The Roadmap to Close the Gap for Vision

Vision loss is 11% of the Indigenous health gap.
Each additional dollar gives $2.50 of cost benefit.

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THE UNIVERSITY OF MELBOURNE

This summary report was updated by Professor Hugh R Taylor AC, Uma Jatkar and Mitchell Anjou of Indigenous Eye Health, Melbourne School of Population and Global Health, The University of Melbourne.

We acknowledge and thank the many community members, colleagues and stakeholders who have been consulted and participated in the development of these recommendations.

This report summarises and develops the findings and recommendations presented in the following reports:

Taylor HR, Anjou MD, Boudville AI, McNeil RJ. **The Roadmap to Close the Gap for Vision: Full Report.** Melbourne: Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne, ISBN 978073404756 4; 2012.

Taylor HR, Anjou MD, Boudville AI, McNeil RJ. **The Roadmap to Close the Gap for Vision: Full Report: Supplements.** 2012; available from: http://iehu.unimelb.edu.au/publications/iehu_reports/roadmap_close_the_gap.

It also draws on the following reports:

Taylor HR, Keeffe JE, Arnold AL, Dunn RA, Fox SS, Goujon N, Xie J, Still R, Burnett A, Marolia M, Shemesh T, Carrigan J and Stanford E (2009). **National Indigenous Eye Health Survey, Minum Barreng (Tracking Eyes).** Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health in collaboration with the Centre for Eye Research Australia and the Vision CRC (ISBN 978-0-7340-4109-8)

Turner A, Mulholland W and Taylor HR (2009). **Outreach Eye Services in Australia.** Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne (ISBN 978-0-7340-4142-5)

Kelaher M, Ferdinand A, Ngo S, Tambuwla N and Taylor HR (2010). **Access to Eye Health Services among Indigenous Australians: An area level analysis.** Melbourne, Centre for Health Policy, Programs and Economics and Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne (ISBN 978-0-7340-4173-9)

Taylor HR, Gruen R, Bragge P, Chau M, Wasiak J, Hewitt A, Forbes A, Parkhill A, Clavisi O, Burchill J, Carrigan J and Sekkoua H (2010). **Accuracy of Screening Methods for Diabetic Retinopathy: A Systematic Review.** Melbourne, The University of Melbourne and Monash University (ISBN 978-0-7340-4154-8)

Taylor HR, Gruen R, Wasiak J, Hewitt A, Bragge P, Chau M, Forbes A, Parkhill A, Clavisi O, Burchill J, Carrigan J, Ferguson R and Sekkouah H (2010). **Trachoma, Antibiotic Treatments of Trachoma: A Systematic Review.** Melbourne, The University of Melbourne and Monash University (ISBN 978-0-7340-4195-1)

Hooshmand J, Taylor HR and Stanford E (2010). **Trachoma Resource Book.** Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne (ISBN 978-0-7340-4171-5)

Taylor HR, Dunt D, Hsueh YS and Brando A (2011). **Projected Needs for Eye Care Services for Indigenous Australians.** Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne (ISBN 978-0-7340-4201-9)

Jones JN, Henderson G, Poroch N, Anderson I and Taylor HR (2011). **A Critical History of Indigenous Eye Health Policy-Making: Towards Effective System Reform.** Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne (ISBN 978-0-7340-4209-5)

Hsueh YA, Brando A, Dunt D, Anjou MD and Taylor HR (2011). **The Cost of Closing the Gap for Vision.** Melbourne, Indigenous Eye Health Unit and Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne (ISBN 978-0-7340-4737-3)

IEHU (2013). **2013 Annual Update on the Implementation of The Roadmap to Close the Gap for Vision.** Melbourne, Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne. www.iehu.unimelb.edu.au

All of these reports are available on the Indigenous Eye Health website at: **www.iehu.unimelb.edu.au**

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Table of Contents

Introduction

Good quality eye services are fundamental to improving the health of Indigenous Australians. This report builds on the National Indigenous Eye Health Survey. It recommends policy changes to improve the quality and sustainability of eye care services.

We acknowledge and build on the successful eye care programs found in several areas that provide high quality eye care for Indigenous Australians.

The Roadmap builds on community consultation and control, the regional delivery of services and national health reforms. It stresses the assessment of population-based needs, strong co-ordination, monitoring of performance and national accountability. It does not include implementation details, phase in costing or additional or replacement costs for infrastructure or equipment.

Highlights

- Blindness rates in Indigenous adults are 6 times the rate in mainstream
- Vision loss accounts for 11% of the health gap
- 94% of the vision loss is preventable or treatable but 35% of Indigenous adults have never had an eye exam
- The Roadmap consists of 42 specific interlocking recommendations
- Eye services need to be increased in remote areas and their utilisation increased in all areas
- Efficient eye care requires co-ordination along the pathway of care to improve efficiency and patient outcomes
- Trachoma elimination needs to include all endemic areas and be continued until it is eliminated
- Eye services require monitoring and evaluation of agreed performance indicators by a nationally accountable body
- Closing this gap is evidence-based, sector-endorsed, cost effective and highly achievable

Current Status of Indigenous Eye Health

The 2008 National Indigenous Eye Health Survey determined the magnitude, distribution and causes of vision loss in Aboriginal and Torres Strait Islander people.

It examined 1694 children (5 – 15 years) and 1189 adults (40 years and over) in 30 sites across the country.

Indigenous children

> better vision than mainstream

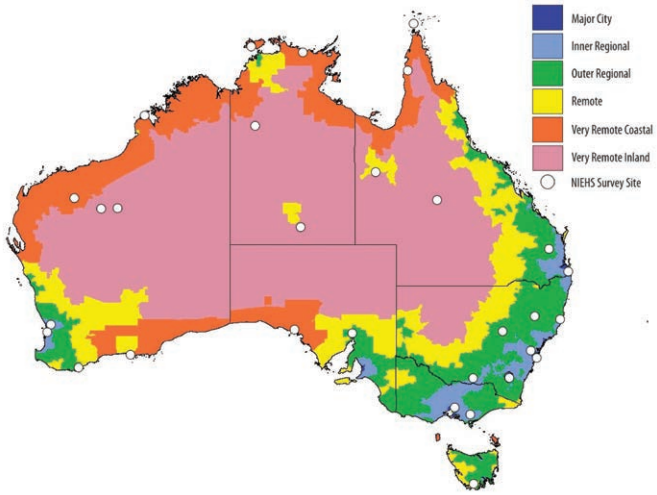
Indigenous adults

> 6 times as much blindness

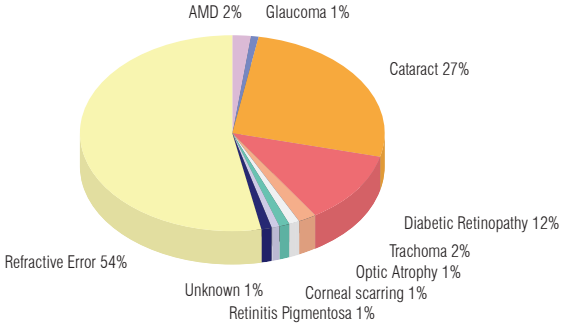
> 94% of vision loss was unnecessary and is preventable or treatable

The unmet need is similar in urban and regional areas as in remote areas

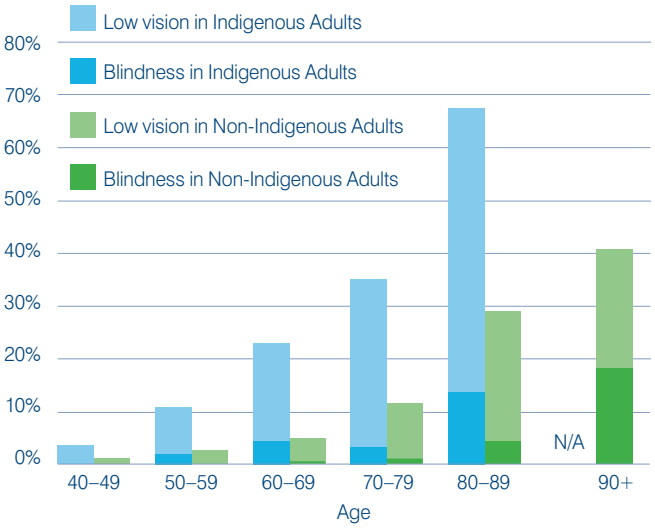
2008 NIEHS site locations



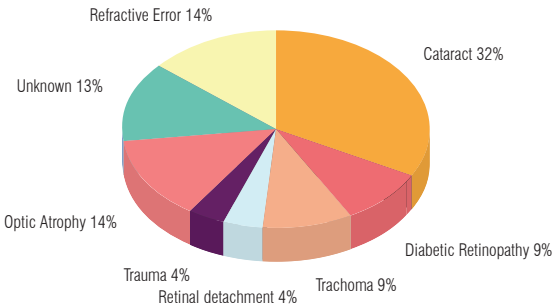
Low Vision (<6/12) in Indigenous Adults



Vision Loss in Adults



Blindness (<6/60) in Indigenous Adults



Crude Prevalence Rates of Vision Loss in Indigenous Australians

State	Children		Adults		Regions	Children		Adults	
	Low Vision	Blindness	Low Vision	Blindness		Low Vision	Blindness	Low Vision	Blindness
NSW	3.3%	0.4%	5.7%	2.4%	Major City	4.5%	0.6%	7.7%	2.6%
NT	0.8%	0%	9.1%	3%	Inner Regional	2.6%	0%	7.8%	2.4%
QLD	0.9%	0.3%	11.6%	0.4%	Outer Regional	1.5%	0%	6.6%	0.6%
SA	0%	0%	9.3%	1.6%	Remote	0.9%	0%	10.2%	0.8%
TAS	0%	0%	4.7%	0%	Very Remote Coastal	1.1%	0.3%	9.5%	1.1%
VIC	0%	0%	6.9%	6.9%	Very Remote Inland	0.3%	0.3%	12.7%	3.9%
WA	1.9%	0.2%	12%	1.8%	**TOTAL**	**1.5%**	**0.2%**	**9.4%**	**1.9%**

Rates of vision loss do not show significant jurisdictional or regional variation – the need for eye care is nationwide

Causes of Vision Loss

Four conditions cause 94% of the vision loss. Each is readily amenable to treatment

Key Finding	Implications
1. Refractive Error	
›Only 20% of Indigenous adults wear glasses for distance compared to 56% in mainstream ›Lack of reading glasses meant that 39% could not see normal print ›An optometrist working in an Aboriginal Health Service led to much better outcomes	›Readily accessible eye services are needed for all Australians ›More and better co-ordinated visits by optometrists or ophthalmologists are required in more remote areas ›Better co-ordination and links between Aboriginal Health Services, clinics and hospitals are needed in urban areas
2. Cataract	
›Blinding Cataract is 12 times more common in Indigenous adults ›But rates of Cataract surgery are 7 times lower ›Waiting time for Cataract surgery is 56% longer than mainstream ›Indigenous Australians are 4 times more likely to have to wait more than 1 year for Cataract surgery	›Cataract surgery needs to be made readily available for all Australians ›Adequate and sustainable funding is required for visiting specialist services ›Proper funding for patient travel to regional hospitals for surgery is required ›Adequate surgical facilities, time and staff must be committed for Cataract surgery ›Excellent co-ordination is required between the patient, community, clinic, hospital and the surgical team
3. Diabetes	
›37% of Indigenous adults have Diabetes and 13% have already lost vision ›98% of blindness from Diabetes is preventable with early detection and timely treatment ›Only 20% have had an eye exam in the last year ›Only 37% needing laser surgery have received it	›All Indigenous people with Diabetes need an eye exam every year and better access to Diabetes education ›Good co-ordination and recall mechanisms are needed ›Sustainable funding (Medicare) is required for retinal photography ›Prompt referral is required for those found to have Diabetic eye disease ›Laser surgery should be available locally but good quality slit lamps and portable lasers are needed
4. Trachoma	
›Two thirds of remote communities have endemic Trachoma ›Adults with Trachoma scarring and in-turned lashes (trichiasis) are found across the country ›Trachoma can be eliminated with the SAFE Strategy (see pages 18–19)	›The extent of Trachoma needs to be mapped clearly ›All children at risk need to be checked regularly ›Elderly people across the country need to be checked for in-turned lashes (trichiasis) and operated on if necessary ›Trachoma elimination programs need to be fully implemented in endemic areas

**Vision loss causes 11% of the health gap;
it is behind cardiovascular disease and diabetes,
equal with trauma but ahead of alcoholism and stroke**

Most vision loss can be corrected overnight

The Patient Journey

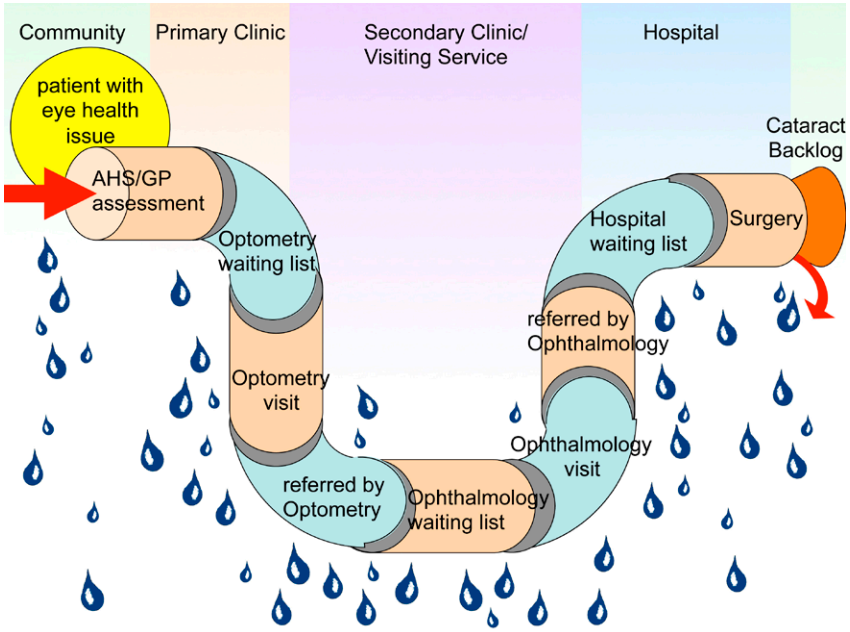
Successful eye health outcomes involve co-ordination of both eye care services and the patient journey

The referral pathway is a leaky pipe with a blockage at its end

It is often very inefficient and wasteful of services

Many people drop out

Because of this, others do not enter



Levels of Co-ordination

Community

- Community liaison provides a vital link between individual community members, their families and the clinic and its services
- This may include identification, transport, interpretation, translation and moral support

Clinic, Primary Eye Care

- Referral of more complex cases to visiting eye team
- Maintenance of patient records and referral lists for visiting eye team
- Scheduling of visits by visiting eye teams
- Co-ordination with other visiting specialists
- Co-ordination of exam rooms, accommodation, equipment and local staff
- Make arrangements for referrals to Regional Hospital
- Schedule follow up visits as required

Eye Team, Secondary Eye Care

- Co-ordination of visits with clinic and community
- Update patient records as necessary
- Communication and co-ordination between visiting optometrists and ophthalmologists
- Mechanism for communication and co-ordination with other visiting specialists
- Specific equipment items brought with team (e.g. lasers, slit lamp)
- Organise a list/information about patients waiting to be seen
- Assistance with patient identification, transport, translation, explanation and support
- Clerical support for forms and paper work
- Referral systems for further management or surgery

Regional Hospital, Tertiary Eye Care

- Organisation of the clinic space, theatre time, staff, accommodation, travel and surgical supplies for the visiting eye teams
- Co-ordination with other visiting specialists
- Organisation and supply of surgical equipment
- Co-ordination of patients who require surgery with community and clinic
- Organisation of travel and other arrangements for patients

National/State/Territory

- Co-ordination of other specialist and allied health visits with the visiting eye team
- Oversight of co-ordination performed at different levels, recruitment, training and support
- Oversight of distribution of visiting eye teams (and other specialists) including ratio of optometric and ophthalmic visits and frequency of visits

Planning the Pathway of Care

Eye Care Co-ordination and Clinical Service Requirements for a 'Region' and a 'Community'

		'Region' of 10,000 people					'Community' of 500 people			
		Community (days*)	Visiting Service (days*)	Hospital (days*)	Total (days*)	EFT	Community (days*)	Visiting Service (days*)	Hospital (days*)	**Total (days*)**
Optometry Clinics										
Patient organisation	2 hr/pt (specs 1 hr)	532			532	**2.5**	26.6			**26.6**
Transport	1 hr/patient	308			308	**1.5**	15.4			**15.4**
Clinic organisation	4 hr/clinic day	110			110	**0.5**	5.5			**5.5**
Team organisation	4 hr/clinic day		106		106	**0.5**		5.3		**5.3**
Clinic support	8 hr/clinic day	133	133		266	**1.3**	6.6	6.6		**13.3**
Optometry Consultations										
Glasses exams			640 people					32 people		
Diabetic exams			962 people					48 people		
Other eye exams			98 people					5 people		
Ophthalmology Clinics										
Patient organisation	2 hr/pt	79	44		123	**0.6**	3.9	2.2		**6.1**
Transport	1 hr/pt	46			46	**0.2**	2.3			**2.3**
Clinic organisation	4 hr/clinic day	23			23	**0.1**	1.2			**1.2**
Team organisation	4 hr/clinic day		23		23	**0.1**		1.2		**1.2**
Clinic support	8 hr/clinic day	23	23		47	**0.2**	1.2	1.2		**2.3**
Ophthalmology Consultations										
Diabetic laser			112 people					6 people		
Hospital										
Patient organisation	2 hr/pt (3 hr preop)	61		61	121	**0.6**	3.0		3.0	**6.1**
Transport	1 hr/pt			15	15	**0.1**			0.7	**0.7**
Clinic organisation	4 hr/clinic day			13	13	**0.1**			0.7	**0.7**
Team organisation	4 hr/clinic day		7	7	13	**0.1**		0.3	0.3	**0.7**
Ophthalmology Surgery										
Catarct surgery				95 people					5 people	
Trichiasis surgery				36 people					2 people	
TOTAL		**1314**	**336**	**95**	**1746**	**8.3**	**65.7**	**16.8**	**4.7**	**87.4**
Optometrist					213	**1.0**				11
Optometry patients					1700 people					85 people
Ophthalmologist					73	**0.3**				4
Ophthalmology patients					243 people					12 people

* days unless indicated as people

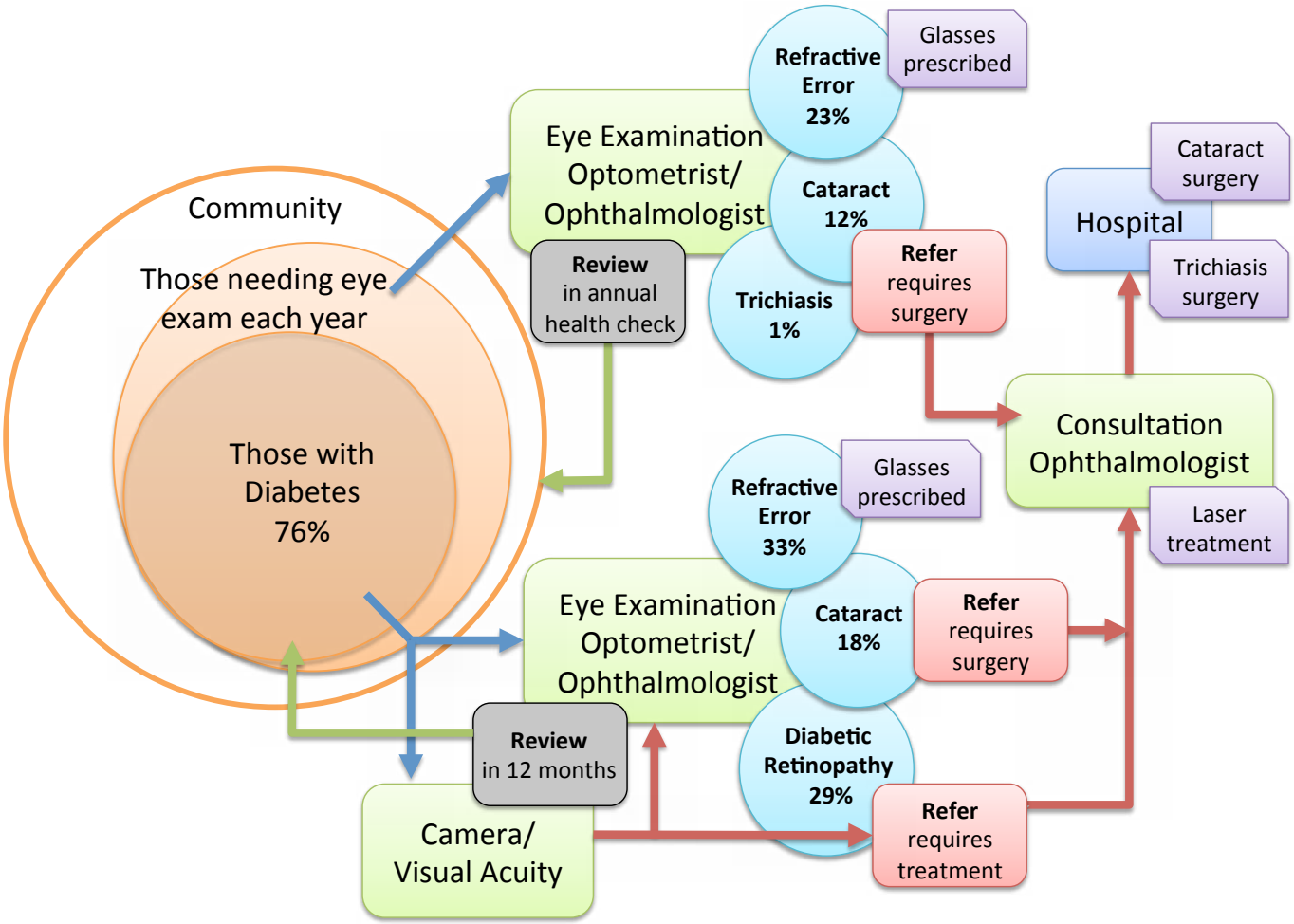
Diabetes and Eye Care

No Indigenous person with Diabetes should be allowed to go more than one year without an eye examination

Three quarters of those people needing annual eye care have Diabetes

A multi-sectoral whole of system approach is required to address the significant burden of Diabetes and Diabetic eye disease

The Pathways for Eye Care



If we can fix and make the eye care pathway for people with Diabetes work effectively, we will have created the system change to support eye care for the whole community.

Recommendations and Conditions

to illustrate the contribution of recommendations to the main eye conditions and reinforce the interdependence between components of the Roadmap

		Cataract	Refractive error	Diabetic retinopathy	Trachoma
1	**PRIMARY EYE CARE AS PART OF COMPREHENSIVE PRIMARY HEALTH CARE**				
1.1	Enhancing eye health capacity in primary health services	✓	✓	✓	✓
1.2	Health assessment items include eye health	✓	✓	✓	✓
1.3	Retinal photography			✓	
1.4	Eye health inclusion in clinical software	✓	✓	✓	✓
2	**INDIGENOUS ACCESS TO EYE HEALTH SERVICES**				
2.1	Aboriginal Health Services and eye health	✓	✓	✓	✓
2.2	Cultural safety in mainstream services	✓	✓	✓	✓
2.3	Low cost spectacles		✓		
2.4	Hospital surgery prioritisation	✓			✓
3	**CO-ORDINATION**				
3.1	Local eye care co-ordination	✓	✓	✓	✓
3.2	Clear pathways of care	✓	✓	✓	✓
3.3	Workforce identification and roles	✓	✓	✓	✓
3.4	Eye care support workforce	✓	✓	✓	✓
3.5	Case co-ordination	✓	✓	✓	✓
3.6	Partnerships and agreements	✓	✓	✓	✓
4	**EYE HEALTH WORKFORCE**				
4.1	Provide eye health workforce to meet population needs	✓	✓	✓	✓
4.2	Improve contracting and management of visiting services	✓	✓	✓	✓
4.3	Appropriate resources for eye care in rural and remote areas	✓	✓	✓	✓
4.4	Increase utilisation of services in urban areas	✓	✓	✓	✓
4.5	Billing for visiting MSOAP supported services	✓		✓	✓
4.6	Rural education and training of eye health workforce	✓	✓	✓	✓
5	**ELIMINATION OF TRACHOMA**				
5.1	Definition of areas of risk				✓
5.2	Effective interventions 5.3				✓
5.3	Surveillance and evaluation				✓
5.4	Certification of elimination				✓
6	**MONITORING AND EVALUATION**				
6.1	Managing local eye service performance	✓	✓	✓	✓
6.2	State and National performance	✓	✓	✓	✓
6.3	Collating existing eye data sources	✓	✓	✓	✓
6.4	National benchmarks	✓	✓	✓	✓
6.5	Quality assurance	✓	✓	✓	✓
6.6	Primary health service self-audit in eye health	✓	✓	✓	✓
6.7	Program evaluation	✓	✓	✓	✓
7	**GOVERNANCE**				
7.1	Community engagement	✓	✓	✓	✓
7.2	Local Hospital Networks and Primary Health Networks	✓	✓	✓	✓
7.3	State/Territory management	✓	✓	✓	✓
7.4	National oversight	✓	✓	✓	✓
7.5	Program interdependence	✓	✓	✓	✓
8	**HEALTH PROMOTION AND AWARENESS**				
8.1	Eye health promotion	✓	✓	✓	✓
8.2	Social marketing eye care services	✓	✓	✓	✓
9	**HEALTH FINANCING**				
9.1	Current spending on Indigenous eye health (non Trachoma)	✓	✓	✓	
9.2	Current spending on Trachoma				✓
9.3	Full additional annual capped funding required	✓	✓	✓	
9.4	Cost to 'Close the Gap for Vision' funded for five years	✓	✓	✓	
	Total number of recommendations	**35**	**34**	**35**	**37**

A single change cannot fix the provision of eye care, each issue needs to be addressed

Why Eye Care is Important

Doing Something about Vision Loss and Eye Health is Important

Vision loss is common

- Most common self-reported health complaint
- Blindness rates are 6 times higher
- Blindness from Cataract is 12 times higher, surgery rates 7 times less

Vision loss has a big impact

- 11% of Years of Life Lost to disability for Indigenous people
- Equal 3rd leading cause of the Gap for health
- Increases mortality rates by at least 2 fold
- Significantly affects the individual, family and community

Vision loss is discrete and fixable

- Cataract surgery restores vision overnight and costs ~$3,000 per QALY
- New glasses improve vision right away
- Diabetic blindness: 98% is preventable and screening costs $15,000 per QALY
- Trachoma can be eliminated with the SAFE Strategy

Vision loss provides a template for other specialist health care

- Requires active community engagement
- Requires good integration into primary health care
- Needs proper co-ordination within a regional basis
- Requires whole of system approach
- The lessons learnt will help link other specialist services with comprehensive primary care

Vision loss can reflect the underlying social determinants of health

- Maintaining and restoring vision is important to be able to address social determinants eg. education and employment
- Achieving equity in eye health status may help close the overall health and social gaps

Nine False Reasons for Not Addressing Blindness

Vision loss is not important in Indigenous communities:

- Vision loss is the equal third leading cause of the Gap in health after heart disease and Diabetes but ahead of trauma, stroke and alcoholism. Indigenous adults have six times more blindness than mainstream and vision loss represents 11% of the overall health gap.

Blindness does not kill people – we need to address the life threatening things:

- Even mild vision loss (<6/12) increases the risk of dying 2.6 times in mainstream Australia. Vision loss from Trachoma in African communities increases the risk of dying by 6.8 times. Mild vision loss prevents independent healthy living.

Eye care is body part medicine, it is not holistic:

- The patient's journey for eye care starts in properly developed, comprehensive primary health care and requires seamless linkage with specialist services. Lessons learnt from integrating specialist eye care visits will inform ways to improve the linkage of primary and specialist care in other health areas.

There are many other more pressing priorities than eye care:

- It is true that there are many health priority areas but 94% of vision loss is unnecessary and much of it can be rapidly reversed. A pair of glasses or Cataract surgery can eliminate vision loss overnight, whereas other chronic diseases (Diabetes, heart disease, alcoholism) cannot be reversed overnight.

It is not worth spending the money on eye care, it is too expensive:

- Eye care is extraordinarily cost effective, for example Cataract surgery costs $3,000 per QALY and Diabetic Retinopathy examinations $15,000 per QALY. In Australia, each $1 spent on eye care yields a $5 return.

We are already spending too much on Aboriginal health and the money is wasted:

- It is true we now spend $1.39 on Indigenous health for each $1 spent on mainstream. (A decade ago it was $0.80 for Indigenous health). As there is three times the morbidity (and vision loss), one would expect to spend at least three times as much even if delivery costs to remote areas were not higher than urban areas. In terms of Cataract surgery, seven times less surgery is done for Indigenous people.

There are not enough specialists to provide the care required:

- The actual increase in the number of optometric and ophthalmic services required is quite small and with the appropriate co-ordination and resources, many specialists are willing to take on this work.

This plan or Roadmap is too complex, it is not all necessary:

- Over the last 30 or so years multiple proposals have been made to address Indigenous eye health. None have worked properly as they overlooked different criteria. This Roadmap has been based on a careful review, new evidence and wide consultations. Each element is interlocked forming an integral chain. It will also provide a template for the delivery of other specialist services to primary care services.

There is no more money to spend on Indigenous health:

- With a relatively small increase in expenditure, there will be a huge increase in efficiency and reduction in waste for Indigenous eye health services. A doubling in funding will increase glasses use by 2.5 times, Diabetes eye exams by 5 times and Cataract surgery by 7 times.

Roadmap Recommendations

1. PRIMARY EYE CARE AS PART OF COMPREHENSIVE PRIMARY HEALTH CARE
to improve identification and referral for eye care needs from primary health care

INTENTION	RECOMMENDATION	OUTCOME
1.1 Enhancing eye health capacity in primary health services		
To ensure primary care staff (first point of contact) understand and include the appropriate basic eye checks and referral in routine screening/evaluation.	That further education programs be developed and implemented to improve understanding of basic eye health among primary health care professionals and Aboriginal Health Services.	Basic eye health is routinely incorporated as part of comprehensive primary care and patients with eye conditions are appropriately referred.
1.2 Health assessment items include eye health		
To ensure that vision and eye health is regularly assessed as part of primary screening and general health assessments.	That primary health care staff know and perform the vision and eye care components that are included in the health assessment forms with appropriate referral as needed.	Poor vision and eye problems are detected early and referred for further assessment.
1.3 Diabetic Retinopathy detection		
To improve the examination, early detection and referral of Diabetic Retinopathy by providing sustainable funding for retinal photography.	That a Medicare item be added to MBS to cover the service costs of taking and reading retinal photographs including the use of telemedicine.	Retinal screening is carried out routinely at primary health care level and Aboriginal Health Services have the capacity and are resourced to offer this service.
1.4 Eye health inclusion in clinical software		
To ensure that primary health care staff are prompted to perform the appropriate eye health assessments as part of routine comprehensive health care.	That all clinical software packages used in Aboriginal Health Services include eye health checking components and modules consistent with national guidelines.	Eye health components are integrated into primary health routine patient management systems.

2. INDIGENOUS ACCESS TO EYE HEALTH SERVICES
to enhance access to Aboriginal and mainstream eye services

INTENTION	RECOMMENDATION	OUTCOME
2.1 Aboriginal Health Services and eye health		
To strengthen the provision of eye health services within Aboriginal Health Services and increase their capacity to identify and refer people needing eye care.	That where possible visiting eye health services, including VOS and MSOAP, are provided within Aboriginal Health Services.	Increased utilisation of eye health services because they are provided in the culturally safe setting of Aboriginal Health Services.
2.2 Cultural safety in mainstream services		
To ensure that all components of the clinical pathway are culturally-safe including in public hospitals and private eye care, and that all staff appreciate Indigenous health needs and are able to facilitate the Indigenous patient's journey.	That service providers involved in the co-ordination of eye care including Local Hospital Networks and Primary Health Networks, consult with local Aboriginal and Torres Strait Islander communities and improve the cultural awareness of their staff and services.	All components of clinical pathway including public hospitals and private services maintain environments that give confidence for Indigenous people to safely access services.
2.3 Low cost spectacles		
To ensure cost certainty and to provide acceptable and affordable spectacles in a timely way.	That nationally consistent Indigenous subsidised spectacle schemes be establish to provide low-cost, quality-assured, cost-certain spectacles to Aboriginal and Torres Strait Islander people.	People acquire and use the glasses they need because of cost certainty and acceptability leading to increased utilisation of eye services because Indigenous people are confident in obtaining useful glasses.
2.4 Hospital surgery prioritisation		
To address the inequitable Cataract backlog due to inadequate surgical output and to ensure that hospital surgery waiting times are no longer a barrier to Indigenous eye care, and thus facilitate the uptake and flow through the referral pathway.	That all jurisdictions aim to reduce the waiting time for Cataract surgery recognising Indigeneity and the high level of co-morbidities and improve consistency in clinical assessment categories across jurisdictions.	The gap for un-operated Indigenous Cataract surgery is eliminated and the surgical pathway is opened because of increased community confidence in services.

3. CO-ORDINATION AND CASE MANAGEMENT
to improve co-ordination of eye care services and the successful navigation of referral pathways

INTENTION	RECOMMENDATION	OUTCOME
3.1 Local eye care co-ordination		
To establish local eye care co-ordination that includes a regional hospital with eye surgical facilities. At a local level there is capacity to provide comprehensive eye care for primary identification and referral for optometry and ophthalmology.	That mechanisms for local co-ordination of eye care will be established within Local Hospital Networks and Primary Health Networks.	All components of the eye care pathway are co-ordinated in each local region to ensure adequate access and use of comprehensive eye care including surgery.
3.2 Clear pathways of care		
To ensure that patients receive appropriate clinical care with minimal delays and without unnecessary visits by having well documented, understandable and well linked referral pathways.	That local co-ordination of eye care is developed along with local referral pathways for all eye care services and these pathways are made known to all service providers involved.	Patients experience a smooth passage throughout and fulfill the referrals required for eye health.
3.3 Workforce identification and roles		
To ensure that within each local area, all the necessary co-ordinating functions in the pathway of care are performed.	That each local area identifies the (existing or additional) personnel and positions required for the proper co-ordination, organisation and delivery of the patient's journey along the pathway of eye care.	The patient journey proceeds uninterrupted because the appropriate and culturally sensitive personnel are in place.
3.4 Eye care support workforce		
To ensure that within each local area, the workforce is appropriately skilled and resourced to meet the eye care needs of their community.	That sufficient people in each local area are appropriately designated, trained and funded to organise and co-ordinate patients along the pathway of care.	People understand and perform the co-ordination required to facilitate the patient's journey.
3.5 Case management		
To ensure that those with high need for eye care (such as Diabetes) receive the necessary eye examinations and that those who are referred for surgery receive that surgery.	That a case management strategy be established within Aboriginal Health Services for all patients at high need for eye care and/or those referred for eye surgery. For patients who have Diabetes, case co-ordination should be provided by chronic disease co-ordinators.	All patients with Diabetes receive an annual eye examination and follow up and all patients referred for surgery receive it.
3.6 Partnership and agreements		
To ensure that the pathway of care is readily navigated and 'leakage' is reduced because all components of the local eye health system work together, communicate, share information and have common understandings and expectations.	That local co-ordination of eye care builds on partnerships and agreements with local service providers and visiting eye services.	Based on clear expectations and understandings, local eye care networks work efficiently and effectively.

4. EYE HEALTH WORKFORCE
to increase availability and improve distribution of eye health workforce

INTENTION	RECOMMENDATION	OUTCOME
4.1 Provide eye health workforce to meet population needs		
To ensure that the eye health workforce is sufficient to meet the population based needs of Indigenous Australians.	That population-based needs analysis is used to determine eye health workforce requirements in all areas of Australia.	Appropriate numbers of eye health providers are available in all areas of Australia.
4.2 Improve contracting and management of visiting services		
To increase the ease of use of funding for visiting services (MSOAP and VOS), so as to attract more visiting eye team services where needed and to improve co-ordination amongst all service providers.	That the contracting of VOS and MSOAP be restructured to provide simple, flexible, co-ordinated and transparent operation and management of these services.	MSOAP and VOS work smoothly and efficiently and that visiting optometry and ophthalmology services are properly co-ordinated.
4.3 Appropriate resources for eye care in rural and remote areas		
To ensure that the appropriate eye health workforce is available in rural and remote areas.	That the eye health workforce and funding are allocated according to population needs with consideration of existing local services.	Services in rural and remote areas are adequate to meet the needs for eye care.
4.4 Increase utilisation of services in urban areas		
To increase the accessibility and use of existing optometry services in urban and regional areas by making them available within the culturally appropriate environment of Aboriginal Health Services.	That Indigenous VOS funding is available for major cities and inner regional areas to support delivery of visiting optometry services in Aboriginal Health Services.	Increased use of optometry services provided within Aboriginal Health Services.
4.5 Billing for visiting MSOAP supported services		
To ensure cost certainty and remove barriers to local service uptake created by inconsistent and uncertain billing arrangements and the charging of additional fees.	That visiting ophthalmologists supported by MSOAP agree to bulk-bill Indigenous patients for clinic services and that MSOAP consider loading arrangements to meet the true cost of service.	Increased use of eye health services because of reduced or removed uncertainty of patient out-of-pocket expenses.
4.6 Rural education and training of eye health workforce		
To encourage newly trained optometrists and ophthalmologists to participate in Indigenous eye care delivery and regard it as a standard part of their ongoing practice and social responsibility.	That during training, eye health providers complete a core component of rural and Indigenous eye health work. Funding should be specifically provided to cover supervision and trainee costs.	More optometrists and ophthalmologists have exposure to and actively seek work in rural and remote areas and Indigenous communities.

5. ELIMINATION OF TRACHOMA
to eliminate blinding Trachoma from Australia

INTENTION	RECOMMENDATION	OUTCOME
5.1 Definition of areas of risk		
To ensure that Trachoma activities are conducted in all endemic areas.	That the mapping of the extent of Trachoma is completed expeditiously.	Areas with Trachoma are clearly defined.
5.2 Effective interventions		
To ensure that appropriate Trachoma interventions are properly delivered in endemic areas.	That the SAFE strategy is fully and comprehensively implemented.	Active Trachoma is rapidly eliminated from the endemic areas.
5.3 Surveillance and evaluation		
To ensure programs are effective and have the anticipated impact.	That the ongoing monitoring and evaluation activities of the National Trachoma Reporting and Surveillance Unit should be continued.	Success and progress are measured and reported.
5.4 Certification of elimination		
To ensure the World Health Organization certifies the elimination of Trachoma in Australia.	That Australia works closely with World Health Organization and participates in the GET 2020 process until Trachoma is eliminated.	Australia is free of blinding Trachoma.

6. MONITORING AND EVALUATION
to capture and report information about progress and improvement of services and outcomes in Indigenous eye health

INTENTION	RECOMMENDATION	OUTCOME
6.1 Managing local eye service performance		
To provide the appropriate service delivery data to inform local management, and allow aggregation of these data at regional, State/Territory and national levels.	That local co-ordination of eye care includes Local Hospital Networks and Primary Health Networks and collects and reports nationally consistent data on eye health programs, service delivery targets and patient outcomes.	Local services are improved by monitoring performance and progress is reported nationally and locally.
6.2 State and National performance		
To provide State/Territory and national assessment of performance to assist local programs and provide accountability.	That local service delivery data be aggregated to provide State/Territory performance information and that this information is aggregated to provide national information.	Service delivery performance data are appropriately used and provide timely analysis and reporting at higher levels and locally.
6.3 Collating existing eye data sources		
To avoid unnecessary duplication, existing eye care data sources are identified and utilised.	That sources of currently available eye health information are identified and drawn into a national eye health reporting framework.	Data and eye health information from national sources are well managed, accessible and applied for eye health service improvements.
6.4 National benchmarks		
To ensure that national benchmarks are developed for the program to guide and support service delivery and create nationally consistent goals and approaches for eye care.	That an appropriate expert committee be established to develop clear, evidence based, eye health sector agreed minimum standards and targets to support eye care service delivery for Aboriginal and Torres Strait Islander people.	Implementation of eye health programs is nationally consistent and supported by a robust evidence base that supports identification of good practice and continuous improvement.
6.5 Quality assurance		
To ensure that services provide high quality eye care and that program management follows best practice.	That measures of service quality and outcomes are developed and applied to Indigenous eye health.	Service quality and satisfaction for eye health outcomes are consistent nationally and all services attain high quality ratings.
6.6 Primary health service self-audit in eye health		
To ensure Aboriginal Health Services can easily assess their ability to provide quality eye care and conform to national benchmarks in eye care.	That an audit tool for Aboriginal Health Services be developed to support delivery of appropriate eye health services.	All Aboriginal Health Services provide well integrated eye care.
6.7 Program evaluation		
To identify progress and outcome successes and share with the broader health system.	That the 'Close the Gap for Vision' initiative is evaluated against program objectives, timelines and measures.	The Gap for Vision is closed by 2020.

7. GOVERNANCE
to ensure that there is national delivery of 'Close the Gap for Vision'

INTENTION	RECOMMENDATION	OUTCOME
7.1 Community engagement		
To ensure eye care services are acceptable and have the full support of the local Aboriginal community.	That eye services are developed and delivered with the engagement of the local community.	Indigenous communities use and champion their eye care services.
7.2 Local Hospital Networks and Primary Health Networks		
To ensure regional Indigenous eye care co-ordination is provided for within Local Hospital Networks and Primary Health Networks.	That local co-ordination of eye care is part of the responsibility of Local Hospital Networks and Primary Health Networks.	Eye health is well co-ordinated with other health services at a regional level.
7.3 State/Territory management		
To provide high level advisory and management committees to review the workings and achievements of local eye networks and to ensure that there is State/Territory government liaison. In particular to be able to identify areas where services are insufficient or not operating appropriately to meet community needs.	That State/Territory Indigenous eye health managers are appointed and State/Territory Indigenous eye health committees are established to provide oversight and support for the Indigenous eye health system.	Eye services within a State/Territory are performing at a high standard and achieving their objectives.
7.4 National oversight		
To provide continuity, oversight and accountability through monitoring national progress and assessing national priorities.	That a National Oversight Body for Aboriginal and Torres Strait Islander eye health is established by government to oversee the implementation of strategies, develop national policy and funding for Indigenous eye health. Reporting to Commonwealth and State/Territory governments.	National coverage, oversight and accountability is maintained with timely reports to government and to all service providers and stakeholders.
7.5 Program interdependence		
To ensure effective improvement in eye care, all the elements of this Roadmap need to be implemented in a clear, branded and unified approach by government, the sector and the community.	That the recommendations be regarded as a comprehensive package to be known collectively as the 'Close the Gap for Vision' initiative. Clearly articulated objectives, timelines and measures will need to be developed.	'Close the Gap for Vision' recommendations be adopted and implemented across Australia and unnecessary vision loss is eliminated.

8. HEALTH PROMOTION AND AWARENESS
to improve awareness and knowledge of eye health in communities to support self-empowerment

INTENTION	RECOMMENDATION	OUTCOME
8.1 Eye health promotion		
To ensure that all community members and health service staff are aware of the importance of eye health.	That an eye health promotion strategy aligned with 'Close the Gap for Vision' be developed within each State/Territory to improve community awareness of eye health.	Community members recognise their own need for eye care.
8.2 Social marketing eye care services		
To ensure that all community members and health service staff are aware of the availability of eye health services (including dates of visiting services) and know how to access them.	That strategies for marketing of local eye services including visiting services is established at the level of Local Hospital Networks, Primary Health Networks and Aboriginal Community Controlled Health Organisations.	Community members know about and are able to use eye services when they need them.

9. HEALTH FINANCING
to ensure adequate funding is allocated to 'Close the Gap for Vision'

INTENTION	RECOMMENDATION	OUTCOME
9.1 Current spending on Indigenous eye health (non Trachoma)		
To estimate the current annual amount spent on Indigenous eye health (non Trachoma).	That the current annual total expenditure on Indigenous eye health (non Trachoma) is estimated to be $17.40 million and this is not adequate.	Currently there is six times more blindness in Indigenous adults than in mainstream and the current resources are not sufficient to provide adequate eye care.
9.2 Current spending on Trachoma		
To estimate the current annual amount spent on Trachoma.	That the current annual total expenditure on Trachoma elimination is estimated to be $4.5 million and this should be continued.	Funding is continued until Trachoma is eliminated. Additional resources needed for health promotion.
9.3 Full additional annual capped funding required*		
Estimate the additional capped funding required each year in service delivery for indigenous eye health to 'Close the Gap for Vision'	That an estimated additional annual capped funding of $19.5 million is provided per year for Indigenous eye health.	For every one dollar spent for eye care in Australia, there is a five dollar return to the community. Indigenous Cataract surgery will be increased 7 times, Diabetic eye care increased 5 times and care of refractive error increased 2.5 times to reduce Indigenous blindness by 6 times.
9.4 Cost to 'Close the Gap for Vision' funded for 5 years*		
To estimate the additional five year forward amounts required for Indigenous eye health to 'Close the Gap for Vision'.	That an estimated additional capped funding of $68.25 million is provided over five years for Indigenous eye health.	This funding will 'Close the Gap for Vision'.

Additional capped funding required to 'Close the Gap for Vision' (2011 dollars in millions)*

	Annual Cost
Commonwealth includes VOS, RHOF	2.92
States/Territories includes State/Territory subsidised spectacle schemes, transport	2.01
Co-ordination includes Commonwealth and State/ Territory Aboriginal Health Workers and other co-ordinator salaries	13.32
Governance and evaluation includes State/Territory and National committees and managers	1.25
Total	**19.50**

Information presented in this table is derived from 'The Cost of Closing the Gap for Vision', University of Melbourne 2011

***estimates do not include new or additional infrastructure costs**

Activities for the Commonwealth

The Roadmap to Close the Gap for Vision requires full funding and implementation, but giving priority to the following activities the Commonwealth can progress specific Roadmap recommendations within existing programs.

1. National oversight and accountability

> National function to monitor and review national data on an annual basis and report to all relevant federal and jurisdictional Ministers
> National oversight for Aboriginal and Torres Strait Islander eye health to provide expert, technical and policy advice and recommendations to federal and jurisdictional governments
> State/territory stakeholder group for jurisdictional overview

2. National leadership

> National leadership
> Establish benchmarks and nationally consistent reporting
> Establish clinical pathways and standards of care
> Support jurisdictional activity

3. Primary Health Networks

> Work closely with ACCHOs
> Assessment of local eye care needs and gap analysis
> Service directory and referral protocols
> Assessment of additional VOS and RHOF needs
> Coordination and case management needs determined and supported
> CTG/ICD chronic disease coordinators

4. Improve RHOF and VOS planning and coordination

> Support and direct jurisdictional fund holders
> Coordination between programs
> Linkages with ACCHOs
> Population based planning
> RHOF and VOS bulk billed
> Urban VOS
> Report number of Indigenous services provided

5. Trachoma

> Continuation of support and enhance health promotion
> Fully engage Education and Housing Departments

6. Cataract surgery

> Ensure equitable Indigenous waiting times and outcomes

7. Diabetes retinal examinations

> Medicare item number for non-mydriatic retinal photography

8. Low cost spectacles

> Nationally consistent provision, best practice and adequate

Regional Implementation

By giving priority to the following activities, regions and jurisdictions can progress the implementation of the Roadmap recommendations.

Define region and population and identify regional surgical hub

> Use locally appropriate boundaries to define region

> Use 2011 Census data for initial needs estimates and provide a starting point for planning – this can be revised as new data becomes available

> The prevalence data from the National Indigenous Eye Health Survey can be used to provide first order estimates of expected disease burden and local population-based needs

> In consultation with the state/territory forum identify hospitals in the regions where public Cataract surgery is to be performed.

1. **Establish regional collaborative network –** Include the regional Closing the Gap committee and other bodies in each region. Representatives should include Aboriginal Medical Services, Primary Health Network, Local Hospital District/Network, regional health authority/department, local eye care practitioners and local health services. State/territory forum to provide state-level support.
2. **Gap and needs analysis for service requirements –** Map current eye care provision (including visiting services) and compare to population-based needs estimate to determine service and other gaps. Look to VOS and RHOF support if additional services required.
3. **Develop regional service directory and referral protocols –** Determine the current services and capacity of locally available services within each region, then develop regional referral protocols through the regional collaborative network.
4. **Identify systems coordination and patient case management staff roles –** The identification of staff and allocation of roles and responsibilities needs to occur at the clinic, hospital and regional level with regional coordination and oversight.
5. **Local planning and action through regional collaborative network –** Collaborative network meets regularly, shares and reviews data, and establishes and reviews plan.
6. **Establish regional data collection and monitoring system –** Develop regional reporting and performance review systems using national performance indicators.
7. **Ensure regional accountability and oversight –** Regional data report and reviewed every six months within and reported to state/territory forum.

Indicators

To be included in National Health Performance and Regional Reports

Service utilisation

1 MBS 715 check (which includes an assessment of vision)

2 **Cataract** surgery rate

3 **Cataract** surgery rate within 90 days of booking

4 Retinal examination for people with **Diabetes**

5 Laser treatment and intravitreal injection rate for people with **Diabetic** retinopathy

Service provision

6 Visiting optometry days (VOS)

7 Visiting ophthalmology days (RHOF)

Jurisdictional performance

8 Subsidised spectacles

9 **Trachoma** prevalence rate – national and jurisdictional

10 **Trachoma** treatment coverage with Azithromycin – national and jurisdictional

Trachoma

- Trachoma is a major blinding infectious eye disease
- It occurs in areas with poor hygiene and living conditions
- Australia is the only developed country to still have Trachoma
- Blinding endemic Trachoma occurs in 60% of outback communities
- Late scarring and in-turned eyelashes (trichiasis) affects 1.4% of older Indigenous people across the country
- Trachoma is still the fourth leading cause of blindness

The National Trachoma Surveillance and Reporting Unit (NTSRU) has collected data since 2006

NTSRU has defined the problem and the progress

Data collection is still far from complete

The SAFE Strategy is not fully implemented

Trachoma screening is often incomplete

Trichiasis screening is often forgotten

Treatment is often not given or with poor coverage

Clean faces campaign and health promotion is incomplete

'Every child with a dirty face is a health hazard'

Trachoma can be prevented with WHO's SAFE Strategy:

Surgery for trichiasis

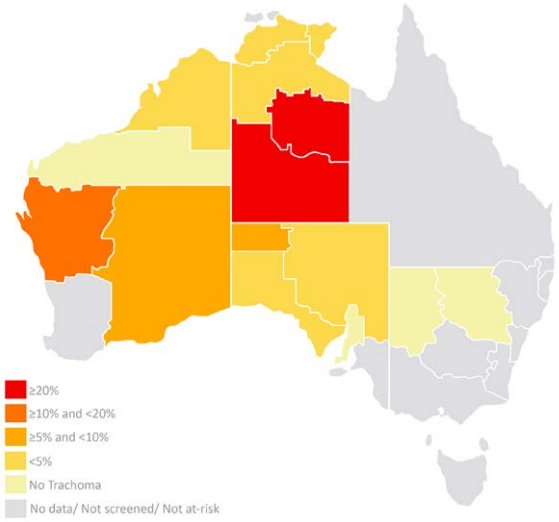
Antibiotic (Azithromycin) treatment

Facial cleanliness and

Environmental improvements

WHO and all Governments including Australia have committed to the Global Elimination of Trachoma by 2020 (GET 2020).

Trachoma Prevalence in Indigenous Children



Trachoma prevalence in children aged 5-9 years and number of communities screened/ number of at risk communities in 2014

From 2014 Report of NTSRU

Regional education and health promotion material

Milpa
The Trachoma Goanna

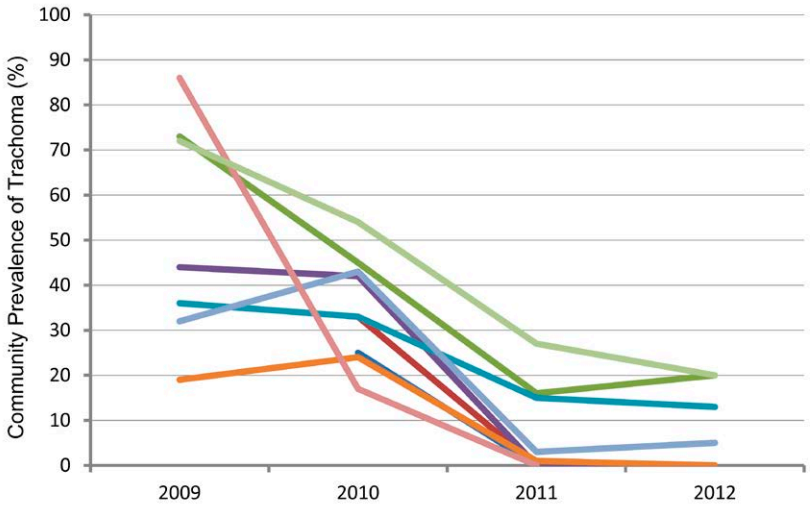
In 2009 the Australian Government committed to eliminate Trachoma in Australia

Current Activities:

- $16 m (2009-2013) was committed to start the elimination of Trachoma
- A further $16.5 m (2013-2017) was committed to continue
- Implementation could have been faster, but once started great progress has been made, especially in the Northern Territory and Western Australia
- More communities have been screened
- More children have been examined
- Treatment coverage has improved
- Health education materials have been more widely used
- "Clean faces, strong eyes" campaign is underway
- AND Trachoma rates are starting to fall

Trachoma rates of 14% in 2009 are now 4% in 2014

When the SAFE Strategy is properly implemented Trachoma rates show marked declines



Community prevalence of active Trachoma in one region in the Northern Territory
(de-identified data; each coloured line represents a separate community)

What is needed now:

- Funds to finish the job and eliminate Trachoma 2017-2020
- Additional funds are needed for health promotion focusing on clean faces and safe bathrooms
- Full engagement with Education and Housing Departments

Eye Health and Roadmap Resources

A number of resources have been developed by IEH to assist with regional implementation and initiatives to close the gap for vision. These are listed below and available online at **www.iehu.unimelb.edu.au**

Regional Implementation Toolkit

Regional implementation 'how to' guide

Eye care services calculator

Regional implementation checklist

Regional equipment checklist

Regional hospital checklist

Service directory template

Referral pathway template

Regional indicator tracking tool

Health promotion resources

Trachoma health promotion

Diabetes eye health promotion

Educational resources

Diabetic retinopathy grading
www.drgrading.iehu.unimelb.edu.au

RAHC trachoma module
www.rahc.com.au/elearning

RAHC eye care module
www.rahc.com.au/elearning

RAHC eye health and diabetes module
www.rahc.com.au/elearning

Trachoma grading and self directed learning
www.iehu1.unimelb.edu.au/trachoma/cera.swf

Roadmap resources and position papers

National oversight

National leadership

Role for jurisdictions

Mandatory MBS 715 eye checks

Cataract monitoring

Clinical practice software

Indicators

Revised costing of the Roadmap

Developing linkages

Engaging with eye care service providers

Fund holders and outreach funding

Education and trachoma

Diabetic retinopathy screening card

Software roundtable report 2013

Regional implementation roundtable report 2014

Health promotion roundtable report 2014

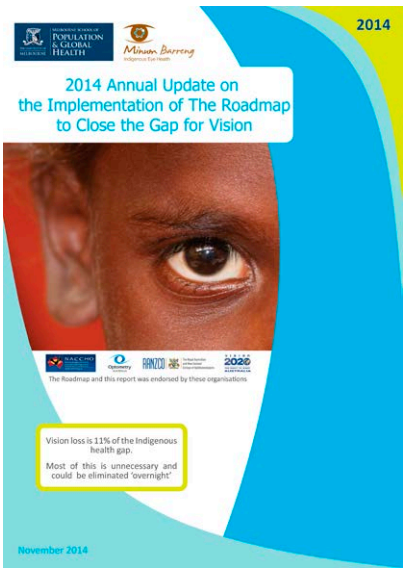
Diabetic retinopathy health promotion workshop report 2015

Medicare Local Collaborative Framework 2013

VACKH Aboriginal Eye Health Strategy 2013-2014

VACKH Aboriginal Eye health Strategy Regional Implementation Information Sheet

Roadmap glossary



The 2014 Annual Update on the Implementation of the Roadmap to Close the Gap for Vision, launched in November 2014, provides the most recent report of progress against the 42 recommendations of the Roadmap.

It is available on line at **www.iehu.unimelb.edu.au**

Glossary

In this document, the terms Indigenous and Indigenous Australians are used to refer to all Aboriginal and Torres Strait Islander peoples.

National Indigenous Eye Health Program Structure

Local Eye Health	Incorporates all eye care services and providers, local and visiting, delivering comprehensive eye care services to meet community requirements and based around a regional hospital with capacity to conduct Cataract surgery
Regional Eye Health Co-ordinator	Responsible for co-ordination of eye health services to Aboriginal and Torres Strait Islander communities in a geographic area
State/Territory Indigenous Eye Health Manager	An individual or organisation responsible for collating eye health program data and information about local eye co-ordination from Regional Eye Health Co-ordinator, Local Hospital Networks and Primary Health Networks within jurisdictional boundaries
State/Territory Indigenous Eye Health Committee	Incorporates existing State/Territory Indigenous eye health committees, organisations and other stakeholders, appointed to support and oversee Indigenous eye health activity and performance in Local Hospital Networks and Primary Health Networks within jurisdictional boundaries and reports to the National Indigenous Eye Health Committee
National Oversight	Function established by the Commonwealth Government to oversee and monitor progress on National Indigenous Eye Health, incorporating existing national advisory committees and other stakeholders and reports to AHMAC

Australian Government's National Health Reforms

Local Hospital Networks	State funded networks of hospitals responsible for making decisions on the day to day operations of hospitals and delivering agreed services
Primary Health Networks (Medicare Locals)	Organisations contracted by the Commonwealth Government to improve primary health services for local communities
Lead Clinician Groups	National and local groups appointed to provide clinical leadership on delivery of safe and higher quality care, consistent with evidence based clinical practices and service delivery

Eye Health Terms

Eye team	Optometrists, Ophthalmologists, accompanied by other support staff
Eye health workforce	Optometrists and Ophthalmologists
GET 2020	Global Elimination of Trachoma by 2020
Primary Eye Care	Includes testing visual acuity near and far, identify and treat minor conditions, Trachoma grading, referral for diabetic retinal screening and more complex cases, assist post surgery and with ongoing treatment
SAFE Strategy	Surgery for trichiasis; Antibiotic (Azithromycin) for treatment; Facial cleanliness; Environmental improvements Strategy

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisations
AHMAC	Australian Health Ministers' Advisory Council
AHS	Aboriginal Health Service
AHW	Aboriginal Health Workers
GP	General Practitioner
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NTRSU	National Trachoma Reporting and Surveillance Unit
QALY	Quality Adjusted Life Year (1 year in good health = 1.0 QALY)
RHOF	Rural Health Outreach Fund
RN	Registered Nurse
VOS	Visiting Optometrists Scheme
WHO	World Health Organization

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The Roadmap to Close the Gap for Vision and the 2014 Annual Update on the Implementation of The Roadmap to Close the Gap for Vision have been endorsed by these organisations.

Authorised by the Harold Mitchell Chair of Indigenous Eye Health, Melbourne School of Population and Global Health, The University of Melbourne.