Letterhead of the Hong Kong
Polytechnic University

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6 January 2000

Ms. Doris Chan
Clerk to Panel
Legislative Council
Hong Kong Special Administrative Region of
the People's Republic of China
Legislative Council Building
Central Hong Kong

Dear Ms. Chan,

Enclosed please find a copy of our submissions for the meeting on 10 January 2000.

There are altogether 15 items.

1.	Letter from members of Department of Optometry and Radiography, The Hong Kong Polytechnic University.	5 pages
2.	Copy of Department of Optometry and Radiography's submission in response to the Harvard Report.	7 pages
3.	Letter from the Hong Kong Society of Professional Optometrists.	3 pages
4.	Letter from the Hong Kong Association of Private Practice Optometrists.	3 pages
5.	Letter from the Hong Kong Optometrists Union.	1 page
6.	Letter from the Department of Health's Optometrists.	1 page
7.	Letter from the Hong Kong Society for the Blind	1 page
8.	Letter from Zhongshan Ophthalmic Centre, Sun Yat-sen University of Medical Sciences, China	1 page

9.	Letter from University of Houston, USA	1 page
10.	Letter from University of Auckland, New Zealand	1 page
11.	Letter from Queensland University of Technology, Australia	1 page
12.	Copy of letter from Queensland Health to optometrists	1 page
13.	Letter from Dr. Damien Smith, Australia, member of Governing Board of World Council of Optometry	5 pages
14.	Copy of a joint submission to Health & Welfare Bureau by the Hong Kong Optometric Association and the Hong Kong Society of Professional Optometrists	23 pages
15.	Clippings.	5 pages

Thank you

Prof. George Woo
Dean
Faculty of Health & Social Studies

Encl.
GW/sy

Letterhead of the Hong Kong

Polytechnic University

4th January, 2000

Member,
Panel on Health Services,
Legislative Council

Dear Honorable Panel Member,

Proposed mechanism for patient referral from optometrists to public clinics/hospitals

We understand that the Health and Welfare Bureau is presently considering a proposal that optometrists should be able to refer patients directly to hospitals operated by the Hospital Authority. As Faculty members teaching the 4-year BSc (Hons) in Optometry programme, we support a proposal which is limited to optometrists on Part I of the Optometrists Register. The purpose of this paper is to provide our answers to some questions which may arise in relation to this proposal.

What is the present situation?

Presently optometrists can refer patients either to general practitioners or to private ophthalmologists. They cannot refer directly to HA eye departments, a situation which gives rise to the anomalous situation whereby they can refer to an ophthalmologist in his or her private office, but not to the same ophthalmologist in the HA.

Are optometrists qualified to make referrals?

Optometrists in the USA, Australia, New Zealand and UK can refer directly to hospital eye departments. In fact, major changes in the UK health care delivery system, designed to improve the cost effectiveness of health services, have resulted in shared care schemes between hospitals and optometrists (e.g. treatment of cataract, glaucoma and of the eye complications of diabetes). This takes patients ***out*** of the hospital system, by using optometrists to monitor their conditions. Agreed criteria are then applied to determine when the optometrist should refer the patient back into the system. The front pages of some relevant journal papers are attached.

Optometry education in Hong Kong is similar to that in Australia, New Zealand and the United Kingdom. Optometry faculty are very well qualified and our clinical education facilities are second to none. We believe that optometrists registered on Part I of the Hong Kong Optometrists Register are able to make competent referrals.

Will this mean excessive referrals to the HA, causing a bottle-neck?

At present there are two routes via which optometrists can refer patients for ophthalmological care. Patients with the necessary financial means usually opt for direct referral to a private ophthalmologist. Private ophthalmologists have welcomed our referrals. Those who cannot afford private care are referred to a general practitioner, who

would usually then refer the patient to the HA. The total number of patients requiring referral will be no greater if a third route, from optometrist to HA, becomes available.

Will referral by optometrists mean more false positive referrals? Does the GP help to filter these out at present?

In the UK, general practitioners, who receive limited training in the diagnosis and treatment of ocular conditions, tend to refer eye problems to the optometrist. This avoids sending patients unnecessarily to hospital eye departments. Optometrists, in turn, refer many cases of non-eye related problems to GPs. There is a mutually supportive relationship between GP and optometrist and the beneficiary is the patient. Research conducted in UK hospitals has shown that optometrists are able to make competent referrals (see research paper from the British Medical Journal, attached). False positive referrals from both general practitioner and optometrist do, and will, occur, but these can be minimized if referral criteria are agreed and there is cooperation between professions.

The ophthalmologist is uniquely qualified to treat eye disease and to perform ocular surgery, yet HA ophthalmologists spend much time performing other duties. We know that their workload is very heavy, and that waiting lists for surgical procedures, such as cataract extraction, are unacceptably long. We appreciate that they worry that giving optometrists referral rights would further increase this load. We believe that the way to deal with this problem is not to reject innovative proposals such as the present one, but rather to improve the efficiency of the service by addressing the causes of the problem. One approach is to ensure that specialist medical staff carry out work for which they alone are qualified, rather than work for which other professions have been trained, at a fraction of the cost to the community. Optometric eye care and referrals from well educated optometrists should be part of a modern eye care system, improving both quality and value.

Yours faithfully,

Prof. G. Woo, OD, PhD

Prof. M. Yap, BSc, MCOptom, PhD

Prof. M. Edwards, FCOptom, PhD

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Clinical Survey

An extended role for the hospital optometrist

J. Oster[1]*, L. E. Culham and R. Daniel[2]

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Summary

The management of patients within shared care programmes would seem to have significant benefits in terms of individuals' convenience, addressing resource needs and expanding professional horizons. To date, these schemes have typically concentrated on the monitoring of patients with diabetes and glaucoma. At Moorfields Eye Hospital, we attempted to develop the role of the hospital optometrist by establishing a study to evaluate the clinical appraisal of new referrals in a busy out-patient clinic. The results showed a high level of diagnostic accuracy which suggests that the role of hospital optometrists may be successfully extended to include some aspects of patient evaluation not typically undertaken. The College of Optometrists. Published by Elsevier Science Ltd. All rights reserved

Introduction

Traditionally, the community optometrist performs routine eye examinations and is legally bound to detect (but not diagnose) ocular abnormalities in patients. The duties of hospital optometrists are usually different since they provide clinical support to ophthalmologists who are ultimately responsible for clinical diagnosis and management. It has been recognised that both community and hospital optometrists have the necessary skills to expand their role and make a greater contribution to patient care.

Various schemes have been put in place over the past eighteen years (Giltrow-Tyler, 1997), ranging from case-finding screening to full multidisciplinary co-management. Within the community, these projects are usually arranged between local optical committees and their health authority, in association with the local ophthalmology department, and are generally referred to as "shared care". They have mainly centred on diabetic and glaucoma monitoring (Giltrow-Tyler, 1997; Warburton *et al.*, 1998), although cataract evaluation has been reported as well (Hodgson, 1994). A recent pilot study in Camden and Islington has involved optometrists in several schemes, the most innovative of which concerns the management of specific anterior segment conditions (Winkler and Meads, 1998). Shared care can also operate within a hospital setting where optometrists work alongside nurses and clinicians in a specialised clinic (Hitchings, 1995). A shared care pilot scheme is being carried out in the glaucoma clinics of Nottingham Hospital (Spry, 1997). Similarly, in the near future Moorfields Eye Hospital will have a report illustrating the outcomes of optometrists' working in the glaucoma clinics.

The concept of extending an optometrist's role in the clinical care within the community has been supported by documents such as the NHS Management Executive in 1991, as discussed by Giltrow-Tyler (1997), and more recently the Government's plans for restructuring the NHS (The NHS Executive, 1998). Furthermore, in 1995 general guidelines were published by the Royal College of Ophthalmologists (RCOphth), the Royal College of General Practitioners and the College of Optometrists on setting up shared care

[1]Optometrist.
[2]Consultant Ophthalmologist.

*Correspondence and reprint requests to J. Oster.

Referral patterns to an ophthalmic outpatient clinic by general practitioners and ophthalmic opticians and the role of these professionals in screening for ocular disease

R J Harrison, J M Wild, A J Hobley

British Medical Journal, 1988

Abstract

Case notes of 1113 consecutive new patients referred to a consultant ophthalmologist at a district general hospital were reviewed to determine the source and efficacy of referrals and the current screening practices of general practitioners and ophthalmic opticians. General practitioners initiated referral in 546 cases (49%) and ophthalmic opticians referral in 439 (39%). Visual loss or visual disturbance was the most important single reason for referral (345 cases; 31%), followed by suspected glaucoma (145 cases; 13%), abnormalities of binocular vision (140; 12·5%), disorders of eyelids or ocular adnexa (127; 11%), and red eye (86; 8%). General practitioners referred many more patients with disorders of the eyelids and adnexa and ophthalmic opticians many more patients with suspected glaucoma. Ophthalmic opticians were far more likely than general practitioners to refer patients with suspected glaucoma correctly.

A total of 180 patients (16%) were referred from ocular screening, in 149 cases by ophthalmic opticians and in 10 by general practitioners. Seventy patients had glaucoma or incomplete features of glaucoma, all of them referred by ophthalmic opticians. Of eight diabetic patients referred by ophthalmic opticians, three had asymptomatic disease and in two diabetes was diagnosed as a result of ocular screening. No patient was referred for asymptomatic diabetic retinopathy from screening by general practitioners. Ophthalmic opticians were more likely than general practitioners to diagnose retinopathy requiring photocoagulation.

Use of a community based service to screen for glaucoma could save unnecessary consultant outpatient appointments. A similar service could facilitate detection of diabetic retinopathy at a stage when treatment is most effective.

Introduction

Since 1948 sight tests have been available without charge to the general public, initially through the Ophthalmic Supplementary Service and since 1975 through the General Ophthalmic Service. Most sight tests are undertaken by ophthalmic opticians (87·5% in 1985-6)[1] and the remainder by ophthalmic medical practitioners. Ophthalmic opticians have a statutory duty under the Opticians Act 1958 and the ensuing General Optical Council rules to refer patients with injury or diseases of the eye to a general medical practitioner, and under the NHS (General Ophthalmic Service) Amendment Regulations 1985 to inform the general practitioner of any abnormality of the eyes. Evidence from studies suggests that the General Ophthalmic Service is a main source of referrals to the hospital eye service, particularly with respect to glaucoma.[2-4] Legislation within the current Health and Medicines Bill, however, proposes to abolish the free NHS sight test for all but certain minority groups. Though the planned legislation was thwarted in the House of Lords, there is no evidence of change in the government's attitude. If the bill is ultimately passed the amount of screening now undertaken will almost certainly decline.

This study aimed at investigating referral practice to the outpatient clinic of a consultant ophthalmologist and at identifying the current screening practices of ophthalmic opticians and general practitioners, particularly with respect to the diagnosis of glaucoma and diabetic retinopathy. An appreciation of the pattern of referrals and of the present effectiveness of screening will help guide any changes in practice that may become necessary should the free sight test be abolished.

Methods

From 1 November 1986 to 31 December 1987, 1437 patients were referred to a consultant ophthalmologist at Burton District Hospital Centre. On the basis of the referral letters patients were allocated urgent, semi-urgent, or non-urgent appointments. The case notes of 1113 of these patients were reviewed. The remaining 324 patients had not been seen by the time the study was concluded.

Most of the patients were seen by a single consultant ophthalmologist and the remainder by a clinical assistant or one of several senior house officers. The sample comprised all routine referrals from general practitioners, hospital doctors (mostly consultants), and community medical officers. A few emergency referrals were included if the patients had been seen originally in the clinic; those initially seen outside clinic times or referred from the casualty department were not included. Many outpatient attendances were initiated by ophthalmic opticians, who referred patients via the general practitioner. General practitioners were requested to include a copy of the optician's report, usually on form GOS18, with their referral letter.

TABLE I—Age

Age (years):	No of patients:

Biographical data were obtained from the case notes including sex, age at time of attendance, and source of referral—that is, general practice, ophthalmic optician or ophthalmic medical practice, hospital doctor, or community medical officer. The referral letters were analysed for reports of symptoms and the primary and secondary reasons for referral. The reason for referral was classified by using a system devised for the study which was based on symptoms and anatomical location. Referral data were also analysed for the types of examinations undertaken by the referring agent—for example, assessment of visual acuity, ophthalmoscopy, assessment of binocular vision, visual field examination (including type of visual field test), measurement of intraocular pressure, and fluorescein staining of the cornea. The ocular diseases of each patient were classified according to the International Classification of Diseases (9th revision) and the extended five digit code "Classification of disorders of the eye" proposed by the International Council of Ophthalmology. Finally, the clinical action taken by the ophthalmologist was recorded.

In the assessment of the role of ophthalmic opticians and general practitioners in screening for ocular disease patients were classified as those with or without symptoms based on information in the referral letter and the history taken by the ophthalmologist. Patients were deemed not to have symptoms if they were unaware of any ocular abnormalities apart from those attributable to refractive error, and referral of these

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British Journal of Ophthalmology 1995; 79: 626

Commentaries

Shared care for glaucoma

The term 'shared care' has become an ophthalmic buzz word to describe the sharing of clinical management responsibilities. It has most frequently been applied to the management of outpatients with chronic glaucoma, but could equally well be applied to any other category of outpatient which the clinic head feels has grown too populous for his staff to handle. I will set out some reasons for the development of the concept and current attempts at administering it as well as problems it can cause.

Primary care for ophthalmic outpatients is provided by ophthalmologists. Any patient with an incurable eye disease, such as glaucoma, will require lifelong supervision within the outpatient department. Constant new referrals without discharges mean an ever increasing number of outpatients with this disease, hence the disproportionately large number of patients with chronic glaucoma in any general outpatient clinic. Without an increase in staffing levels to meet demand, the extra numbers are only managed by reducing the intervals between visits or by squeezing out (discharging) other categories of outpatient. This approach suffices for a while but sooner or later the attention available for each patient is reduced, patient care suffers, and 'quality' falls. Often charter standards fail to be met as well. There is, therefore, a major incentive for ophthalmologists to try and lighten this outpatient load.

One option would be to depute paramedical personnel either within the eye department or outside it to manage some of these patients. Such an approach to the management of chronic ophthalmic disease can be called 'shared care'.

Shared care has, on the face of it, much to recommend it; relief for the hard pressed ophthalmic outpatient clinic, better and more economical throughput of patients, maintenance of charter standards, and greater cooperation with our paramedical colleagues. It has also definite problems including legal responsibility for patient care and safety of the patient. Therefore, it is worth looking at the experimental models under way or in the pipeline.

The MRC is funding a pilot study at Bristol whereby the management of chronic glaucoma by ophthalmologists in the eye clinic is being compared with that given by community optometrists. The efficacy, practicality and, eventually, success of the experiment is awaited with interest.

In Sheffield, Glasgow, and other centres shared care is confined to the hospital (a method preferred by a majority of ophthalmologists surveyed by our royal college recently). Here optometrists, orthoptists, and nurses work alongside clinicians in a semiautonomous unit, adhering to protocols of management and asking for advice when problems are identified. The safety and efficacy of this approach will be compared with the 'outreach' Bristol approach in a study to be embarked upon by Richard Wormald at Moorfields Eye Hospital.

If neither 'experiment' works, perhaps because of poor disease control, a legal difficulty, or patient/ophthalmologist unhappiness, then two options remain – either to assign more staff to outpatient management of chronic disease or to allow this patient group to suffer a decline in clinical standards as more and more patients attend for treatment. The former might be justified under the current contracting system with resources following patients, although there is little sign of it at present. The latter will be associated with a rise in patient complaints and litigation, as well as decreasing job satisfaction for the luckless practitioner.

Assuming that a model of shared care works, should it be adopted nationally? To do so would overcome the problems outlined above. Who would participate? Primary care physicians (general practitioners) will not acquire the necessary skills in the foreseeable future. There are few clinical assistants remaining nationwide. Almost by default for the community this leaves the optometrists, while in hospital the choice is wider. Would optometrists in the community want to participate? To judge by recent discussions, many are prepared to do so. With suitable controls concerning the legal position, examination skills, and treatment protocols their profession would fulfil current needs. Care would need to be taken to erect 'Chinese walls' to prevent temptation by the treating optometrist from becoming the selling optometrist as well. With these provisos the optometrist in the community could join in 'shared care' schemes and assist in the management of our chronic ophthalmic diseases such as glaucoma. It will be up to our respective colleges to establish guidelines. Any community care scheme can only function with the cooperation of all the participants, both medical and administrative. We would have to avoid the American experience of having 'shared care' imposed without prior testing for efficacy or safety or considering its effect on other community eye health.

ROGER HITCHINGS

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Department of Optometry & Radiography

Submission in response to the report "Improving Hong Kong's Health Care System: Why and for whom?"

Introduction

The Department of Optometry & Radiography welcomes the opportunity to respond to the report, "Improving Hong Kong's Health Care System: Why and for whom?"

This Department is the sole provider of formal education for optometrists, diagnostic and therapeutic radiographers in the Hong Kong SAR.

Our interest in the report lies in the fact that our graduates participate in the delivery of health care in the Hong Kong SAR. Consequently, changes in the health care system may have an impact on the scope of practice and employment opportunities of our graduates. This will, in turn, have an impact on the way we educate the future optometrists and radiographers of the Hong Kong SAR.

The current health care system

1. Medically-driven

This Department agrees with the observation made in the report that the current health care system in Hong Kong is medically driven.

The evidence for this can be seen by a cursory review of the staff who make up the senior management of the Department of Health and the Hospital Authority.

Medical dominance is also evident from the appointed membership and chairmanship of the statutory regulatory bodies for non-medical health professions such as Optometry and Radiography.

2. Other health professionals - untapped resource

Optometrists and radiographers educated at the PolyU are on par with those from the UK, Australia and New Zealand. However, their deployment in the workplace, particularly in hospital settings, does not fully reflect their skills and capabilities. For instance, optometrists in the HA are deployed as no more than refraction technicians in the Eye Department. In major hospitals elsewhere (e.g. Moorfields Eye Hospital), optometrists play a much wider role in patient eyecare. Indeed, a recent study at Moorfields Eye Hospital showed that an optometrist's diagnostic accuracy of eye diseases presented in a primary eyecare clinic is high. (Oster et al, 1999). Many major hospitals in the UK and Australia have Optometry departments. The irony in Hong Kong is that although our degree level optometry graduates are trained and educated to the same level as UK optometrists, their deployment and salary in the hospital sector is that of a technician (*see Appendices 1 and 2*). Ultimately, the community has lost out, both in terms of the

investment made in the tertiary level education of optometrists and in the quality of service received when members of the community have to visit the hospital.

In a similar manner, radiographers in Hong Kong hold very little formal authority though the level and quality of education is at least equal to that of the countries mentioned previously. The regulatory bodies which govern the scope and range of practice of radiography, are invariably controlled by medical personnel, and increased responsibility is discouraged. Radiographers are mostly employed in situations where they are not expected to assume any level of responsibility. Any ambition our young graduates have for continuing education or professional development is rapidly stifled by lack of incentives. Changes within the Hospital Authority, however, do suggest a larger role for radiographers. Developments in Australia, Britain and North America show that radiographers are not only able to assume a greater degree of responsibility in radiology departments, but that their contribution supports the role of the radiologist and can lead to a decreased need for radiology personnel.

Appropriate deployment of optometrists and radiographers, reflecting their full scope of skills, will bring savings to the hospital sector and improve quality of service.

3. System of patient referrals

Another irony of the current healthcare system is the system of patient referrals from private optometrists to the hospital sector. Hospital eye departments in Hong Kong do not accept referrals from optometrists. Instead, the patients must be referred to a general practitioner first and then onward to the hospital eye department. A general practitioner would have had no more than 2 to 3 weeks of training in eye disease whereas an optometrist *specializes* in the eye and vision.

If the goal is to achieve maximum efficiency from the patient's point of view, it would make a lot more sense for general practitioners to refer patients to optometrists to determine if the patients required monitoring or management outside the hospital system or an urgent appointment at hospital eye department. A significant number of patients who present at a hospital eye department only require optometric services and these cases can be filtered at this stage. This minor change in the referral route alone will significantly reduce the long waiting lists in hospital eye departments.

Recommendations for change

1. The Department supports a system where the money follows the patient. Such a system offers choice to patients and encourages competition within the healthcare sector.

2. The Department supports an overhaul of the current healthcare system. Any future system should integrate all healthcare professionals within its framework.

3. The Department supports appropriate deployment of healthcare professionals. There should be no artificial barriers to service provision. If the government, through its educational institutions, see fit to educate its healthcare professionals to a particular level of skill and competence, these professionals should be free to practice to the full scope of their training.

References

Oster J, Culham LE, Daniel R. An extended role for the hospital optometrist. Ophthal Physiol Opt, 1999, 19:351-356

Appendices

Appendix 1 - salary comparisons between UK & HK hospital optometrists in relation to other healthcare professionals

Appendix 2 - course outlines of the BSc(Hons) in Optometry and BSc(Hons) in Radiography

Comparison of Salaries of Different Professions in Medical Health Care in the UK
(Salaries in Sterling Pounds per annum)

	Clinical Scientists	Hospital Optometrists	Dieticians	Midwifery	Orthoptists	Physiotherapists	Radiographers	Pharmacists
0	12298	12298	14180	8315	13655	13655	13665	Grade A/B
1	12790	12790	14715	8615	14180	14180	14180	14,000 to
2	13302	13302	15250	8915	14715	14715	14715	20,000
3	13833	13833	15785	9215	15520	15250	15250	(newly
4	14386	14386	16465	9525	15785	15785	15785	registered)
5	14962	14962	17225	9845	16465	16465	16465	
6	15561	15561	17990	10170	17225	17225	17225	
7	16181	16181	18755	10500	17990	17990	17990	Grade C
8	16830	16830	19665	10850	18755	18755	18755	21,000 to
9	17504	17504	20575	11210	19665	19665	19665	23,000
10	18203	18203	21485	11590	20575	20575	20575	
11	18931	18931	22090	11990	21485	21485	21485	Grade D
12	19688	19688	22700	12420	22090	22090	22090	25,000 to
13	20475	20475	23320	12855	22700	22700	22700	30,000
14	21296	21296	24940	13290	23320	23320	23320	
15	22145	22145	25770	13755	24120	24120	24120	Grade E
16	23033	23033	26610	14225	24940	24940	24940	31,000 to
17	23953	23953	27490	14705	25770	25770	25770	34,000
18	24910	24910	28390	15190	26610	26610	26610	(Pharmacy
19	25908	25908	29390	15725	27490	27490	27490	Operations
20	26945	26945	30390	16310	28390	28390	28390	Manager)
21	28022	28022	31400	17030	29390	29390	29390	
22	29143	29143		17775		30390	30390	(information
23	30308	30308		18495		31400	31400	provided on
24	31522	31522		19240		32520		2 July 1999)
25	32782	32782		19985				
26	34094	34094		20735				
27	35458	35458		21495				
28	36876	36876		22255				
29	38350	38350		23025				
30	39885	39885		23795				
31	41479	41479		24580				
32	43140	43140		25375				
33	44866	44866		26170				
34	46660	46660		26965				
35	48528	48528						
36	50468	50468						

Comparison of Salaries of Different Professions in Medical Health Care in Hong Kong

(Salaries in Hong Kong Dollars Per Month As At June 1999)

	Hospital Optometrists	Dieticians	Midwifery	Orthoptists	Physiotherapists	Radiographers	Pharmacists	Dental Officer	Speech Therapists
0	18,140	23,170	14,300	18,140	19,055	19,055	35,285	40,500	23,170
1	19,055	24,320	15,160	19,055	20,010	20,010	36,940	42,405	24,320
2	20,010	26,805	16,095	20,010	21,010	21,010	40,500	46,485	25,530
3	21,010	28,075	17,100	21,010	22,075	22,075	42,405	50,190	26,805
4	22,075	29,395	18,140	22,075	23,170	23,170	44,395	52,520	28,075
5	23,170	30,785	19,055	23,170	24,320	24,320	47,970	55,000	29,395
6	24,320	32,190	20,010	24,320	25,530	25,530	50,190	60,190	30,785
7	25,530	33,705	21,010	25,530	26,805	26,805	52,520	62,780	32,190
8	26,805	35,285	22,075	26,805	28,075	28,075	57,525	65,490	33,705
9	28,075	36,940	23,170	28,075	29,395	29,395	60,190	68,310	35,285
10	29,395	38,695	24,320	29,395	30,785	30,785	62,780	71,240	36,940
11		40,500	25,530	**30,785**	**32,190**	**32,190**	65,490	72,815	38,695
12	**MPS 13-23**	42,405	26,805	**32,190**	**33,705**	**33,705**	68,310		40,500
13		44,395		**33,705**	**35,285**	**35,285**	71,240	**MPS 30-44**	42,405
14		46,485	**MPS 9-21**	**35,285**	**36,940**	**36,940**	72,815		44,395
15				**36,940**	**38,695**	**38,695**		(efficiency bar	46,485
16		**MPS 18-33**		**38,695**	**42,405**	**42,405**	**MPS 27-44**	after MPS 37)	
17		(Omit pt 20)		**40,500**	**44,395**	**44,395**		(Omit pts 32,	**MPS 18-33**
18				**42,405**	**46,485**	**46,485**	(efficiency bar	34 & 38)	
19				**44,395**	**47,970**	**47,970**	after MPS 35)		
20				**46,485**			(Omit pts 29,		
					MPS 14-24	**MPS 14-24**	33 & 37)		
				MPS 13-23	(Grade II)	(Grade II)			
				(Grade II)					
					MPS 25-33(A)	**MPS 25-33(A)**			
				MPS 24-33	(Grade I)	(Grade I)			
				(Grade I)					
					(efficiency bar	(efficiency bar			
					after MPS 28)	after MPS 28)			
					(Omit pt 30)	(Omit pt 30)			

Document 3

Letterhead of The Hong Kong Society of Professional Optometrists

Members
Panel of Health Services
Legislative Council

1st January, 2000

Dear honorable panel members,

Direct Referral from Optometrists to Public Hospitals

The Hong Kong Society of Professional Optometrists was established in 1982 and with a current membership of around 250 formally trained optometrists. We aim to promote high standards of eye and visual health care services to the Hong Kong public and to enhance the practice of Optometry in Hong Kong for the best interest of Hong Kong's people.

The role of optometrist is the primary health care provider who cares for the functionally inadequate visual system. We are educated and trained in the normal and abnormal physiology of the eyes and the psychophysics of vision.

According to Code of Practice of the Optometrists Board of Hong Kong:
Part III, 3 Relationship with Other Professionals
3.1 Any Patient who appears to the optometrist to have an ocular abnormality which might require specialized attention should be referred for the appropriate professional care.

Very often, we diagnose ocular disease conditions through our typical eye examinations. However, we are frustrated that we cannot refer those patients directly to the eye departments of public hospitals. At the present time, we can only refer those patients either to general practitioners or to private ophthalmologists. General practitioners typically follow the optometrist's referral recommendations while adding little or no information. Private ophthalmologists routinely accept referrals. Patients who cannot afford private medical services will take a

needless and longer route to the eye departments of public hospitals. Obviously, it leads to inconvenience to the patients and delayed medical treatment may also lead to serious irreversible damage in many ocular diseases such as retinal detachment.

The role of optometrists in primary health care is well recognized and optometrists can make direct referral to eye departments in public hospital in some developed countries, e.g. United Kingdom, Australia and New Zealand. It is a well-known fact that the inclusion of Optometry in these health care systems can improve the cost effectiveness of health services. Optometry education provided by the Hong Kong Polytechnic University is comparable to that in these countries. So we strongly believe that all of our members can make competent referrals.

In conclusion, establishment of direct referral mechanism from optometrists to the eye departments in public hospitals would be a small but significant step so as to improve the quality and reducing costs in providing eye care services to the Hong Kong people.

Finally, we stress that the role of optometrists in the planning and implementation of local primary health care system should not be ignored by the Government of Hong Kong.

Thank you for your kind attention.

Yours Faithfully,

Dominic C.P. Chim
President
Hong Kong Society of Professional Optometrists

視光師是誰

視光師（OPTOMETRIST）、
眼科醫生（OPHTHALMOLOGIST）和
眼鏡技術員（OPTICIAN）之分別：

視光師（OPTOMETRIST）
——如上。

眼科醫生（OPHTHALMOLOGIST）
——包括開眼藥處方和做眼科手術。

眼鏡技術員（OPTICIAN）
——依照視光師或眼科醫生所開的處方來配眼鏡及調較眼鏡。

如有任何疑問，請詢問你的視光師。

謹向以下公司致意：

香港專業視光師學會
The Hong Kong Society of
Professional Optometrists

視光師（OPTOMETRIST）是提供眼睛保健的專業人員，他們善於測定視覺功能，診斷視覺及眼睛毛病，更會利用光學鏡片、視覺矯形訓練等等方法去增強或矯正視覺功能。

學習與受訓範圍

大致可分爲：

- 眼睛解剖學
- 眼睛病理學
- 生理學
- 神經解剖學與視覺心理學
- 藥劑學
- 眼鏡光學與鏡片製造
- 生理光學
- 理論與臨牀視光學

工作簡介

1. 視覺檢查

視光師的工作包括檢查病人的視力、色覺、立體覺等等。其中較爲人所熟悉的工作是進行驗光，以辨別視力毛病的性質及度數。香港人最常患的眼睛毛病是遠視、近視及散光，而一些老年人由於生理上的轉變，老花便是他們主要的問題。

2. 配置有框眼鏡

經驗光後，視光師便會因應個別的需要開處方，利用不同的鏡片來矯正病人的視力。

3. 驗配隱形眼鏡

視光師首先檢查病人的眼睛以確定他們是否適合配戴隱形眼鏡。驗配後，視光師還會指示病人正確的護理及配戴鏡片方法。更重要的是要配戴者作定期檢查，確保眼睛健康。

4. 眼睛健康檢查

視光師不能開藥或動眼部手術，但他們可以檢查病人的眼睛健康狀況，如發現病人患有眼病（例如青光眼、視網膜病變）或身體疾病（例如糖尿病、高血壓），視光師便會將他們轉介給眼科醫生或家庭醫生處理。

5. 視覺矯形訓練

某些視覺毛病（例如弱視、斜視）是可以透過視覺矯形訓練而得到改善的。視光師會因應個別情況，設計療程，爲病人進行視覺矯形訓練。

6. 提供諮詢服務及教育公衆

視光師能提供眼睛保健及護理常識，以減低人們眼睛或視力受損的機會。而且，視光師亦會參予一些爲社團及公衆驗眼服務等大型活動，令公衆關注他們的眼睛健康。

Document 4

Letterhead of The Hong Kong Association of Private Practice Optometrists

January 1, 2000

Role of optometrists in Hong Kong's health care system

Patient referral from optometrists to public clinics/hospitals

Dear Legislative Council Panel Members on Health Services,

We are aware that the Health and Welfare Bureau is presently considering a proposal that optometrists should be able to refer patients directly to hospitals and ophthalmic units operated by the Hospital Authority.

Representing private optometry practitioners in Hong Kong, The Hong Kong Association of Private Practice Optometrists maintains primary eye care as one of our objectives in our services to the public. We firmly believe that direct referral of patients to public hospitals is in the best interest of the public.

Current Situation

Presently, if an ocular condition such as glaucoma, cataract or retinal detachment is detected, an optometrist can either refer the patient to a general practitioner or to an ophthalmologist in private practice but the channel in referring patient to public hospitals directly does not exist. In other words, we can refer, but only to a general practitioner or an ophthalmologist in private practice. They welcome our referrals.

Public Interest

According to the Code of Practice of the Optometrists Board of Hong Kong Part III, Section 3.1: Any patient who appears to the optometrist to have an ocular abnormality which might require specialized attention should be referred for the appropriate professional care.

Again, we can and should refer; but again, referral has to go to a private practitioner. Someone who might be less well off will either have to put up with the higher cost to see a private ophthalmologist or to be referred to a general practitioner at a slightly lower cost (but more time) to be then referred to the hospital. Or they will have to be told to visit the hospital out-patient department to have their ocular conditions revisited all over again.

In these latter cases, the patient has to wait for approximately five and a half months to see the ophthalmologist at the eye department, according to the Harvard Report. Some conditions cannot wait! Is this in the best interest of the public? Is this the best way to address resource needs?

International Standards

Our counterparts in the UK, USA, Australia and New Zealand are all able to refer directly to medical disciplines in public hospitals. Part I optometrists in Hong Kong are either trained overseas in these countries or trained in the Optometry program at the Hong Kong Polytechnic University which is recognized to be equivalent to training programs in Australia, New Zealand and the UK. If optometrists in those countries can refer directly and successfully, what is it in our society and system that stop us from doing just the same?

In the UK, various schemes have been put in place over the past 18 years, ranging from case-finding screening to full multidisciplinary co-management to seek significant benefits in terms of individuals' convenience, addressing resource needs and expanding professional horizons. These projects, generally referred to as "shared care", are usually arranged between optometrists and their health authority, in association with the ophthalmology department. Shared care has been reported to be of greater patient benefit than conventional care.

In the US, it has been estimated that approximately 95% of the patients who seek the services of a vision care practitioner do so because of an optometric problem, whereas the other 5% do so because of a medical problem.

Another US study shows that the largest portion (70%) of actual and perceived eye care needs in an equally age-distributed patient population is the optometric management of visual anomalies.

If Hong Kong has a similar situation to the UK and the US, then it deserves far more than just a direct referral system for optometry, it constitutes a revamp of the entire eye care regime to include the role of optometry in the health care system to maximize resources.

We therefore believe that the direct referral mechanism is a necessary and logical first step towards better patient care. We sincerely hope that you would support our view that it is in the best interest of our society and the most efficient use of public resources to have optometrists refer patients directly to public eye clinics and hospitals.

Thank you for your attention.

Yours truly,

Greg Wu Chor Nam
President
The Hong Kong Association of Private Practice Optometrists

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3. Theodore Grosvenor. Primary Care Optometry, 3rd edition, 1996

4. Catania LJ, Roberts JS. Eye care delivery in prepaid group practice. Proceedings of the 27th Annual Group Health Institute, Los Angeles: CA, June 1977

Document 5

Letterhead of The Hong Kong Optometrists Union

Member
Panel on Health Services
Legislation Council

4 January, 2000

Dear honorable member,

Direct referral from optometrists to public eye clinics

We are optometrists working in eye clinics of Hospital Authority. We support the proposal that optometrists registered in Part I of the Optometrist Register could refer patients directly to public eye clinics.

The current situation in Hong Kong is that optometrists can only refer those patients requiring ophthalmological services to private ophthalmologists, or general practitioner who may then refer them to public eye clinics. The indirect route (i.e. through general practitioners to eye clinics) does not merely cause inconvenience to patients, but more importantly may unnecessarily delay treatment.

Optometrists in USA, UK, Australia and New Zealand play an important role in primary health care. They directly refer patients to suitable professionals, including public ophthalmologists, when patients' conditions deem necessary. Optometrists registered in Part I in Hong Kong have received similar training as those in the above said countries. We believe that we could contribute more than what are now doing in improving the primary health care services. The referral by optometrists is unlikely to cause a sharp increase in number of new cases in public eye clinics, as those patients would be referred by general practitioners anyway.

Thank you for your kind attention.

Yours Faithfully,

Dickson Ho
Chairman
Hong Kong Optometrists Union

Document 6

3rd January, 2000
Members,
Panel on Health Services,
Legislative Council

Dear Honorable Panel Member,

Proposed mechanism for direct patient referral from optometrists

We are writing to express our views regarding a proposal for patient referral from optometrists to hospitals operated by the Hospital Authority. As optometrists working under the Department of Health, we strongly support the proposal.

At present, the Department of Health is providing primary eye care services to children and students through the Child Assessment Service and Student Health Service. The services include determination of refraction, assessment of binocular vision and colour vision, evaluation of ocular health, contact lens evaluation and fitting, as well as vision therapy. Also we are responsible for issuing spectacle prescriptions to the patient, monitoring their eye problems and counseling when necessary. Those are tasks within the scope of practice of optometry.

However, we are not permitted to refer patients directly to eye clinics in HA hospitals when he/she has eye problems or requires medical eye care. Instead, the patient is asked to see a medical officer to get a referral letter signed by the medical officer. This referral process is clumsy, inflexible and costly.

The expectation of patients requiring medical treatment in the services of DH is increasing and the workload of the medical officers is very heavy. Therefore, referral directly from optometrists can avoid adding extra workload to the medical officers and let them concentrate on their consultation as well as the operation of the clinics. Also, it can reduce the waiting time, the total consultation time as well as the inconvenience to the patients. That provides more efficient and high quality services to the patients.

Finally, as we received comprehensive university optometry education and professional clinical training in HK which is similar to that in United Kingdom and Australia, we believe optometrists registered on Part I of the Hong Kong Optometrists Register are able to make competent referral.

Yours faithfully,

Cheung Chi Ho	Lam Kin Shing	Wong Tze Wai
Tong Kam Man	Liu Sau Kuen	Cheung Pui Yi

Document 7

Letterhead of The Hong Kong Society for the Blind

Our ref: GELVC/2000
Your ref:

Members
Panel on Health Services
Legislative Council

4 January, 2000

Dear Honuorable Panel Members,

The Hong Kong Society for the Blind is a non-profit making charitable organization and is the principal service provider in providing comprehensive services to the visually impaired in Hong Kong. Among other services, the Society operates a speciality clinic, the General Eye and Low Vision Clinic (GELVC), to provide ophthalmological, optometrical and low vision services to patients in need of eye care services, especially the visually impaired. Referral system has been established between optometrists and ophthalmologists in GELVC. We are in the opinion that optometrists with appropriate training are capable of making referrals directly to general practitioners and eye doctors and such practice helps avoid unnecessary delay for medical management.

As far as we know, referral systems between optometrists and medical practitioners have been established by many organizations, clinics and private practices except for public clinics. Therefore, allowing optometrists to directly refer patients in need of medical care to public clinics will give patients the right to choose to be referred to private or public clinics.

Thank you for your attention.

Yours Sincerely,

Grace Chan (Mrs.)
Director

Document 8

中山眼科中心的信頭

叶鍵雄教授
香港九龍紅勘
香港理工大學　視光學與放射科學系主任
1999 年 12 月 29 日

尊敬的叶健雄主任：

我謹以廣州中山眼科中心主任的名義，向您致以新年的問候！

在 20 世紀即將過去，21 世紀即將來臨之際，我衷心感謝您們一直給予的關心和支持，祝願您們在工作上取得更大的進步，也希望我們之間的交流合作更愉快。

中山醫科大學中山眼科中心是國內最大的眼科中心，下設眼科醫院、眼科研究所和防盲治盲辦公室，中山醫科大學眼科視光學系也設在本中心。中心集醫療、科研、教學和防盲治盲於一體，是我國眼科學重點學科和衛生部眼科重點實驗室的依托單位，也是世界上最具規模的 20 間眼科中心之一。中心現有在職員工 400 餘人，擁有中國工程院院士 1 名，正副高級專業技術職稱 60 餘人，其中，博士導師 9 人，碩士導師 29 人，技術力量雄厚。下屬眼科醫院是國內最大的眼科醫療基地，設有病床 300 多張。我們每天平均接待眼科病人一千多人，他們來自全國各地，也包括香港、澳門、台灣及東南亞地區，其中約 1/4 需要視光學的檢查、診斷和矯治。在這部分病人當中，常常發現有病理狀態如白內障、青光眼、眼腫瘤、眼眶病、眼底病、眼肌疾病等。這些病早期發現就能得到及時的診治，其預後就大不相同。

在新的世紀到來的時候，我很高興地看到我們在眼保健的領域裡有很多可以合作的前景，我們很樂意將我們眼科醫院的各種專業條件和專業經驗提供出來爲您們認爲需要的患者服務。當然，我們同時也很樂意分享您們在眼科視光學教育、研究、臨床等諸方面的成就與經驗。

祝

新年進步！

中山醫科大學
中山眼科中心主任

葛堅教授
1999 年 12 月 30 日

Document 9

Letterhead of UNIVERSITY OF HOUSTON

College of Optometry
Office of the Dean

January 3, 2000

Professor Maurice Yap
Department of Optometry and Radiography
Hong Kong Polytechnic University
Hung Hom Kowloon
Hong Kong Fax: 85 22 764 7612

Dear Professor Yap:

It is my understanding that the Hong Kong Legislative Council Subcommittee on Health Services plans to examine the profession of optometry in the context of primary health care. The specific question posed is "whether eye departments in hospitals should accept referrals directly from optometrists or expect optometrists to refer to family medical practitioners who then would send the patient to the eye department?"

In all states in the United States, eye departments and privately practicing ophthalmologists accept referrals and requests for consultation from optometrists. With the focus on patient access, quality care and cost, direct referrals are expected and considered the norm in the U.S. It is still true in some health maintenance organizations (HMO) that triage of all patients entering that particular healthcare system, for any purpose, is conducted by allied medical personnel and family practice physicians. Such triage does not occur in eye departments in hospitals. Indeed, these departments routinely receive direct referrals from optometrists and other primary care physicians and ophthalmologists.

The optometrists in Hong Kong have the education, training and clinical experience to refer directly to subspecialist ophthalmologists located in eye departments in hospitals. Indeed, it is my understanding that optometrists in the United Kingdom, Australia and New Zealand also refer to and seek consultation directly from ophthalmologists in eye departments in hospitals.

Cordially,

Jerald W. Strickland
Dean

JWS/saj

The University of Auckland

Department of Optometry and Vision Science

Robert J Jacobs

Clinic Director

64 9 - 3737 599 ext 6019

email: r.jacobs@auckland.ac.nz

Faculty of Science
The University of Auckland
Private Bag 92019
Auckland, New Zealand

Medicine and Health Science Campus
85 Park Road, Grafton
Telephone: 64 9 - 373 7599
Facsimile: 64 9 - 308 2342

Document 10

23 December, 1999

Prof. MKY Yap
Head
Department of Optometry and Radiology
Hong Kong Polytechnic University
Hung Hom
Kowloon
Hong Kong.

Dear Maurice

In reply to your query about the referral protocols for optometrists in New Zealand, I am happy to provide the following information.

When a condition requiring referral for diagnosis / treatment is detected by an optometrist, the optometrist is able to refer the patient directly to any of the primary, secondary or tertiary health care providers in New Zealand.

Ophthalmologists and Hospital Eye departments both accept direct referrals from optometrists. A copy of the referral letter or note is of course sent to the patient's General Practitioner so that he/she has complete records of the patient's care.

For example
(i) where eye symptoms or signs are found indicating that ophthalmological care is required the patient can be sent directly to the Hospital Eye department;
(ii) where visual field plots indicate that a lesion is likely to be in the visual pathways beyond the eye / optic nerve a referral directly to the Hospital Neurology department (again with a copy to the GP) is made and accepted.

If you have any further queries about the referral structure in NZ please let me know

Kind regards

Yours sincerely,

Robert J Jacobs (PhD)
Associate Professor
Clinic Director

Letterhead of Faculty of Health
Queensland University of Technology

Professor Maurice Yap
Head, Department of Optometry and Radiography
Hong Kong Polytechnic University
Hung Hom
Kowloon
Hong Kong.

December 22 1999.

Dear Maurice;

Re: Referral practices of Optometrists in Australia.

Thank you for your inquiry regarding the above matter. Following the examination of the patient, and where an ocular and/or systemic disease is diagnosed or suspected, optometrists in Australia usually refer as follows:

To the ophthalmologist in private practice
To the patient's general medical practitioner
To the eye department of a local hospital.

For several decades, optometrists have had the right of direct referral to ophthalmologists in private practice, with the patient recouping fees under the terms of the Medicare agreement. Optometrists can also refer directly to the patient's GP and to the Eye Department of a hospital. In the latter case, the patient does not have to go through their GP first, thus saving time, resources and money. Optometrists also send a written report to the GP when the patient is referred elsewhere. The system works well and to the benefit of all concerned, - especially the patient.

I hope this is helpful.

Yours sincerely;

PETER G SWANN
Associate Professor
School of Optometry.

Letterhead of QUEENSLAND HEALTH

PERFORMANCE MANAGEMENT BRANCH

Enquiries to: Dorothy Vicenzino
Surgical Access Team
Telephone: (07) 322 52483
Facsimile: (07) 323 41865

Dear Optometrist

On 30 April 1999, the third quarterly publication of the *Elective Surgery Waiting List Report* was released. This report provides details regarding the status of elective surgery waiting lists in Queensland, for 33 major elective surgery hospitals by urgency category and by specialty. The main aim of the publication is to provide practitioners who refer patients to public hospitals for surgery, with information that will enable them to make informed decisions and to discuss referral options with their patients.

The report is available on the Queensland Health internet and intranet sites (http://www.health.qld.gov.au/). However should you require a hard copy of this report and future publications, please supply your contact details below and return to the Surgical Access Team, 16th floor, Queensland Health Building, PO Box 48, Brisbane 4001.

I believe the information contained within the *Report* will be of use to optometrists when referring patients to Queensland public hospitals.

Yours sincerely

(Mr) Ross Pitt
Deputy Director-General
(Planning & Systems Division)
21/5/1999

Name: .....

Position: .....

Address .....

Phone: (work) ..... (mobile) ..... (other) .....

DR DAMIEN P SMITH AM
BAppSc MScOptom PhD (Melb) LOSc FAAO FVCO
Optometry & Contact Lenses

Professor George WOO
Dean
Faculty of Health & Social Studies
The Hong Kong Polytechnic University
Hunghom, Kowloon
Hong Kong

6 January 2000

Dear Professor Woo,

I am pleased to respond to your request for comment on the role of Optometry in primary eyecare and more specifically on the matter of direct referral by optometrists to secondary and tertiary level eyecare services.

PRIMARY EYE CARE IN AUSTRALIA

In Australia the optometrist is the primary eyecare practitioner, and for about 95% of Australians, an optometrist is their first and only point of contact with the eyecare system.

Under Medicare, the universal health insurance program that covers medical and optometrical services in Australia, any Australian may consult any optometrist or medical practitioner and be reimbursed 85% of the scheduled professional fee.

Any Australian has direct access to an optometrist (no prior medical referral or approval is required), and the optometrist can directly refer the patient to an ophthalmology provider (there is no requirement for a general medical practitioner to serve as an intermediary).

Optometry's Scope of Services

Under Section 23A and Schedule 1 of the Health Insurance Act 1973-75, the scope of services for optometrists was statutorily defined as:

> **All services as are ordinarily rendered in relation to consultation on vision problems, including:**
> - **the taking of the patient's case history**
> - **examination of the eyes and related structures to determine the presence of vision problems, eye manifestations of disease and other abnormalities**
> - **refraction**
> - **measurement of ocular motility and coordination**
> - **tonometry**
> - **the performance of further indicated tests eg gonioscopy**
> - **consultation procedures relating to prescription and adaptation of spectacle or contact lenses or other optical aids**
> - **the use of visual training regimen to preserve or restore maximum visual efficiency.**

Davies Building
7 Cookson Street, Camberwell 3124, Victoria, Australia
Telephone (+61 -3) 9882 9122 Facsimile (+61 -3) 9882 6203

It should be noted that

- refraction is **not** the definition of Optometry but rather just one of many clinical procedures included within the definition of Optometry
- optical dispensing and spectacle making are not included in the statutory description of the role of Optometry.

The scope of services of Optometry has recently been expanded to **include the use of pharmaceutical agents for the treatment of disease in the eye**.

Legislation has been passed in the State of Victoria, and is imminent in the State of Tasmania, which permits optometrists to use topical antibiotic, antiviral, anti-glaucoma and corticosteroid drugs for the treatment of eye disease.

Optometrists in Australia are already permitted to use a wide range of topical drugs for diagnostic purposes eg topical surface anaesthesia, and they already perform minor procedures such as superficial foreign body removal and lacrimal lavage.

Optometrists also manage facilities for refractive surgery by excimer laser, and comanage patients undergoing refractive surgery.

State and Commonwealth governments in Australia have recognised that optometry is the most cost-effective resource for the provision of primary eyecare. Optometrists are university trained as eyecare specialists, are easily accessible to the community, and are affordable by both public and private sectors.

Using optometrists to provide primary eyecare is regarded as efficient health services planning because:

- it utilises a professional group at its optimal level of competence
- it avoids using a professional group who are relatively poorly trained in eyecare and better utilised elsewhere (general medical practitioners), and
- it does not divert well persons to secondary professionals or tertiary facilities trained or designed for the treatment of unwell persons (ophthalmology services)

In recent years Australian society has benefited by direct government action to permit community access to a wide range of health services delivered by persons who are not trained as medical practitioners.

Governments now recognise that the medical profession has historically used political process and influence to suppress or control alternative forms of health service, and that such manipulation, whilst purported to be for protection of the public welfare, was simply self-serving, anti-competitive, and intended solely to maintain medical prestige and high financial returns to medical practitioners. (see Willis, Evan *Medical Dominance* Allen & Unwin, North Sydney 1989)

DIRECT REFERRAL BY OPTOMETRISTS TO OPHTHALMOLOGISTS

Private Sector Primary Eyecare

Optometrists have always been permitted to refer patients directly to ophthalmologists, except that prior to 1969 such direct referrals attracted a lesser health insurance benefit for the patient under the National Health Act in place at that time.

In 1969, after two public inquiries (the Nimmo Committee and a Senate Select Committee) the Australian Government formally endorsed direct referral by optometrists to ophthalmologists and such referrals became embedded within Australia's health care system on the same terms as referrals by general practitioners to ophthalmologists.

The Government accepted that requiring general medical practitioners to act as an intermediary in the referral of a patient by an optometrist to an ophthalmologist:

- always benefited the general medical practitioner but rarely benefited the patient
- was wasteful of optometrists as an adequately trained clinical resource
- was inefficient because the general medical practitioner rarely performed any clinical function but simply fulfilled bureaucratic paperwork
- was medically inappropriate because it often prejudiced clinical outcomes by delaying the commencement of treatment
- was an unnecessary cost to health insurance without added value
- was an artificial complication unrelated to quality of care or cost efficiency

In the thirty years since 1969, a number of studies have documented that optometrists refer patients at rates consistent with the known epidemiology of medical eye disorders, and with a very high level of accuracy of diagnosis.

It should be noted that the Australian Medical Association and the Royal Australian College of Ophthalmologists opposed the right of direct referral, but that opposition was regarded as self-serving, a perception reinforced by the subsequent public success of direct referral and the failure of the predicted adverse consequences to materialise.

Public Sector Primary Eyecare

Public sector primary eyecare in Australia is mainly delivered through optometrists in private practice who examine patients and bill the Government directly so there is no cost to the patient. There is no restriction on access to optometrists and optometrists are independent and autonomous in all of their clinical decisions concerning diagnosis and management. War service veterans are entitled to primary eye care in exactly the same way.

Any patient found to have a condition requiring ophthalmological opinion or treatment is referred directly to public hospitals that offer ophthalmological services with no requirement for involvement of a general medical practitioner in the referral process.

In addition, some State Governments provide primary eyecare through optometrists employed in regional community health centres or large public optometric clinics.

State Governments also provide subsidised eyewear (spectacles and contact lenses) for social welfare beneficiaries through schemes delivered by optometrists in private practice, by public optometric clinics and by public hospitals.

Public Sector Secondary and Tertiary Eyecare

In Australia, public sector tertiary eyecare is through public hospitals.

Public hospitals in Australia accept referrals directly from optometrists and there is no requirement that the referral be made through a general medical practitioner.

The importance of Optometry to the public sector system is reflected in the fact that an optometrist served on the Committee of Management of Australia's largest specialty eye hospital, the Royal Victorian Eye and Ear Hospital, for over twelve years, appointed and reappointed by successive health ministers from both conservative and socialist governments.

It should also be noted that utilisation of such hospitals for primary eyecare is actively discouraged as an inappropriate use of specialist resources.

ROLE OF OPTOMETRY IN HONG KONG

My understanding is that Government in Hong Kong has two conflicting policies with respect to optometry.

On one hand Government supports a vigorous and rigorous education programme at The Hong Kong Polytechnic University to produce superbly trained optometrists qualified at graduation to provide extremely high quality primary eyecare. On the other hand it ignores optometry as a community resource for primary eyecare, choosing instead to use general medical practitioners with less training in eyecare, or to divert primary eyecare patients to providers of ophthalmology services at unnecessary additional cost to the public purse.

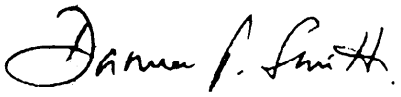
Frankly, given the very high standard of current education and training of optometrists in Hong Kong, resulting in a level of clinical competency thought by many international observers to be higher than the current standard in the UK, it is almost scandalous that Optometry in Hong Kong is so ineffectively utilised by Government.

Governments in Australia, New Zealand, UK, Canada and USA have recognised that optometrists are highly trained specialist clinicians in eyecare who are able to provide the most accessible, continuous, cost-effective primary eyecare. Those same governments recognise that general medical practitioners have extremely limited training and experience in even the common disorders of vision and the eye. As a consequence of those two very demonstrable facts, governments encourage the utilisation of optometrists in primary eyecare and discourage any significant role for general medical practitioners. To an objective observer there seems no rational reason why it should be different in Hong Kong.

I trust these comments are helpful to a thoughtful and informed review of the role of Optometry in eyecare in Hong Kong.

Please do not hesitate to request explanation or clarification of any of the matters I have aired in this response.

Yours truly.



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Letterhead of The Hong Kong Optometric Association
The Hong Kong Society of Professional Optometrists

Harvard Team
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Government Secretariat
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13 August 1999

Dear Sir/Madam,

The Hong Kong Society of Professional Optometrists and The Hong Kong Optometric Association welcome the opportunity to respond to the discussion document "Improving Hong Kong's health care system: why and for whom?", and submit for consideration the attached document.

This outlines Optometry's response, and The Hong Kong Society of Professional Optometrists and The Hong Kong Optometric Association would welcome the opportunity to discuss the points raised in our response with the Harvard team, the Department of Health, the Hospital Authority and The Hong Kong SAR Government.

Yours sincerely,

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Hong Kong Society of Professional Optometrists

and

Hong Kong Optometric Association

Joint Response

to

Improving Hong Kong's Health Care System: Why and for Whom?

August 1999

Summary

1. The Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association, whilst supportive of the need to examine health care funding in Hong Kong, are disappointed that the review undertaken by the Harvard team does not recognise the roles of non-medical health care professions.

2. The role of optometry in the provision of health care is examined. Illustrations of the health care role of optometry in the Hong Kong context are given.

3. The review of health care undertaken does not address the issue of vision and eye care as a component of the health care system. Visual problems are a significant health care issue in Hong Kong, and a review of the health care system should encompass this.

4. The omission of vision and eye care in the proposals, and the omission of discussion of roles of non-medical health care professionals are deficiencies of the report.

5. Providing quality health care cost-efficiently needs effective use of health care resources, including non-medical health care professions such as optometry.

6. The Society and the Association recommend that:

   (a) eye care be included in the future health care system

   (b) consultation should take place with all health care providers as stakeholders in the health care system

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Preface

This document is submitted jointly by the Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association.

Both associations aim to promote high standards of eye and visual health care services to the Hong Kong public and to develop and enhance the practice of optometry in Hong Kong for the benefit of Hong Kong's citizens.

The combined total membership of the two associations is around 1,000 optometrists, which represents the vast majority of registered optometrists in Hong Kong. The Optometric profession is therefore one of the largest health care professions in Hong Kong. Members of the Society of Professional Optometrists and the Hong Kong Optometric Association together would provide eye examinations to approximately 4.5 million Hong Kong citizens every two years. No other health care profession in Hong Kong other than medicine would have this level of contact with Hong Kong society. In fact, virtually every Hong Kong resident will access the professional services of Optometry for visual health care at some time in their life.

The profession of Optometry has seen rapid development in Hong Kong in the last decade. The Department of Optometry and Radiography at the Hong Kong Polytechnic University produces graduate optometrists of a standard comparable to western societies, and has developed a world recognised centre for vision research in Hong Kong, with a strong staff and postgraduate research programme. In the last few years, the non-graduate element of the profession has also been regulated by means of the Supplementary Medical Professions Ordinance, Cap 359 of the Laws of Hong Kong, which provides for the registration of all optometrists. This registration of optometrists in Hong Kong, along with the parallel development in optometric education, has enabled the Optometric profession to make an increased contribution to health care in Hong Kong, now and in the future.

Introduction

The optometric profession has previously submitted to the then Hong Kong Government on the inclusion of the optometric profession in Hong Kong's health care system. These submissions were in response to the Working Party on Primary Health Care's call for submissions in 1989, and in response to the Working Party report "Health Care for All" in 1991. The profession's submission documents outlined the role and responsibilities of optometrists in health care, and indicated areas where optometric input to health care would increase the quality of health care provided in Hong Kong.

In its response to the Working Party on Primary Health Care report, the optometric profession commented:

> "It is the view of Optometry that a review of primary health care services should encompass all health care professions which provide a point of first contact with health care. It seems to Optometry that recognition has not been given to health care professions which provide promotive, preventative, curative and rehabilitative care, and that the role professions other than medicine and nursing play in providing health care should be considered in the overall planning and delivery of primary health care in Hong Kong.
>
> Examination of the recommendations (*sic: of the Working Party*) demonstrates a commitment to improving the availability and standards of medical care as the primary health care source. The recommendations largely ignore the role that other health care professionals can play in the delivery of primary health care, and the role which these professions can play in the planning and implementation of the primary health care system.

> The responsibility to make health care accessible to all without restriction carries with it the responsibility to ensure that the costs of health care delivery are kept manageable. Appropriate usage of health care resources will serve to reduce the cost of health care delivery in Hong Kong. The full use of appropriately trained health care professionals in the roles for which they have been trained and in which they have made demonstrably successful contributions to health care will make the Government's commitment to delivering health care for all easier to realise."

These statements were published in 1991. It is now some eight years later, and a further report on the restructuring of Hong Kong's health care system has been commissioned by the Government and published for public comment. The same criticisms levelled at the earlier reports on health care in Hong Kong can be levelled at the report of the Harvard team.

The most significant oversights of the Harvard report, as in the Working Party on Primary Health Care report, are in its failure to firstly recognise the role of non-medical health care resources, and secondly to explore the use of the non-medical health professions in the provision of more accessible, quality health care at realistic cost.

Again, the emphasis of the Harvard report is in the area of medical care, rather than health care. International experience would indicate that the two terms are not synonymous. Medical care alone is not health care. Optimal health care in developed countries is based on effective integration of multiple health care professions, including optometry, physiotherapy, occupational therapy and dentistry. Given that a major thrust of the Harvard team's recommendations for restructuring the funding and delivery of health care relate to providing health care for the elderly and chronic diseases related to the development of society, it is both surprising and disappointing that the significant input of the optometric profession (and the other health care groups mentioned) has been ignored in the deliberations. That these professions were not consulted by the Harvard team is not unexpected given the predominantly medical

backgrounds of the team and the sponsoring stakeholders. Additionally, many team members may not have experience of the legitimate role of optometry in the delivery of primary health care in many developed countries.

The Harvard team acknowledges that medicine has a very strong and obvious conflict of interest and a resulting conflict of commitment in the health (medical) care system that has evolved in Hong Kong [1]. This will not be resolved if the same players operate under a revised funding structure. Equally, high standards of health care are not limited to institutional medical practice in hospitals or out-patient centres. All Hong Kong trained health care professionals should have access to, and involvement in, the health care delivery system.

In a report on the economic and professional aspects of disease prevention and health promotion, Marshall [2] has noted that vision disorders are the second most prevalent chronic health problem in the United States; and as such they should be considered as a major target of preventative and promotive health care. The Harvard report essentially ignores visual health care in its comments. Given the high incidence of myopia in Hong Kong, and that cataract, a treatable condition, is the main cause of blindness registrations in Hong Kong, the lack of provision for visual health care in the planned revision of Hong Kong's health system must be questioned.

This response document will demonstrate the significant contribution the Optometric profession can make to health care in Hong Kong. The profession would welcome the opportunity to discuss points raised in this submission with members of the Harvard team, the Department of Health, the Hospital Authority, and the Hong Kong SAR Government.

The Optometrist as a participant in health care

Optometry defined

Optometry is an independent primary health care profession which encompasses the prevention and remediation of non-medical disorders of the visual system through the examination, diagnosis and treatment of visual disorders and the recognition and diagnosis of related eye and systemic manifestations of disease.

The optometrist is a first contact primary health care practitioner who cares for the functionally inadequate visual system. Optometrists are educated and trained in the normal and abnormal physiology of the eyes and the psychophysics of vision. Optometrists are trained to determine the health status and functional capability of the visual system, including the evaluation of the refractive, accommodative, ocular-sensory-motor and perceptual components of the visual system.

Optometrists diagnose, treat and prescribe for conditions requiring spectacles, contact lenses, visual training/therapy (orthoptics), preventive and corrective procedures and devices for alteration of vision anomalies. Optometrists are trained to employ a spectrum of pharmaceutical agents in their diagnostic procedures. Optometrists also provide advice and management of visual ergonomic and occupational visual problems, and provide rehabilitative care for patients with visual disabilities.

Optometrists diagnose ocular and systemic disease conditions reflected in the eyes and, as necessary, refer patients to the appropriate health care provider.

Optometrists, as the first contact point with health care for many individuals, also provide a screening service for the detection of eye disease and systemic disease. A number of reports indicate the number of referrals made by optometrists to other health care professions, notably to ophthalmology as a secondary care service[3-6]. Steinmann[7] indicates that optometrists are responsible for detecting most cases of glaucoma and ocular hypertension in Oxfordshire. Similarly, Brittain, Austin and

Kelly[8] suggest optometrists are more effective diagnosers of glaucoma than general practitioners. Port[3], in a survey encompassing nearly 75,000 eye examinations performed by optometrists in the United Kingdom, reports 6% of patients seen were referred to a medical doctor. Port also comments that optometrists are in an unusual position in terms of health screening. Virtually everyone over 45 years of age needs some form of presbyopic correction, and will usually visit an optometrist for this purpose. Ocular and systemic conditions known to affect this age group can be effectively screened by optometrists during optometric consultations, as indicated above. Additionally, owing to the high incidence of myopia in Hong Kong, frequencies of visits to optometrists would be higher than in Western countries.

The survey reported by Port also illustrates that a significant percentage of patients attending for eye care do not have conditions necessitating medical care. This is similar to the experience of the members of the Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association where roughly 80% of patients seen have refractive problems only. This has obvious import in the provision of health care in Hong Kong when resource allocation and provider utilisation options are considered.

The optometrist in health care

The Harvard team's *Special Report #2: International Comparison of Health Systems* has illustrated differing international modes of financing and delivery of health care. The analysis, however, is largely restricted to an analysis of hospital and physician health care delivery. In the countries studied, optometry has a significant role in the delivery of health care. This has either not been recognised by the investigating team, or worse still, simply overlooked. Optometric services are part of the National Health system in the United Kingdom and the Medicare and Medicaid systems in the United States. In Canada, all provincial government health insurance plans include optometric benefits. Optometry is the only non-medical health care profession participating in Australia's Medicare system. In fact, optometric fees are capped

under Medicare in Australia, with optometrists agreeing to charge only the Government scheduled fee for services to all patients, an arrangement which does not exist with medicine. The inclusion of optometry in these health care systems is recognition of the ability of optometry to provide cost-effective quality health care.

The role of optometrists as primary care practitioners is demonstrated by a number of published studies in both medical and optometric scientific journals[9-16]. These studies illustrate the health care role of optometrists in shared or integrated care for patients suffering chronic illness; areas that are highlighted by the Harvard team for specific attention in funding and the establishment of care systems, whether this be through the MEDISAGE/HSP or the Competitive Integrated Health Care option. Visual problems are not an insignificant health problem in the elderly. Weiler, Chi and Lubben[17], in a report of a preventative health care programme for the aged note the most frequently reported chronic conditions affecting the aged. They indicate that visual problems have an 18% frequency, comparing to cardiovascular problems (13%) and hypertension (24%). The MEDISAGE plan should also include visual health care in its provisions for long term care of the elderly. Optometry has significant expertise in managing visual problems in elderly patients, and in rehabilitative care for the visually impaired, a significant number of whom are elderly patients.

Under the recommended Health Security Plan (HSP) option, the benefit package proposes inpatient and outpatient services for chronic illnesses. The proposed plan will allow patients to choose between public and private providers, but then refers to providers as "doctors" or "physicians"[18]. The Optometric profession supports the idea of health insurance for chronic illness, and the philosophy of the "money following the patient", allowing the patient to choose an appropriate provider. In the terms of the Harvard report, however, this choice is only referenced in terms of public versus private medical care. Other health care professions, including Optometry, are ignored.

Optometry respectfully submits that eye care provided by registered optometrists with appropriate levels of skills and knowledge be included in the proposed HSP, and later in the Competitive Integrated Health Care System long term should these solutions be adopted as suggested. The Harvard team in fact indicates that under Competitive Integrated Health Care, the proposed insurance will encompass the whole range of services from preventative and primary care to rehabilitative care[19]. International comparisons can be made to demonstrate the involvement of Optometry and eye care in such health care systems. Visual health care is a necessary component of any health plan determined for an ageing population.

The case for the inclusion of Optometry and eye care in the revised health care system in Hong Kong is even more compelling when the statements in the Harvard report relating to eye care are considered, notwithstanding the fact that inclusion of eye care is one proposed "carrot" for people to join an integrated health plan. In the analysis of waiting times for first appointments, the average time to clear the ophthalmology first appointment waiting list approximates five and a half months (22 weeks), nearly double the time for the specialty with the next longest time, and 20 times longer than the shortest time[20]. The actual consultation time for ophthalmology was the shortest, at five minutes[21]. In the same paragraph, the Harvard Report also indicates that no accommodation is made for the elderly, who often need longer consultation times[21]. As a large number of patients who seek eye care are elderly, the current system is failing to provide quality care to these patients. The costs of providing ophthalmologic care are also identified as among the highest[22]. These figures reflect an inappropriate use of resources as much as demand for services. The Harvard team suggests contracting out some surgical procedures, such as cataract surgery[23]. Using optometrists in roles commensurate with their training would allow greater usage of ophthalmologists time to undertake cataract surgery in the public sector.

In the experience of members of the Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association, optometrists currently employed within eye clinics are under utilised, performing only refractive assessments. Screening of patients into those needing medical eye care and non-medical eye care is undertaken

by an ophthalmology resident, and the results of the limited optometric examinations undertaken are reviewed by a consultant ophthalmologist, thus unnecessarily duplicating effort and increasing the cost of the delivery of care. A recently published (1999) study from Moorfields Eye Hospital in London has found that hospital based optometry had a 97% accurate diagnostic rate for new referrals compared to consultant ophthalmology[24]. The study concludes that the role of the hospital optometrist could be expanded to include diagnostic patient evaluations for new referrals; in effect, to determine which patients need ophthalmological medical care from those who do not. These conclusions apply equally as well to optometrists employed in Hong Kong hospitals and outpatient clinics.

Additionally, at present, Eye Clinics in public hospitals are not accepting direct referrals from optometrists for patients identified by the optometrist as needing medical eye care. Referrals from optometrists have to be directed through a general medical practitioner, inconveniencing the patient and increasing delay in assessment and treatment, as well increasing costs for the patient. That referrals from a health care practitioner trained specifically in the management of vision and its disorders through a four year university honours degree must be filtered through a general medical practitioner, who has undertaken two weeks training in ophthalmology during the five years of medical studies[25], seems somewhat illogical and inappropriate. It must be stressed that Optometry does recognise that best health care for the patient is achieved by an integrated multidisciplinary approach, and thus sharing of information between a patient's health care practitioners is ethical and moral. Re-establishment of direct referral from optometrists to the Eye Clinics would be a small but significant step in reducing delays and costs in providing ophthalmological eye care when necessary.

That these situations exist reflects the current dominance of the medical monopoly in determining health care policy in Hong Kong, as the Harvard report comments[26].

The following examples will illustrate the need to provide visual health care within a health care system, and the role of optometry.

Diabetic eye care

Diabetes mellitus has been identified by the Harvard team as an increasingly prevalent chronic illness in Hong Kong [27]. A study of diabetic retinopathy conducted in the Bristol and Avon region of the United Kingdom [9-11] has outlined the role that optometrists play in the management of this condition. Southgate surveyed referral patterns of optometrists [4] and showed that of 96 patients with ocular signs of diabetes seen by optometrists during the survey period, 42 patients (44%) were not known to be diabetic. Of the 96 patients, 80% had been seen by their general medical practitioner within the previous three months, 90 percent within the previous six months, and 95% in the previous year. These figures demonstrate that optometrists were responsible for the detection of previously undetected diabetes, even though patients had been previously examined by their physician. This indicates that optometrists may be better equipped by their training and style of practice to detect diabetic ocular signs than are general practitioners.

Currently accepted standards of eye care for patients with diabetes mellitus exist internationally. Protocols for the examination of diabetic patients for the presence of sight threatening retinopathy and criteria for referral have been established by the National Health and Medical Research Council in Australia and the American Academy of Ophthalmology in the USA for example. These guidelines for care standards include the regular assessment of vision and ocular health. The worth of such care guidelines have been demonstrated by Javitt and co-workers in two separate studies which show significant cost savings when screening and treatment for eye disease in diabetics is undertaken [28-29]. Savings estimated from screening for diabetic eye disease were in the order of US$250 million annually in the US, equating to an average net saving of US$975 per patient. The Florida Diabetes Retinopathy Task Force analysed practice patterns of both ophthalmologists (physicians) and optometrists for diabetic patients and found similar practice patterns [30]. Hammond and co-workers state that optometrists detect diabetic eye pathology as effectively as ophthalmologists [31]. Lazaridis et al. provide support for optometric care for diabetic

patients in finding that family physicians in Indiana refer more frequently to optometrists for diabetic eye care than to ophthalmologists, especially for mature onset diabetes [32].

Optometry has a well defined and well documented role in providing visual health care in this patient population. In the Hong Kong context, this could occur both within institutional health care, and in the private sector under the umbrella of a subsidised insurance plan like the HSP where funds follow the patient to the provider. As optometrists in the great majority are in private practice, a negotiated fee structure relating to these eye examinations would reduce the cost to Government in providing eye care to diabetics in the first instance, as capital costs would be borne by private sector optometrists. Once the need for ophthalmological eye care has been determined, this can be provided at the secondary level of health care within the Specialist Outpatient Clinic. As the studies above demonstrate, optometry is capable of providing the primary care role in this instance.

Eye care in children

The visual screening under the Combined Screening Programme of the Education Department examines around 100,000 six year old students each year. The current screening protocol effectively screens only for myopia and astigmatism (refractive errors which will affect distance acuity), and amblyopia (and hence strabismus) [33]. The screening failure rate of 5%[33] is low compared to other studies, which give higher failure rates as they screen for binocular defects affecting visual performance. Hanks and Chapman[34] found a screening failure rate of nearly 15% in a group of Australian children, and Wang[35] has reported a 33% incidence of visual defects in a group of Chinese children.

Research from the Department of Optometry and Radiography, Hong Kong Polytechnic University has shown that the incidence of myopia in children in Hong Kong rises rapidly with age. Approximately 15% of 7 year old children are myopic, with the incidence increasing by around 5% per year, resulting in about 60% of the 12

year old population being myopic. This shows that myopia is a significant visual health problem for Hong Kong children. This incidence of myopia is also not being fully detected by the current screening programme.

Additionally, a significant body of evidence indicates that a number of visual and ocular defects are associated with the presence of learning difficulties[36-47]. These relate primarily to disorders of the binocular visual system.

Eye care is thus important to schoolchildren in Hong Kong. Indeed, it could be argued that the high incidence of myopia represents a type of public health problem for Hong Kong. Provision for eye care for children within the proposed HSP/Competitive Integrated Health Care options would be justified on these grounds. The involvement of private sector optometrists in providing this visual health care is a cost-effective option for the Government.

Multidisciplinary Health Care

The point was made early in this submission that optimal health care is based on an effective integration of multiple health care professions. Shared care programmes involving optometry have been widely reported in the ophthalmic literature involving conditions such as glaucoma, diabetes, hypertension, anterior segment conditions, the management of low vision, and the co-management of cataract and refractive surgery patients[7-16,31,48-50].

Conclusion

While supportive of the need to examine health funding in Hong Kong, the Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association have some concerns regarding the proposals as described in the Harvard report.

In the first instance, the Society and the Association are disappointed at the lack of consultation with non-medical health care professions, and with the lack of recognition of these professionals in not only the provision of health care in Hong Kong, but also in the planning processes. These same concerns were expressed in Optometry's earlier submissions to the Working Party on Primary Health Care 8-10 years ago. With the advent of legislation governing the practice of Optometry and other health care professions, it would be hoped that their expertise would be used by the Government in health care provision and planning. Unfortunately, it appears nothing has changed.

Secondly, the emphasis on future planning for health care in Hong Kong is directed at medical, hospital and clinic based services, and in the areas of long term care for the aged and chronic illness; at least in the mid-term. Future plans for a more widespread integrated health care system are more distant. Health care is more than medical and institutional care. Full involvement of all health care professions is important for the effective delivery of health care in Hong Kong. Optimal use of appropriate health care professionals will have cost-saving implications due to best use of resources available.

With particular reference to vision and eye care, the Society and Association in this submission have outlined the role of optometry as a health care profession. Examples of optometry's participation in health care demonstrate optometry can provide effective care cost-effectively.

The Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association recommend:

(a) that eye care be included in the future health care funding system, whether this be the MEDISAGE/HSP option in the short-mid term, or the Competitive Integrated Health Care option long term

(b) consultation should take place with all health care providers as stakeholders in the health care system

The Hong Kong Society of Professional Optometrists and the Hong Kong Optometric Association would welcome the opportunity to discuss the issues raised in this submission with the Harvard Team, the Steering Commitee, the Department of Health, the Hospital Authority and the Hong Kong SAR Government.

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Centre for Social Policy Studies,
The Hong Kong Polytechnic University
香港理工大學社會政策研究中心

Public Forum

講座摘要

Whither Hong Kong's Health Care Reform ?

香港醫護改革何去何從?

SPEAKERS 講者:

題目：大改革或自我改善
Ms Amy Ho, Lecturer, Department of Applied Social Studies
何寶英女士，應用社會科學系講師

題目：要計劃經濟還是要自由選擇? 要社會保障還是要自求多福?
Dr. Lo Wing Lok, Vice-President, The Hong Kong Medical Association
勞永樂醫生，香港醫學會副會長

題目：醫護改革的下一頁：人盡其才，化零為整
Dr. Thomas Wong, Acting Head, Department of Nursing and Health Sciences
汪國成博士，護理及醫療科學系署理系主任

題目：善用資源、廣用專才
Dr. Carly Lam, Assistant Professor, Department of Optometry and Radiography
林小燕博士，視光學及放射學系助理教授

COMMENTATORS 評論員:

Ms. Iris Chan, Chairperson, Alliance for Patients' Mutual Help Organizations
陳幸青女士，病人互助組織聯盟主席

Mr. Chung Kim Wah, Assistant Professor, Department of Applied Social Studies
鍾劍華先生，應用社會科學系助理教授

Date : May 28th, 1999 (Friday)
日期 : 一九九九年五月二十八日(星期五)
Time : 2:00 pm - 5:00 pm
時間 : 下午二時至五時
Venue : Senate Room (AG708), The Hong Kong Polytechnic University
地點 : 香港理工大学教務會議室 (AG708)

善用資源、廣用專才

視光學及放射學系助理教授　林小燕博士

哈佛醫療融資報告發表，有很多值得參考之處，其中一樣就是資源運用的問題。作爲一個訓練基層醫療專業人員的工作者，我覺得現時香港醫療資源未得到最好運用我本身是眼科視光師，已經有十幾年經驗了。或者我舉一些有關視光行業的例子，大家就可以見到，只要在資源運用上面作出適當的改動，情況就可以很不同。

根據有關的資料，現時香港人若感到眼睛不舒服，需要由普通科醫生轉睇眼科醫生。由開始直至能見到眼科醫生，就需要等候五個月的時間，而這個人就算見眼科醫生，也只能得到平均時間 5.5 分鐘的眼科醫生服務，大家覺得這個現象是否要有改善呢？

其實這個現象的形成是因爲所有感覺到眼睛不舒服的人，無論是什麼問題，都只能經轉介才能見眼科醫生。或者大家都不知道香港輪候眼科病人當中，有六成的問題只需要視光檢驗配帶眼鏡。如果我們將這批病人交由視光師處理，這樣有其他眼疾的病人所需等候的時間就可以減低百份之六十了，亦即是由五個月減兩個月。要注意的是，這個減低六成的等候時間，是無須多撥一分一毫的。

各位，這就是我提出改善資源運用的意思。根據現時的醫療架構，所有的病人，無論患的是什麼病，都是首先見註冊醫生，再由註冊醫生轉介至實習專科或專科醫生。輪候時間很長，受害的當然是病人本身。其他的醫療專業人員，雖然已經受過足夠訓練，也是愛莫能助。

這個情況無論在北美或歐洲都不會出現。或者，讓我再舉一個在香港已經實踐的成功例子。香港盲人輔導會屬下的普通眼科及低視能診所，聘用了相等於一位眼科醫生和六位眼科視光師。病人在診所人員的解釋和幫助下，有選擇眼科醫療服務的權利。這個做法，將六成求診的病人選擇由視光師處理，使在職的眼科醫生有充裕的時間照顧有眼疾的病人，這樣的選擇在現時的醫療制度是缺乏的。

今日我想大家注意一個問題，香港並不是沒有足夠的醫療人員，去令到我們的醫療人員和我們的醫療系統達到歐美的水平，而是我們的分工和輪候的方法實在太過落後。香港政府花這麼多錢，訓練很多醫生以外的醫療專業人員，然後又忽略了這麼簡單的安排，我覺得這是一個極大的浪費現象。

最後，我想強調一點，如果單循是改動一下眼科輪候驗眼配鏡的做法，就可以將病人等候時間由五個月減至兩個月；這樣的改動，在其他醫療專業都能夠獲得到正視的情況之下，我想信香港的醫療系統就立刻得到大幅的改善 — 而且是不須要增加任何資源呢！政府現時聘請了二十五位眼科視光師，若能將未來眼科空缺的位置，由更多的眼科視光師來填補，一定更能事半功倍。

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THE HONG KONG POLYTECHNIC UNIVERSITY
OFFICE OF COMMUNICATIONS AND PUBLIC AFFAIRS

SOURCE: Hong Kong Standard

DATE: 28 June, 1999

How 'arrogance' affects eye care

By Mary Ann Benitez

A PATIENT suffering from retina detachment visited the eye clinic at Hong Kong Polytechnic University earlier this month. He was diagnosed with myopia, but was sent to see a general practitioner, not an ophthalmologist.

Before an individual can see an ophthalmologist in Hong Kong, he needs to see a general practitioner first before he can be accepted for government care. After the optometrist demonstrated that the man had retina detachment, the service head called an ambulance for the patient and did the referral to a consultant at the nearby Queen Elizabeth Hospital where he was treated.

Professor George Woo, dean of the university's faculty of health and social studies, cites this case to demonstrate how optometrists are still rated as second-class professionals who cannot make patient referrals directly to doctors because of what he calls "medical arrogance".

"In Canada I see a retina detachment. I pick up the phone, followed with a fax-letter to the emergency hospital and to the physician, no fanfare," says Prof Woo, a licensed optometrist in North America who served with the University of Waterloo as a professor for 26 years until his return to Hong Kong a few years ago.

The reverse is true in Canada and the United States where GPs — or general practitioners — cannot do referrals to ophthalmologists whereas optometrists can.

Nearly 10 years since Polytechnic University launched its four-year optometry degree program, Prof Woo says the profession's status has not improved, particularly in the Hospital Authority hierarchy where optometrists do only the work of optical technicians, are the lowest-paid among health-care professionals and are supervised by nurses.

He was seconded to the university in the late 1980s to design and start up the program, launched in 1990. Each year 70 students are admitted to the course. He went back to Waterloo until he retired and took up the professorship of optometry at the university.

In other countries, optometry is considered a full-fledged profession: on par with doctors, dentists, nurses and pharmacists. In Hong Kong, optometrists are lumped under the Supplementary Medical Professions (Amendment) Bill — together with physiotherapists, radiographers, occupational therapists and medical laboratory technologists.

Wages are nowhere near the pay scale in Britain, where hospital optometrists can earn up to £50,468 (HK$640,000) a year, compared with £26,965 for midwives and £32,520 for physiotherapists and nurses. Optometrists earn half the salary of pharmacists and are paid less than physiotherapists in Hong Kong.

Prof Woo says that 10 years ago, when the Bill was introduced, there were claims of a medical monopoly because each of the boards and councils except one was headed by a doctor. That hasn't changed in the 10 years since, he says.

The Harvard report on the health-care system talks about medical monopoly — but ironically the consultants who made the survey were guilty of propagating the practice, he says. Many of the associations and professions consulted by the Harvard team were doctors. The university, which trains more health-care professior than any other, was not e invited for discussions, nor w the various associations health-care professionals sulted.

"The report reflected p ably medical dominance cause it's discussing mec care in Hong Kong by con ing predominantly medical sonnel," Prof Woo says.

Because the report identi weaknesses in the medical tem, he says the medical fession and the governm which has aggressively ported it, should be to blam the ills in the system.

He remains doubtful if reform will be pushed thro as past consultations had "all window-dressing". He he is not seeking recognitio the profession for its interest but to improve quality of eye services patients. "What you need patient seeing an optor first. If what they need is g and refraction, the optor can do (that). The optor can also check the eyes.

"When it has to do wi diseases of the eye, then y see secondary and tertiar by ophthalmologists."

THE HONG KONG POLYTECHNIC UNIVERSITY
OFFICE OF COMMUNICATIONS AND PUBLIC AFFAIRS

SOURCE: Apple Daily

DATE: 21 May 1999

四萬人排期數月睇眼科

輪候過久誤病情 視光師爭轉介權

【本報訊】理工大學眼科視光學系最近替病人進行驗眼時，發現有病人出現視網膜脫落的情況，若延遲診治將會出現永久失明，但礙於目前公立醫院只接受醫生紙轉介眼科病人，但視光師則無權轉介，故該學系現正向醫管局爭取轉介權，並要求當局承認視光師在基層眼科服務內的角色，以縮短眼科輪候時間。

理工大學及社會科學院院長胡志城教授表示，理工大學有全亞洲最好的視光學診所。（黃家俊攝）

現時有近四萬人輪候公立醫院眼科服務，新症輪候時間平均達四個月，部分病人更長達八至九個月才獲首次治療。

轉介制度不公平

理工大學醫療及社會科學院院長胡志城教授昨日表示，該名險些導致永久失明的老翁，由於經濟能力有限不想向私家醫生求診，故最後要經大學內的視光師向相熟醫生求助，替其撰寫醫生紙才可成功轉介到眼科醫院治療。他批評醫管局對眼科病人的轉介制度不公平，沒有考慮到視光師亦可替病人作眼疾檢查。

胡志城認為，本港的醫療制度完全由醫生主導，故哈佛教授離慶倫對本港醫生的批評是正確的。

他指出，外國的視光師與普通醫生一樣，不但可將有眼疾的病人直接轉介給眼科醫生診治，亦有資格用藥，故視光師可替病人進行檢驗青光眼眼壓及進行結膜炎等治療，而外國醫院亦會先安排病人求診視光師，除非有嚴重眼疾及須進行外科手術，否則毋須轉介予眼科醫生處理。

胡志城表示，該學院現正聯同專業視光師學會約見醫管局，要求當局承認三百多名擁有使用藥物資格的專業視光師（即一級註冊視光師）有轉介病人的資格，以及大量增聘視光師，代替眼科醫生替病人檢查眼睛，甚至治療部分眼疾，以加快市民輪候看醫生的時間，因為隨着人口老化，眼疾病人亦會持續增加。

醫生診症時間短

醫管局發言人表示，公立醫院目前有二十五名視光師，該局會考慮有關意見。

據病人互助組織聯去年一項眼科的調查更發現，其中有兩成患有糖尿視網膜病變的眼科病人亦有兩成要輪候七至八個月才獲診治。由於有五成受訪者表示診症少於五分鐘，故病人除了擔心輪候時間過長令病情惡化外，亦不滿醫生診症時間過短。