the same time that the Victorian Aboriginal Spectacles Subsidy Scheme was being implemented, the Federal government awarded ACO funding for five additional VOS sites to provide services to rural and regional Aboriginal communities. These are:

- Mildura Aboriginal Cooperative
- Murray Valley Aboriginal Cooperative, Robinvale
- Swan Hill and District Aboriginal Cooperative
- Njernda Aboriginal Cooperative, Echuca
- Coomealla Health Aboriginal Corporation, Dareton NSW

**The Victorian Aboriginal Spectacles Subsidy Scheme**

In 2010, as part of the ‘Closing the Gap’ initiative, the Victorian government provided new funding of $180,000 over three years to ACO to make spectacles more affordable for Aboriginal Victorians accessing the VES.

The objective of the funding is to help provide 1,800 visual aids over three years (1 July 2010 to 30 June 2013) with the aim of ensuring better vision for more Aboriginal Victorians.

The model for the Scheme was developed by DH in conjunction with ACO and includes:

- An expanded range of spectacle frames to those available through the VES, to improve patient choice. The frames were selected with input from community elders, facilitated by the Victorian Aboriginal Health Service (VAHS).
- A patient contribution of $10.00 per visual aid (more for non-standard lenses, such as photosensitive lenses).
- Eligibility for the subsidised frames broadened to all Aboriginal Victorians, regardless of Pensioner Concession Card or Health Care Card entitlements.
- Extending the same subsidy to all Aboriginal patients who had a current outstanding account with ACO for VES spectacles.

Otherwise, the Scheme is administered under the rules of the VES and provides patients (every two years from the date of ordering providing always that new lenses or glasses are clinically necessary) access to:

- one pair of reading glasses and one pair of distance glasses or
- one pair of bifocal glasses or
- one pair of multifocal glasses when documented clinically necessary or
- contact lenses if clinically necessary
- low vision aids as clinically necessary

ACO’s existing working relationship with VACCHO, its members, Aboriginal Community Controlled Health Organisations (ACCHOs) and other Aboriginal community groups across Victoria was recognised as providing an opportunity to promote the Scheme to eligible clients.

**Rural extension to the Victorian Aboriginal Spectacle Scheme**

In December 2010, an additional $140,000 was provided by DH to ACO to expand the Scheme. The funding is to provide an additional 1,069 visual aids (428 per year) in rural and regional areas from 1 February 2011 to 30 June 2013. These are to be provided through private optometry practices already providing the VES.

The expansion was designed to ensure that ACCHOs are able to refer to a practitioner in their locality. The other benefits of making the Scheme available in rural and regional areas are expected to be:

- Encouraging development of good relations between a local optometrist and local Aboriginal clients.
- Eliminating travel and improving access to services for people requiring eye care.
• Encouraging optometrists to work collaboratively with primary health care providers in their locality.

Expansion of the Scheme 2012-13

In March 2012, DH approved provision of an additional $100,000 to be provided to ACO in 2012-13 to deliver an additional 810 visual aids (370 metropolitan and 440 rural and regional) by June 2013.

The Australian College of Optometry (ACO)

ACO is the leading public optometry institution in Australia, conducting research and providing clinical services, professional development, education and membership to the optometry profession. ACO was established in 1940 and has over 800 members and more than 150 employees.

ACO has a history of providing eye care services to disadvantaged Victorians including an integrated model for delivery of eye care services to Aboriginal Victorians.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

VACCHO is the peak body for Aboriginal health in Victoria, representing 24 Aboriginal health services (members) throughout Victoria. Each member is an ACCHO delivering primary health services to their local community.

VACCHO plays a role in supporting relationships between ACO and ACCHOs for provision of optometry services and delivery of the Victorian Aboriginal Spectacles Subsidy Scheme. VACCHO responds to enquiries about the Scheme from ACCHO staff, mainstream organisations and community members. Where optometry services are not available at an ACCHO, VACCHO can facilitate links with private optometry services to ensure access to the Scheme for clients. VACCHO also plays a role in identifying training needs for ACCHO health workers.

VACCHO has contributed to a National Eye Health DVD which will be launched in 2012. It includes stories from individuals who have accessed the Victorian Aboriginal Spectacles Subsidy Scheme.

The Victorian Advisory Council on Koori Health’s Eye Health Subcommittee

The Victorian Advisory Council on Koori Health’s Eye Health Subcommittee (the VACKH Subcommittee) comprises representatives from major stakeholders in eye health and Aboriginal health in Victoria, including both the State and Commonwealth governments, VACCHO, the Royal Victorian Eye and Ear Hospital, ACO and the University of Melbourne and other sector representatives including Vision 2020 Australia, Vision Australia and the Royal Australian and New Zealand College of Ophthalmologists.

The community need for a subsidised spectacles scheme for Aboriginal clients was communicated by various stakeholders including ACO, VACCHO and VAHS. In 2010, the Victorian Aboriginal Spectacles Subsidy Scheme was approved by the VACKH Subcommittee. At this time, the Subcommittee recommended a future evaluation of the Scheme. In 2012 DH identified an opportunity to resource the evaluation internally.
Evaluation Approach

The evaluation methodology was developed by the evaluator in consultation with the program provider, ACO and with input from the University of Melbourne and VACCHO. The methodology was presented to the VACKH Subcommittee on 7 November 2011. The Subcommittee approved the program logic (Attachment 1) and agreed that the evaluation should proceed immediately.

Purpose of the evaluation:
1. To assess the effects of the Scheme against its intended outcomes as described in the program logic model (Attachment 1).
2. To assess the relative effects of different models and strategies employed to deliver the Scheme, on achieving its intended outcomes.
3. To understand the Scheme’s success factors and capture engaging stories and highlights.

Priority audiences for the evaluation:
1. Managers of the Scheme in the Department of Health Aboriginal Health Branch.
2. Current and potential providers of the Scheme via ACO.
3. VACCHO and its member organisations.
4. The eye health sector (optometrists, ophthalmologists and others involved in delivery of services).

Planned uses of the evaluation:
1. To provide summary evidence about the Scheme’s effects and to build an evidence-base to support future policy opportunities for the Scheme.
2. To provide data and information to support Victoria’s approach to closing the gap.
3. To inform ACO of the relative effectiveness of different approaches to delivering the Scheme and any opportunities for improvement.
4. To assist in the transfer of lessons to various relevant audiences within Victoria and interstate if requested.
Research Methods

Program logic model

As a preliminary step, the evaluator reviewed existing documentation about the Scheme and consulted with the program delivery organisation (ACO) and an eye health research expert to develop a diagram that maps out the Scheme, its key activities and intended objectives into a program logic model. The model is at Attachment 1.

Service delivery data

Quantitative data from ACO’s existing clinical data collection systems about services delivered and the population receiving services was extracted and analysed. Data is available from:
- the ACO-operated clinic at VAHS
- Aboriginal outreach clinics²
- VOS at Mildura Aboriginal Cooperative
- VOS at Murray Valley Aboriginal Cooperative, Robinvale
- VOS at Swan Hill and District Aboriginal Cooperative
- VOS at Njernda Aboriginal Cooperative, Echuca
- VOS at Coomealla Health Aboriginal Corporation, Dareton NSW
- VOS at Lake Tyers Aboriginal Trust, and
- VOS at Moogji Aboriginal Cooperative in Orbost.

Service provider interviews

A sample of seven service providers (one ACO employee and six private practitioners) were interviewed via telephone regarding engagement and capacity building strategies employed by ACO. Comments regarding the challenges of delivering the Scheme and the effects of various strategies employed to overcome these were also captured. The interview questions are provided at Attachment 2.

Patient change stories

ACO provided the evaluator with a collection of patient change stories collected (written) by ACO-employed optometrists on the anticipated benefits for patients who attended an optometry consultation in an ACO-operated service (at VAHS and on some of the VOS trips) since commencement of the Scheme. Patients attending services signed consent forms for their information to be used in ACO annual reports, websites, promotional materials and other publications developed by the ACO which are not of a commercial nature. Each patient who signed the consent form was advised verbally that their stories may also contribute to an evaluation of the Scheme by the Department of Health.

The patient change stories were analysed to provide complementary evidence to the quantitative service delivery data for some, but not all of the Scheme’s intended outcomes.

Community awareness

Initially VACCHO and the evaluator had agreed to work together to develop an online survey for distribution to ACCHOs to seek feedback on the Scheme, to understand their experiences and perspective on the value of the Scheme and to assess the community’s awareness of eye health issues.

Specifically the survey would investigate four intended outcomes for which ACO does not have the necessary data and information, being:
- Aboriginal communities’ engagement in the delivery of services
- increased awareness of eye care issues by health workers in ACCHOs
- increased number of enquiries for eye services at ACCHOs

² These include the Western Suburbs Indigenous Gathering Place, Bunurong Health Service, Billabong BBQ, Rainbow Place and Eastern Access Community Health with referrals from Mullum Mullum Gathering Place. ACO attends community health days organised by the Victorian Aboriginal Childcare Agency, Victorian Aboriginal Community Services Association Ltd and others.
increased awareness of eye risks within Victorian Aboriginal families.

It was proposed by VACCHO that it would be advantageous for three representatives per organisation to complete the online survey, including Chief Executive Officers, Practice Managers and Aboriginal Health Workers.

The evaluator drafted an online survey, however, it has not been possible to undertake the planned survey at the time of completing this report.

Data limitations

A key limitation on the evaluation has been the amount of service delivery data, including baseline data available to analyse whether the Scheme is achieving its intended outcomes.

Current service data is limited to a subset of providers of the Scheme. As listed above, these are the ACO-operated clinic at VAHS, the Aboriginal outreach clinics and VOS trips. A further limitation is the range of data items collected by the ACO-operated services which has meant it is not possible to provide evidence of achievement of all of the Scheme’s intended outcomes.

The only data available from private practices delivering the Scheme and from ACO-operated metropolitan clinics is the number of spectacles ordered. There is no data available on other aspects of the service (for example referrals to specialists) or on non-spectacle dispensing occasions of service.

In terms of a baseline, data is limited to that available from the ACO-operated clinic at VAHS. Prior to commencement of the Scheme, providers of the VES were not required to identify clients’ Indigenous status, as eligibility for the VES is based on Pensioner Concession or Health Care Card status. Although ACO was delivering services specifically to Aboriginal communities through five outreach services and VOS trips to Orbost and Lake Tyers prior to commencement of the Scheme, these services were still developing in 2010 therefore comparison of service provision at these sites pre- and post-commencement of the Scheme is not considered a fair comparison.

In some instances it has been difficult to identify the impact of the Victorian Aboriginal Spectacles Subsidy Scheme as distinct from the expanded delivery of the VOS. ACO commenced new VOS trips to Swan Hill and Echuca in March 2011 and to Dareton, Robinvale and Mildura in April 2011. Therefore, increases in optometry consultations for example, could be attributed to both commencement of the Victorian Aboriginal Spectacles Subsidy Scheme and commencement of new VOS trips.

Roles and responsibilities

The evaluator identified the following roles and responsibilities for the evaluation:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
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</thead>
<tbody>
<tr>
<td>Contribute to design of evaluation approach and methods</td>
<td>VACKH Subcommittee</td>
</tr>
<tr>
<td>Coordinate and lead design of evaluation approach</td>
<td>Evaluator</td>
</tr>
<tr>
<td>Extract data from existing systems</td>
<td>ACO</td>
</tr>
<tr>
<td>Analyse ACO data and write up</td>
<td>Evaluator</td>
</tr>
<tr>
<td>Engage providers of Scheme in evaluation, including promoting</td>
<td>ACO</td>
</tr>
<tr>
<td>survey, recruiting people to be interviewed</td>
<td></td>
</tr>
<tr>
<td>Design, conduct and analyse service provider surveys and</td>
<td>Evaluator</td>
</tr>
<tr>
<td>interviews</td>
<td></td>
</tr>
<tr>
<td>Disseminate findings to key audiences (above)</td>
<td>DH, ACO and the University of Melbourne</td>
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</tbody>
</table>
Findings Part 1: Effects of the Scheme against its intended outcomes

The Scheme’s objectives were drawn from funding agreements and project plans, and clarified through the development of a program logic model during the planning stage of the evaluation. The model is provided at Attachment 1.

The objectives of the program fall into immediate intended outcomes, short-term impacts and long-term impacts. This section presents the data available to support each of the intended outcomes. The key findings from the data available to support each of the intended outcomes are provided at the end of each section.

**Intended Outcomes**
- More optometrist consultations
- More spectacle prescriptions issued
- Earlier identification of vision-threatening eye disease
- Engaging new clients who haven't accessed services before
- Improved uptake of spectacle use
- More Aboriginal communities engaged in delivery of optometry services
- Increased awareness of eye care issues by health workers in ACCHOs
- Increased number of enquiries for eye services at ACCHOs
- Increased awareness of eye health risks within Victorian Aboriginal families

**Timeline for implementation of the Scheme**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Victorian Aboriginal Spectacles Subsidy Scheme</td>
<td></td>
</tr>
<tr>
<td>commenced</td>
<td>July 2010</td>
</tr>
<tr>
<td>Funding for rural extension of the Scheme approved by DH</td>
<td></td>
</tr>
<tr>
<td>VOS commenced at Swan Hill and Echuca</td>
<td>March 2011</td>
</tr>
<tr>
<td>VOS commenced at Dareton, Robinvale and Mildura</td>
<td>April 2011</td>
</tr>
<tr>
<td>Funding for expansion of the Scheme in 2012-13 approved by DH</td>
<td>March 2012</td>
</tr>
</tbody>
</table>

**More optometrist consultations**

An important feature of the Victorian Aboriginal Spectacles Subsidy Scheme is that it encourages people to have an eye check undertaken. Figure 1 shows a significant increase (116 per cent) in the total number of consultations conducted from the first six months of the scheme (July to December 2010) to the second six months of the Scheme (January to June 2011). The data represents consultations conducted at ACO-operated services (VAHS clinic, Aboriginal outreach services and VOS trips)\(^3\). VOS trips occur quarterly.

The increase in activity from the six-month period July to December 2010 to the six-month period January to June 2011 is attributable to:
- commencement of VOS trips to Swan Hill and Echuca in March 2011 and to Dareton, Robinvale and Mildura in April 2011.
- An increase in the number of consultations conducted at Aboriginal outreach services from 78 to 183.
- An increase in consultations conducted at VAHS from 174 to 204.

\(^3\) Data does not capture Aboriginal clients seen at the ACO-operated clinics at Carlton, metropolitan clinics or other outreach clinics.
• Marginal increases in the number of VOS consultations conducted at Lake Tyers and Orbost.

Figure 1 shows that overall, approximately 60 per cent of consultations are first visits meaning the patient has not been seen within an ACO-operated service in the past two years. Approximately 40 per cent are subsequent visits meaning the patient has been seen within an ACO-operated service within the past two years. In this data, the terms ‘first’ and ‘subsequent’ do not relate to the length of the consultation and associated Medicare billing codes.

ACO representatives advise that the majority of spectacles are likely to be prescribed in first visits. Subsequent visits are typically review appointments and follow-up for patients with a range of eye conditions including diabetes where yearly review is recommended. The increase in first consultations from 163 in July to December 2010 to 399 in January to June 2011 is likely to indicate an increase in consultations where spectacles are prescribed. The increase could be attributable to both commencement of the Victorian Aboriginal Spectacles Subsidy Scheme and initiation of VOS trips to five new sites.

![Figure 1: Number of consultations (first and subsequent) in ACO-operated services](image)

In terms of comparing the number of optometrist visits pre- and post-commencement of the Scheme, data available from the ACO-operated clinic at VAHS indicates an increase in service provision. Figure 2 shows that from 2006 to 2010, an average of 316 optometrist consultations were conducted at VAHS per year. In 2011, 509 optometrist consultations were conducted at VAHS.

The increase reflects the implementation of the Victorian Aboriginal Spectacles Subsidy Scheme and a simultaneous increase in optometry clinic days from five half days per fortnight to four to six full days per fortnight. VAHS and ACO representatives have advised that waiting time data is reviewed regularly by both organisations and that the provision of additional sessions was in response to increased waiting times (demand) for services. The initial lag in uptake of services in July to December 2010 can be attributed to the time it took to promote the Scheme to community members and to establish additional optometry sessions.
Further comparisons of the level of service provision pre- and post-commencement of the Scheme are not possible as other VES providers (both private optometrists and ACO-operated services) have not been required to identify the Indigenous status of people accessing the VES.

Anecdotal evidence provided during the telephone interviews with providers indicates an increase in demand for private optometry services in rural and regional areas following commencement of the Scheme. One optometrist working in private practice in a regional town said he had seen an initial spike in the number of patients coming in for assessments when the Scheme started. Another private optometrist in a rural area said that although she had been providing the VES for 17 years, she had not seen significant numbers of Aboriginal patients until last year when the Scheme commenced. She considers she has now worked through quite a large part of the community who need an assessment and/or glasses. A third optometrist working in private practice in a regional area said he now sees patients who found the price of spectacles under VES a barrier and can now afford spectacles.

The VOS clinics at Lake Tyers and Orbost were still developing prior to July 2010. Therefore a comparison of service levels pre- and post-commencement of the Scheme is not a good indicator of demand.

### Key Findings

1. The number of consultations conducted in ACO-operated services (VAHS clinic, Aboriginal Outreach services and VOS trips) increased 116 per cent from the first six months of the Scheme (July to December 2010) to the second six month period (January to June 2011). This is largely attributable to commencement of new VOS clinics.

2. In July to December 2011, there were 84 per cent more optometry consultations conducted at VAHS than in the six months prior to commencement of the Scheme (January to June 2010).

3. Anecdotal evidence from private optometry practices indicates an increase in demand for services from Aboriginal clients following commencement of the Scheme.
More spectacle prescriptions issued

<table>
<thead>
<tr>
<th>Services</th>
<th>Spectacles available to 30 June 2013</th>
<th>Spectacles ordered by 31 December 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>1800</td>
<td>1236 (69%)</td>
</tr>
<tr>
<td>Rural and regional</td>
<td>1069</td>
<td>551 (52%)</td>
</tr>
<tr>
<td>Total</td>
<td>2869</td>
<td>1787 (63%)</td>
</tr>
</tbody>
</table>

Table 1: Spectacles ordered by all services to December 2011

Table 1 shows that by 31 December 2011, 63 per cent of the spectacles to be provided under the Scheme to June 2013 had been ordered. This comprises 69 per cent of the glasses available through metropolitan services and 52 per cent of the glasses available through rural and regional services. Based on projections, a ‘run out’ date of July 2012 for metropolitan services and December 2012 for rural and regional services was anticipated.

In March 2012, the Department of Health approved $100,000 additional funding to expand the Scheme in 2012-13. It is anticipated this will provide a further 810 pairs of glasses (370 in metropolitan services and 440 in rural and regional services) by June 2013.

Collection of spectacles

Data on the number of patients who are prescribed glasses but do not pay for or collect them is available from the ACO-operated services (VAHS clinic, Aboriginal outreach services and VOS trips). In September 2011, there were only three (3) out of 107 patients (or approximately three per cent) who had ordered but not paid for or collected glasses under the Scheme. This compares with six (6) out of 38 patients (or approximately 16 per cent) who had ordered but not paid for glasses in July 2010 and indicates the affordability and acceptability of the frames by patients under the current Scheme.

Cost of glasses

The cost of individual client orders indicates high client acceptability of the spectacles available under the Scheme. Table 2 shows that to 30 June 2011, 641 patients state-wide had ordered spectacles through the Scheme. Of these patients, 87 per cent had placed orders totalling $20 or less indicating the purchase of one or two pairs of $10 spectacles. A further seven (7) per cent had placed orders of between $20 and $100, however, some of these may be due to patients being charged VES prices at the very beginning of the Scheme, when some providers were unclear about the new pricing structure.

Only seven (7) per cent of orders were greater than $100. ACO representatives advise this is sometimes due to patients purchasing more expensive frames, however, it is typically due to the purchase of photosensitive lenses, which are not clinically required but enable indoor and outdoor wear.

The patient change stories collected by ACO-employed optometrists included a number of patients who had previously not purchased glasses or attended for eye checks because of the cost of glasses. A more limited range of spectacles are available under the VES from a minimum cost of $36.

<table>
<thead>
<tr>
<th>Spectacles orders</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 or less</td>
<td>557</td>
<td>87%</td>
</tr>
<tr>
<td>More than $20 but less than $100</td>
<td>42</td>
<td>6.5%</td>
</tr>
<tr>
<td>More than $100</td>
<td>42</td>
<td>6.5%</td>
</tr>
<tr>
<td><strong>Total to 30 June 2011</strong></td>
<td>641</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2: Cost of individual orders to 30 June 2011
Frames
There were comments from providers and in the patient change stories that the frames available under the Victorian Aboriginal Spectacles Subsidy Scheme are much better in terms of appearance, quality and comfort than those available through the VES. Some patients had previously been using readymade glasses due to the appearance and/or cost of frames under the VES. Others had opted to order more expensive frames than those available under the VES and some of these patients had not paid for or collected their glasses.

Key Findings

4. There is good uptake of the Scheme by eligible clients. Projections based on uptake in the first 18 months of the three-year Scheme indicated a ‘run-out’ date of glasses approximately 12 months earlier than intended. Additional funding of $100,000 from the Department of Health will be provided in 2012-13 towards meeting the projected shortfall.

5. In September 2011, there were only three (3) per cent of patients who had ordered but not paid for or collected their glasses (compared with 16 per cent prior to the Scheme) indicating the affordability of the Scheme and the acceptability of the frames by patients attending consultations.

6. The majority of patients to date (at least 87 per cent) have ordered $10 spectacles indicating good acceptability by patients attending consultations, of the range of frames available under the Scheme.

7. There is anecdotal evidence that some patients attending consultations to access the Victorian Aboriginal Spectacles Subsidy Scheme had not been for eye checks or ordered glasses due to the cost of spectacles prior to the Scheme.

8. There is anecdotal evidence that patients prefer the appearance, quality and comfort of the range of glasses available under the Victorian Aboriginal Spectacles Subsidy Scheme than those available under the VES.

Earlier identification of vision-threatening eye disease

There are four conditions that cause 94 per cent of vision loss in Aboriginal Australians. These are refractive error, cataract, diabetes and trachoma (not prevalent in Victoria). Each is readily amenable to treatment.

Optometrists play a key role in the detection, treatment and/or management (including referral to specialists as appropriate) of a range of eye problems including those that can lead to vision loss and blindness. The Victorian Aboriginal Spectacles Subsidy Scheme presents an opportunity to identify vision-threatening eye disease in clients who attend for an eye check.

Service delivery data for this section is available from VOS trips only.

Refractive error

Uncorrected refractive error is a major cause of vision loss that is cheaply and easily corrected with spectacles. Optometrists play a role in diagnosing and treating refractive error.

Table 3 contains data from the VOS trips indicating a high number of patients attending consultations are prescribed glasses. The lower number of glasses prescribed at Lake Tyers and Orbost is due to a higher number of children being examined during ‘Kids Health Days’.

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4 The University of Melbourne, National Indigenous Eye Health Survey, 2009
5 The University of Melbourne, Roadmap to Close the Gap for Vision, Full Report 2012
## Table 3: Data from VOS trips indicating numbers of glasses prescribed

<table>
<thead>
<tr>
<th>VOS trip</th>
<th>Period of trips</th>
<th>Total patients examined</th>
<th>Glasses prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mildura, Dareton,</td>
<td>Apr 2011 – Nov 2011</td>
<td>239</td>
<td>234</td>
</tr>
<tr>
<td>Robinvale combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swan Hill, Echuca combined</td>
<td>Mar 2011 – Oct 2011</td>
<td>178</td>
<td>152</td>
</tr>
<tr>
<td>Lake Tyers, Orbost combined</td>
<td>Aug 2010 – Jan 2012</td>
<td>125</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>542</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>482</td>
</tr>
</tbody>
</table>

Figure 3 shows the ratio of spectacles prescribed to consultations performed at VAHS remained steady at around 0.5 until the introduction of the Scheme when it increased to around 0.9.

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**Cataract**

Blinding cataract is 12 times more common in adult Aboriginal Australians than non-Aboriginal Australians\(^7\). Optometrists play a role in diagnosing cataracts and referring patients to Ophthalmologists for surgery as appropriate. Cataract surgery rapidly restores vision.

On the VOS trips outlined in Table 3, there were five (5) diagnoses of cataract or approximately one (1) per cent of patients.

**Diabetic retinopathy**

With timely treatment, 98 per cent of vision loss due to diabetes can be prevented\(^8\). Optometrists play an important role in screening for diabetic retinopathy. An ACO Optometrist involved in delivery of the Victorian Aboriginal Spectacles Subsidy Scheme provided the following description of optometry services for patients with diabetic retinopathy:

> Optometrists provide eye examinations to determine whether there is any diabetic retinopathy or macular oedema (fluid accumulation or bleeding in the central part of the retina (macula) that is responsible for fine detail vision). If minimal or mild changes are noted, optometrists advise the patient and their

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\(^6\) Some patients may be prescribed more than one pair of glasses

\(^7\) The University of Melbourne, *National Indigenous Eye Health Survey*, 2009

\(^8\) The University of Melbourne, *Roadmap to Close the Gap for Vision*, 2011
GP of the outcome and recommend a review visit at an appropriate time. The patient is advised to attend for an examination promptly if any change in vision is noted. If moderate to severe diabetic retinopathy or macular oedema is noted, a prompt referral to an ophthalmologist with laser facilities is organised by the optometrist in collaboration with the ACCHO or the patient’s GP.

Optometrists also provide education and advice for health centre staff and community members about the effects of diabetes on the eye and the importance of good control of diabetes, blood pressure and cholesterol in preventing eye complications from diabetes.

ACO optometrists work with diabetes educators and Aboriginal health workers and nurses to assist with achieving good eye care outcomes for people with diabetes. ACO optometrists will discuss diabetes regularly with ACCHO staff and have assisted in enhancing review and recall processes at the ACCHOs.

In ACO-operated services (VAHS clinic, Aboriginal outreach services and VOS trips) the number of patients examined with diabetes increased from 22 patients in September 2010 to 79 patients in June 2011\(^9\). The increase coincides with the commencement of VOS at Swan Hill, Echuca, Dareton, Robinvalle and Mildura. On some trips, as high as 43 per cent of patients examined had diabetes. For example, in May 2011 a total of 40 patients were seen in Dareton, Robinvalle and Mildura and 17 of these patients had diabetes.

Whilst the increase in the number of patients with diabetes is attributable to a greater number of patients being seen rather than a higher detection rate, it is critical that more Aboriginal patients who have diabetes access appropriate eye care on an annual basis.

**Summary of diagnoses other than refractive issues**

Optometrists typically refer to specialists (ophthalmologists) for chronic eye diseases: diabetic retinopathy, cataract and glaucoma. Without baseline data it is not possible to say whether ‘more’ diagnoses or referrals are being made, however, it is possible to see that there is detection and provision of care for more conditions than refractive error.

Table 4 below provides a summary of the outcomes from the VOS trips. Column D indicates the number of diagnoses of conditions other than refractive issues. Other diagnoses are predominately for:

- dry eye
- pterygium
- age related macular degeneration
- oculomotor issues
- diabetic retinopathy
- cataract, and
- glaucoma

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\(^9\) Based on patients billed using Medicare code 10915 for ‘examination of the eyes of a patient with diabetes mellitus’. The actual number of patients with diabetes may be higher as patients can be correctly coded using other Medicare codes, however, these codes can also be used for patients without diabetes.
### Table 4: Summary of outcomes from VOS trips

ACO representatives advise that for every client who is seen on a VOS trip, a brief report of the outcome of the eye examination is provided to the ACCHO. Column F indicates provision of a more detailed report written for more complex outcomes or when the patient’s GP is not within the ACCHO. The reports indicate an interaction between the optometrist and a primary health care provider to ensure clinical information is shared and/or coordination of care between service providers occurs.

At VAHS, the optometrists enter a summary into the Communicare patient record system (electronic database) for every client seen so that the information can be provided to GPs and other health care providers as required. Communicare also provides a recall system to prompt patient review appointments. At other metropolitan visiting sites, a letter/report is sent to the ACCHO for every client seen.

The issue of cost for specialist assessment and treatment was raised by two of the private practitioners during the telephone interviews. One practitioner commented that ophthalmological management is a key challenge including weighing up whether a patient would prefer to travel (for example to Melbourne) for treatment at no cost or to pay for treatment locally. This Optometrist commented that there is one visiting Ophthalmologist available locally who bulk bills, however, the Optometrist does not want to ‘load him up’ with every patient. A further three Ophthalmologists are available locally but do not bulk bill.

Similarly, another private practitioner commented that she sees many Aboriginal clients with diabetic retinopathy. She believes the Scheme is enabling identification of eye disease and appropriate referrals to be made; however, the cost of seeing a retinal specialist (typically $200 out-of-pocket) may prevent some clients from following up on the referral.

#### Patient change stories

ACO provided a collection of practitioner reflections on the anticipated benefits for patients who attended an optometry consultation in an ACO-operated service and may have been prescribed spectacles under the Scheme. A summary of the anticipated visual benefits for 45 patients who were prescribed glasses is provided in Table 5 below.

### Table 5: Visual benefits

<table>
<thead>
<tr>
<th>Visual benefits</th>
<th>Number of patients</th>
<th>Percentage&lt;sup&gt;10&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>21</td>
<td>47%</td>
</tr>
<tr>
<td>Paid work</td>
<td>13</td>
<td>29%</td>
</tr>
<tr>
<td>Education/study</td>
<td>8</td>
<td>18%</td>
</tr>
<tr>
<td>Driving</td>
<td>8</td>
<td>18%</td>
</tr>
</tbody>
</table>

<sup>10</sup> Some patients reported multiple benefits
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer work</td>
<td>8</td>
<td>18%</td>
</tr>
<tr>
<td>Reduce headaches</td>
<td>8</td>
<td>18%</td>
</tr>
<tr>
<td>Watching television</td>
<td>7</td>
<td>16%</td>
</tr>
<tr>
<td>Other hobbies</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>Parenting/family activities</td>
<td>4</td>
<td>9%</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>4</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 5: Practitioner reflections on anticipated visual benefits for patients prescribed glasses

There were seven stories indicating that the patient’s improved eyesight would assist them in their role within an Aboriginal organisation, providing care or other services to Aboriginal people. The range of positions held by these patients included managers of health and other programs, drivers and administrative staff.

Further health benefits attributed to wearing the correct glasses included patients being able to read food labels when shopping to help improve management of their diabetes and being able to read medication labels. One patient was going to use her glasses to read knitting patterns which she had taken up to help her quit smoking.

The practitioners commented on seeing patients who were attending consultations to access $10 glasses but indicated they would return for future appointments for a range of reasons including regular eye examinations, seeking diabetic eye reviews or to have another eye condition monitored as required.

Key Findings

9. Data from the VOS trips indicates:
   - A range of eye conditions are being detected in people attending consultations for eye checks including refractive error, cataract, diabetic retinopathy and glaucoma which are amongst the leading causes of vision loss in Aboriginal Victorians.
   - Referrals are being made to specialists for eye conditions as required.
   - Primary care providers are being informed of the outcomes of patients’ eye examinations.

10. The out of pocket expenses for patients referred to specialists was raised as an issue by two optometrists working in private practice. One practitioner commented that it may prevent some clients from following up on the referral.

11. Uncorrected refractive error is a major cause of vision loss that is cheaply and easily corrected with spectacles. A high proportion of patients attending VOS trip consultations are prescribed glasses. The rate of glasses being prescribed in VAHS clinic consultations has increased since commencement of the Scheme.

12. The number of patients with diabetes seen in ACO-operated services (VAHS clinic, Aboriginal outreach services and on VOS trips) increased from 22 patients in September 2010 to 79 patients in June 2011. As high as 43 per cent of some patients examined on VOS trips had diabetes (for example Dareton, Mildura and Robinvale in May 2011).

13. ACO optometrists report a range of anticipated visual benefits for patients as a result of having access to $10 glasses including a new or improved ability to read, study, work and undertake activities of daily living.
Engaging new clients

There is limited data available on whether patients attending consultations have accessed optometry services prior to commencement of the Scheme.

Data available from the ACO-operated services (VAHS clinic, Aboriginal outreach services and VOS trips) shows that since commencement of the Scheme, a total of 1549 consultations have been conducted across these services. Of these, 934 (or 60 per cent) were first visits meaning the patient had not been seen in an ACO-operated service in the previous two years. Whilst this provides an indication of the number ‘new’ patients to ACO services in the last two years, the data does not indicate whether these patients accessed optometry services (ACO-operated or other) prior to two years. Also, the data does not indicate whether these patients accessed optometry services from a provider other than ACO (for example a private provider) within the last two years.

The only source of data on first consultations conducted pre- and post-commencement of the Scheme is from the ACO-operated clinic at VAHS. Figure 4 shows an increase in the number of first consultations conducted from 71 in January to June 2006 to 164 consultations in July to December 2011.

![Figure 4: Number of first optometry consultations conducted at the ACO-operated clinic at VAHS from 2006 to current](image)

In the patient change stories provided by ACO, there are numerous references to patients who had probably been in need of an eye assessment for some time, some up to 10 years, due to developing vision problems, headaches or making do with readymade glasses but who prior to the Scheme had not attended due to various reasons. Not being able to afford glasses was the main reason provided for not attending an optometry appointment. There were also references to several patients who had previously been referred to a specialist but had not attended.

Of the six private providers interviewed, two referred to seeing patients who have not previously accessed optometry services or who have not accessed services for a long time. One optometrist said he feels the Scheme will allow many more people who are not accessing optometry services to do so. Two providers said they now see patients who found the cost of glasses under the VES a barrier.

Two providers commented that there may be Aboriginal people in the community who are not comfortable attending a mainstream provider. One provider commented he would feel “upset
to learn people did not feel comfortable coming into his practice” but that he understands some Aboriginal people perceive barriers in mainstream practices. Both providers said there is a need for the Scheme to be delivered out of ACCHOs to ensure access for all Aboriginal people who require optometry services. Two private practitioners commented on the potential for there to be a duplication of service where patients have access to the Scheme locally through a VOS trip and a private optometry practice.

Five of the six private providers interviewed said ‘no shows’ (people not attending the practice for scheduled appointments) was one of the biggest challenges in delivering the Scheme. All five providers said that support from the local ACCHO had been critical in improving attendance rates since commencement of the Scheme (see Findings Part 2 below).

### Key Findings

14. There is limited data available to demonstrate whether new clients are accessing optometry services as a result of the Scheme. There is data showing an increase in the number of first consultations conducted across the ACO-operated services (VAHS clinic, Aboriginal outreach services and VOS trips). ‘First’ is defined as a consultation for a patient who has not accessed an ACO service in the past two years.

15. Both ACO-employed and private practice optometrists report seeing patients who have been in need of an eye assessment for some time, but who have not attended prior to the Scheme for various reasons, mainly cost.

16. Two of the private providers interviewed considered it advantageous for the Scheme to be delivered out of ACCHOs to ensure access for all Aboriginal people as there may be some members of the community who do not feel comfortable accessing mainstream providers.

### Community impacts of the Scheme

Engaging more Aboriginal communities in delivery of optometry services was identified as one of the intended outcomes of the Scheme. Since commencement of the Scheme, there are new optometry services (and subsidised spectacles) available to Victorian Aboriginal people via VOS trips to Mildura, Robinvale, Swan Hill, Echuca and Dareton.

Subsidised spectacles and associated optometry services are available to Aboriginal clients through a range of private optometry practitioners in rural and regional areas. Information provided by ACO indicates there are at least 22 participating VES optometry practices who now offer the Victorian Aboriginal Spectacles Subsidy Scheme. This number includes multiple sites of some providers and represents a considerable increase in new providers of services to Aboriginal clients.

The private practitioners are located in the following towns with some towns having more than one optometry provider:

- Bairnsdale
- Ballarat
- Belmont
- Camperdown
- Drysdale
- Euroa
- Geelong
- Hamilton
- Lakes Entrance
- Lang Lang
- Mildura
- Newcomb
- Orbost
- Portland
- Shepparton
Whilst it is not possible to quantify the number of new partnerships between private practice optometrists and ACCHOs, five of the six private optometrists interviewed said the ACCHOs supported them in delivery of the Scheme. Some of the providers mentioned that their relationship with the ACCHO had been established prior to the Scheme, to support delivery of the VES.

At this time, it has not been possible to gather evidence to support the following intended outcomes of the Scheme:

- Increased awareness of eye care issues by health workers in ACCHOs.
- Increased number of enquiries for eye services at ACCHOs.
- Increased awareness of eye risks within Victorian Aboriginal families.

The evaluator drafted an online survey for ACCHOs in order to gather information to support the above intended outcomes. It would be beneficial to investigate with ACCHOs their level of engagement in the Scheme, beyond the existence of new services as listed above.
**Findings Part 2: Models and strategies**

This section covers the engagement strategies employed by ACO to encourage optometrists to be part of the Scheme and what the ACO has done to support practitioners to implement the Scheme. It covers the key challenges identified by service providers in implementing the Scheme and what strategies have been employed to overcome these.

Telephone interviews with six optometrists working in private practice and one ACO-employed optometrist were the key source of information for this section.

**Engagement strategies**

Providers were asked to comment on engagement strategies employed by ACO and whether there was anything in particular ACO did to encourage them to be part of the Scheme. All providers said they received a letter from ACO inviting them to be part of the Scheme. All were already providing the VES and some saw this as the reason they were invited. No one mentioned engagement strategies employed by ACO in addition to being contacted in writing.

Representatives from ACO advised that they employed a range of engagement strategies depending on the private practice. Some practices were sent letters, some were e-mailed and others were contacted by telephone or visited. All practices were reminded most months in the VES Rural Practice Updates. It would appear that the private optometrists who participated in the telephone interviews registered their interest in the Scheme on receipt of the ACO letter and therefore no further correspondence from ACO was required.

**Provider justification for involvement**

Three providers commented on their motivation for being involved in the Scheme. The main incentive to participate was the sense of community service provided by the Scheme. Two providers saw the Scheme as an opportunity to improve a service to the local Aboriginal communities and to make glasses more affordable to this client group.

One private provider said there was a slight financial incentive for the practice to be involved. Another commented that the financial incentive alone would not be enough to encourage private practice optometrists to be involved. This provider said appointments can take longer with some eligible clients due to multiple health issues and the management and coordination required with follow up. She commented that some optometrists can not afford to allocate appointment slots to less profitable patients, particularly if there is a risk of 'no show'. This provider said being in a rural area meant her overheads are lower therefore cost is less of a concern for her. As she has children she is unable to go overseas to undertake aid work. She sees her involvement in the Scheme as an opportunity to provide a much-needed service to disadvantaged people within her own community.

**ACO support**

Providers were invited to comment on what support they had received in delivering the Scheme. One provider commented that ACO had provided phone support during the start up of the Scheme. Another said full-day cultural training sessions have been offered in Melbourne, however, this provider has not been able to afford the time to attend.

A private optometrist who attends one of the VOS clinics said ACO had been very supportive generally, for example working through the bureaucratic issues with how the Scheme is delivered. He said clinics are now accepted by the community, whereas when his practice was trying to independently run a clinic for Aboriginal clients (for 15 years) without the Scheme and support from ACO, there would be a full book of appointments but often very few people turned up.

No one specifically identified support from ACO to facilitate a relationship with the local ACCHO, however, three providers commented that because of the practice’s existing relationship with the local ACCHO, no support was required from ACO in this area.
An ACO-employed optometrist said ACO provides cultural awareness training to its staff (available since before commencement of the Scheme). Through this training and the opportunity to attend optometry clinics in Aboriginal health services, ACO is expanding the number of staff members who are confident in delivering optometry services to Aboriginal communities. Amongst these staff, an informal network of support is developing to share information and experience. The employee commented that when attending optometry clinics in Aboriginal health services, there is opportunity to interact with other clinicians, for example Aboriginal health workers, dieticians, diabetes educators, podiatrists and general practitioners. This allows the optometrists to promote the importance of eye care, to raise awareness of their role and increase referrals. This employee believes there may be further opportunities like this to build capacity within ACCHOs.

Three of the private providers were not aware of any specific supports offered by ACO.

Challenges and strategies

As stated earlier, five of the six private providers interviewed said ‘no shows’ (people not attending the practice for scheduled appointments) was one of the biggest challenges in delivering the Scheme. All five providers said that support from the local ACCHO had been critical in improving attendance rates since commencement of the Scheme. Following are some examples of the comments provided.

- The ACCHO has been fantastic in supporting the Scheme. The nurse fills in the paperwork and client attendance at appointments has improved due to her involvement.
- A list of optometry clients is kept at the ACCHO. The ACCHO follows up with clients and will provide transport to appointments to collect glasses if required. The ACCHO has a good relationship with the community and this has been the biggest help in reducing ‘no shows’.
- The nurse at the local ACCHO is the main referrer. Patients not attending for appointments was an issue when the Scheme started. Now the nurse brings four patients over on a Friday. If someone cancels, she knows who else is waiting for an appointment and will call to see if they are available at short notice. This has reduced the ‘no shows’ and increased the number of clients attending follow up appointments.
- A small number of clients do not show. Some clients coming from the ACCHO have a case worker.

In terms of paperwork, one provider commented that it has been streamlined but was unsure if this was undertaken by ACO or the local ACCHO. ACO representatives advise that there has been no specific initiative on paperwork. Some providers commented that the ACCHO helps ensure clients have signed the forms. In contrast, one provider said the paperwork is onerous. He is required to fill in three forms for every pair of glasses ordered: one for ACO, one for the VES and one for the Government about the Scheme. [The evaluator is not aware of any form required by the Government]. One provider said the plan to move to on-line forms would be a positive change.

Future support

In terms of what support providers think would be useful in the future, one provider said cultural awareness training, [although she was aware this was already being offered]. Another provider felt more assistance was needed in identifying eligible clients. He said whilst the majority of clients come from the ACCHO, a percentage self-refer and he was concerned that asking about Indigenous status could cause offence to some Aboriginal and non-Aboriginal people. There was confusion amongst some providers about whether referral from the ACCHO is required in order to be eligible for the Scheme.

The private optometrist working in a VOS clinic commented that the systems ‘fall down a bit’ at the Aboriginal health service. He commented that the ACCHO is good at referring but can lack enthusiasm for the clinics. He said it would be good if VACCHO could visit to understand the issues and provide support in keeping the ACCHO engaged in the clinic.
Key Findings

17. The private providers interviewed were contacted via letter from ACO inviting them to become providers of the Victorian Aboriginal Spectacles Subsidy Scheme. They were not aware of any additional engagement strategies employed by ACO to encourage them to deliver the Scheme.

18. The main incentives amongst the private providers for being involved in the Scheme was the sense of community service the Scheme provides and to make spectacles more affordable to Aboriginal people in their local community. There is only a slight financial incentive for private providers to deliver the Scheme and some commented this alone would not be enough to encourage optometrists working in private practice to be involved.

19. The private providers commented that ACO had provided administrative and other support to commence delivery of the Scheme. Most were aware of the opportunity to undertake cultural awareness training at ACO but none had undertaken this.

20. The issue of clients not attending for scheduled appointments was one of the biggest challenges identified by the private optometrists in delivering the Scheme. Most said support from the ACCHO had been crucial in overcoming this.

21. The issue of eligibility for the Scheme was raised. There was confusion amongst some providers about whether referral from the ACCHO is required in order to be eligible for the Scheme. One provider commented that more support is needed to understand culturally appropriate ways of identifying a client’s Indigenous status.

Lessons from the University of Melbourne’s Roadmap to Close the Gap for Vision – Full Report 2012

In 2012, the University of Melbourne’s Indigenous Eye Health Unit published The Roadmap to Close the Gap for Vision – Full Report. This detailed report provides 42 recommendations to the Australian Government for policy development to ‘Close the Gap for Vision’. There are a number of findings from the review that relate to provision of subsidised spectacles schemes, including that:

- Cost-uncertainty (clients not knowing if they will be asked to pay for spectacles and how much this might be, or if they will be likely to be referred to an ophthalmologist) prevents many clients from regularly accessing optometry services, particularly in areas where there are no low-cost spectacle schemes. (Page 48).

- Uncorrected refractive error is a major cause of vision loss that is cheaply and easily corrected with spectacles. [Nationally], access to a good supply of low-cost spectacles would address 54% of the vision loss and low vision of Indigenous Australians. (Page 49).

- The success of the Victorian and New South Wales [subsidised spectacles] programs is clear. Also, they are the only schemes that are specifically for Indigenous Australians. The uptake of these services demonstrates that when cost-certainty is assured and high-quality spectacles and services are provided, Indigenous clients will seek access to the service, they are willing to pay for these services and they recommend them to their friends and family members and so address the unmet need. (Page 52).

- Fear and embarrassment associated with eye health services were frequently mentioned as negative influences on a patient’s choice not to access services… Negative experiences could include not understanding the practitioner and becoming confused, experiencing discomfort during examinations, not receiving any treatment and so gaining no benefit, or being charged gap fees for services or for expensive spectacles. (Page 55).
There is debate around charging fees for spectacles provided through a subsidised scheme. Many argue that providing spectacles at no-cost diminishes the value placed on the spectacles and services. In contrast, others argue that any charge (even nominal) is a barrier that would limit access for many Indigenous people. Cost is identified as the most common reason Indigenous people do not go to a health professional when needed. However cost-uncertainty for spectacles was commonly reported to the research team as the reason for not visiting the optometrist. The recently introduced Victorian Indigenous spectacle scheme demonstrates that when spectacles are provided for low and certain cost, the service is accepted and accessed by Indigenous clients. (Page 95).

The overall recommendation from the Roadmap in relation to subsidised spectacles is:

- That a nationally consistent Indigenous subsidised spectacle scheme be established to provide low-cost-quality-assured, cost-certain spectacles to Aboriginal and Torres Strait Islander people. (Page 105).
Key findings

Below is a summary of the key findings from the evaluation:

1. The number of consultations conducted in ACO-operated services (VAHS clinic, Aboriginal Outreach services and VOS trips) increased 116 per cent from the first six months of the Scheme (July to December 2010) to the second six month period (January to June 2011). This is largely attributable to commencement of new VOS clinics.

2. In July to December 2011, there were 84 per cent more optometry consultations conducted at VAHS than in the six months prior to commencement of the Scheme (January to June 2010).

3. Anecdotal evidence from private optometry practices indicates an increase in demand for services from Aboriginal clients following commencement of the Scheme.

4. There is good uptake of the Scheme by eligible clients. Projections based on uptake in the first 18 months of the three-year Scheme indicated a ‘run-out’ date of glasses approximately 12 months earlier than intended. Additional funding of $100,000 from the Department of Health will be provided in 2012-13 towards meeting the projected shortfall.

5. In September 2011, there were only three (3) patients who had ordered but not paid for or collected their glasses indicating the affordability of the Scheme and the acceptability of the frames by patients attending consultations.

6. The majority of patients to date (at least 87 per cent) have ordered $10 spectacles indicating good acceptability by patients attending consultations, of the range of frames available under the Scheme.

7. There is anecdotal evidence that some patients attending consultations to access the Aboriginal Spectacles Subsidy Scheme had not been for eye checks or ordered glasses due to the cost of spectacles prior to the Scheme.

8. There is anecdotal evidence that patients prefer the appearance, quality and comfort of the range of glasses available under the Aboriginal Spectacles Subsidy Scheme than those available under the VES.

9. Data from the VOS trips indicates:
   - A range of eye conditions are being detected in people attending consultations for eye checks including refractive error, cataract, diabetic retinopathy and glaucoma which are amongst the leading causes of vision loss in Aboriginal Victorians.
   - Referrals are being made to specialists for eye conditions as required.
   - Primary care providers are being informed of the outcomes of patients’ eye examinations.

10. The out of pocket expenses for patients referred to specialists was raised as an issue by two optometrists working in private practice. One practitioner commented that it may prevent some clients from following up on the referral.

11. Uncorrected refractive error is a major case of vision loss that is cheaply and easily corrected with spectacles. A high number of patients attending VOS trip consultations are prescribed glasses. The rate of glasses being prescribed in VAHS clinic consultations has increased since commencement of the Scheme.

12. The number of patients with diabetes seen in ACO-operated services (VAHS clinic, Aboriginal outreach services and on VOS trips) increased from 22 patients in
September 2010 to 79 patients in June 2011. As high as 43 per cent of some patients examined on VOS trips had diabetes (for example Dareton, Mildura and Robinvale in May 2011).

13. ACO optometrists report a range of anticipated visual benefits for patients as a result of having access to $10 glasses including a new or improved ability to read, study, work and undertake activities of daily living.

14. There is limited data available to demonstrate whether new clients are accessing optometry services as a result of the Scheme. There is data showing an increase in the number of first consultations conducted across the ACO-operated services (VAHS clinic, Aboriginal outreach services and VOS trips).  ‘First’ is defined as a consultation for a patient who has not accessed an ACO service in the past two years.

15. Both ACO-employed and private practice optometrists report seeing patients who have been in need of an eye assessment for some time, but who have not attended prior to the Scheme for various reasons, mainly cost.

16. Two of the private providers interviewed considered it advantageous for the Scheme to be delivered out of ACCHOs to ensure access for all Aboriginal people as there may be some members of the community who do not feel comfortable accessing mainstream providers.

17. The private providers interviewed were contacted via letter from ACO inviting them to become providers of the Aboriginal Spectacles Subsidy Scheme. They were not aware of any additional engagement strategies employed by ACO to encourage them to deliver the Scheme.

18. The main incentives amongst the private providers for being involved in the Scheme was the sense of community service the Scheme provides and to make spectacles more affordable to Aboriginal people in their local community. There is only a slight financial incentive for private providers to deliver the Scheme and some commented this alone would not be enough to encourage optometrists working in private practice to be involved.

19. The private providers commented that ACO had provided administrative and other support to commence delivery of the Scheme. Most were aware of the opportunity to undertake cultural awareness training at ACO but none had undertaken this.

20. The issue of clients not attending for scheduled appointments was one of the biggest challenges identified by the private optometrists in delivering the Scheme. Most said support from the ACCHO had been crucial in overcoming this.

21. The issue of eligibility for the Scheme was raised. There is a misconception amongst some providers that clients are required to be referred from the ACCHO to be eligible for the Scheme. One provider commented that more support is needed to understand culturally appropriate ways of identifying a client’s Indigenous status.
Recommendations

1. Victoria’s Aboriginal Spectacles Subsidy Scheme should continue to be delivered to ensure access to low-cost spectacles for all Aboriginal Victorians.

2. The Scheme should continue to be included in the Victorian Government strategic directions for Aboriginal health – Koolin Balit 2012-2022.

3. To inform future levels of service, further work should be undertaken to understand and address the need for subsidised spectacles from Victorian Aboriginal people including if there is a level of unmet need.

4. Gaps in service provision and any barriers to people accessing the Scheme should be identified and addressed. Interviewing eligible clients who have not accessed the Scheme should be explored as an avenue for highlighting barriers.

5. The Australian College of Optometry should clarify with the private optometry providers of the Scheme that it is available to all Aboriginal Victorians and that referral from an Aboriginal Community Controlled Health Organisation (ACCHO) is not a requirement for accessing the Scheme.

6. Information and or training should be provided to private optometrists to support culturally appropriate practices for asking all patients whether they identify as Aboriginal or Torres Strait Islander.

7. The relationship between ACCHOs and local private optometry practices delivering the Scheme should be recognised as a key success factor in the Scheme and opportunities to foster these relationships should be supported.

8. Opportunities to improve data collection should be explored including ways to measure the indirect outcomes of the Scheme such as earlier identification and treatment of vision-threatening eye disease.

9. The online survey drafted to capture ACCHO feedback on the Scheme should be undertaken.
Program Logic Model: Victoria’s Aboriginal Spectacles Scheme (Draft as at 13 September 2011)

Target Population for program is all Aboriginal Victorians. Priority group = Aboriginal Victorians with highest likelihood of vision loss

<table>
<thead>
<tr>
<th>External Inputs</th>
<th>Program Activities</th>
<th>Intended Outcomes</th>
<th>Short-term Impacts</th>
<th>Long-term Impacts</th>
</tr>
</thead>
</table>
| ACO existing relationships with 7 communities/ACCHOs | Spectacles available for $10 total fee
NB: $10 represents both an accessible price point and provides cost surely | Green boxes are proposed measures | Better vision for More Aboriginal Victorians | Social Impacts:
* Social connection
* Income
* Prevent accidents/safety
* Study
* Family connection
* Driving |
| ACO established systems & processes providing subsidised spectacles through VES | Wider selection of frames, endorsed by elders | More optometrist consultations | National Indigenous Eye Health Survey |
| Visiting Optometrist Scheme extended to 5 rural communities, and increased in metro communities (inc. 3x at VAHS) (DoHA $) | Community awareness raising of eye health and the Specs scheme by VACCHO | More specific prescriptions issued | Improved uptake of spectacle use
Spectacle collection rates |
| Community education materials about eye health disseminated to Aboriginal communities | Engagement of existing 17 VES practices to participate in scheme | Earlier identification of vision-threatening eye disease | | Clinical evidence from diabetes proves this causal link |
| Established organisational partnerships and project governance through VACKH Eye Health Subcommittee | Direct delivery of scheme through VOS | Engage new clients who haven’t accessed services before
* Number of client assessments that indicate no eye care in previous 3 years
* Testimonials/vignettes from providers | This causal line has been proven in Aboriginal communities by Anthea Burnett study (unpublished); and Theo Voss |
| Medicare Well Persons Health Checks | Capacity building of sites/practices inc. sharing good practice models; cultural training; facilitate partnerships with local ACCHOs; strengthen systems of care | More Aboriginal communities engaged in delivery of optometry services
Number of new VOS sites in Aboriginal communities
Number of partnerships formed between VOS practices and ACCHOs
Increased awareness of eye care issues by health workers in ACCHOs | | \_More preventative eye care services
Number of referrals to ophthalmologists and relevant referrals to GPs (for diabetes management etc) |
| Previous successful eye health program (78 years ago) and infrastructure/knowledge it created | | Increased awareness of eye care risks within Vic Aboriginal families | | \_Increased comprehensive primary care use
* Client service use post spectacle prescription? vignettes
* Number of referrals by optometrists to other services in ACCHOs or mainstream GPs |

**Acronyms**
- VES: Victorian Eyecare Scheme
- VOS: Visiting Optometrist Scheme = optometrists directly employed by ACO visiting community organisations or gathering places to provide eye care
- ACO: Australian College of Optometry = primary funding agency for Aboriginal Spectacles Scheme
- VACKH: Victorian Advisory Committee on Koori Health; involves Vic Dept Health, Federal Office for ATSI Health (OATSIH) and VACCHO
Attachment 2 - Provider Interview Questions

1. Demographics

1.1 What is your role in the Aboriginal Spectacles Scheme?
   - Employed by ACO and visiting communities
   - Private practice delivering VES/ASS
   - Other

1.2 How long have you been involved in the Scheme?

1.3 What is the location of the practice where you provide the service?
   - Rural/regional/metropolitan

2. Outcome/Impact Vignettes

2.1 Are you able to share with me any examples of clients who have benefited from the Scheme?
   - How has the client benefited?
   - Examination outcome/s:
     - What service/spectacles did the client receive?
     - Was the client referred on to other services?
   - What impact will the service/spectacles have on the client’s health and life?
   - Do you have any patient quotes?
   - Client history:
     - What was the client’s presenting eye problem?
     - Had the client received previous eye services?
     - Was there previous engagement with any other health services? Has engagement improved?
     - What was the approximate date the client was consulted?
     - What was the client’s gender?
     - What was the client’s age?

3. Relative effectiveness of the engagement and capacity building strategies employed by ACO

Now, some questions about the support you have received to engage in the Scheme.

3.1 How did you first become involved with the Scheme?

3.2 Did anything that ACO did make you want to be a part of it? (Engagement strategies employed by ACO)

3.3 What support have you received?
   - Sharing good practice models
   - Cultural training
   - ACO facilitating partnership with local ACCHO
   - ACO strengthening systems of care, e.g. recall systems

3.4 Which support most helpful? By whom? College/local ACCHO/other?
3.5 Which support was least helpful?

3.6 Was further support needed? Not yet received?

4. Other comments