



The Association of Ophthalmologists

Challenges and Opportunities faced by UK Ophthalmologists

We are in the midst of fundamental changes in the way healthcare is delivered in the UK. The introduction of market forces into healthcare, through plurality of provision, payment by results (PBR), and patient choice, has opened up new opportunities and challenges for UK ophthalmologists. Uniformity of provision has been one of the main features of the UK healthcare system. These are being remodelled so that doctors including ophthalmologists have the opportunity to work in state owned traditional hospital trusts, Independent Sector Treatment Centres (ISTCs) as employed or seconded surgeons, or in owned or co-owned independent facilities. Furthermore, ophthalmologists may decide to work in the community rather than the hospital setting. The introduction of multiple providers reflects the government's attempt to make healthcare more responsive to patients. This has been driven by the public's changing expectations of healthcare in the 21st century which, the government feels, has fundamentally changed since the inception of the NHS. We may or may not agree with these policies or the manner of their implementation. However, there is no question that it will result in diversification of the ophthalmologist's place and pattern of work. It will bring UK ophthalmic services closer to the healthcare models of continental Europe. In the UK, optometrists and dentists have experienced diversification of service provision for many years. As similar developments start in Ophthalmology, the highest standards of professional leadership and behaviour will be required to ensure that patients receive the best possible care, irrespective of where they choose to have their treatment.

What are the main current issues facing ophthalmic services?

The current government is committed to keeping the purchasing arm of the NHS, as well as providing everyone with healthcare which is 'free at point of delivery', regardless of where patients are treated. However, it aims to diversify the provision of healthcare, so that both public and independent sector providers deliver care to NHS patients, at agreed national tariffs and quality standards. The 'patient choice' programme introduces a new concept of patients' ability to choose which facilities and physicians they prefer, as well as the ability to 'exit' from providers who do not respond adequately to their needs. This policy encourages new entrants into the healthcare market who will deliver care for NHS patients in ways that were not previously possible. The government believes that increased efficiency and productivity will flow from the introduction of market forces - albeit heavily regulated - into healthcare. Ultimately the policies mean that providers who are not chosen by patients will not survive. It remains to be seen how much political will this government has to allow some state facilities to go under as a result of this competition. Doctors and health service managers have raised objections on the grounds that such introduction of market forces will undermine the long-term planning of healthcare services. Proponents and supporters of the reforms have responded that under the old centralised, monopoly planning NHS, services have not been sufficiently productive, and that there is room for some of the market incentives seen in other healthcare systems. There is a feeling, however, that we should accept that patients will increasingly choose services from multiple providers.

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Community ophthalmic services

At present there are approximately four million outpatient visits to our hospital departments. The UK is unique among European and North American countries in caring for so many patients in the hospital setting. Elsewhere patients are seen by ophthalmologists in community settings/offices, assisted by a range of paramedics e.g. ophthalmic technicians, optometrists, ophthalmic nurses and orthoptists. Now similar models are being developed for the UK. In the autumn of 2005, the Department of Health will publish results of pilot community Ophthalmology services. This will, inevitably, be followed by expansion of such community services. As the changes evolve, there will be challenges:

- **Quality of care:**

The standard of care in community ophthalmic services must equal or better that provided in hospital clinics. GPs with Specialist Interest (GPSIs) are already starting to offer these services and the trend towards new community providers will continue. However, in our opinion, it must be the responsibility of ophthalmologists to ensure that an excellent quality of care is provided to the public. This will be achieved through training and supervision.

- **Clinical leadership:**

Who is going to lead these community ophthalmic services? Ophthalmologists could relinquish responsibility for the care of ophthalmic patients to GPSIs and optometrists, or take the lead by setting up community facilities/offices, with paramedic assistance. In a setting where patients are worked up by ophthalmic assistants, ophthalmologists have an important role in finalising management plans for patients, with resultant efficiency savings. Our optometrist colleagues argue strongly for optometrist-led community ophthalmic care. Currently there are at least seven optometrists for each UK ophthalmologist. Although many feel that there are too few trained ophthalmologists in the UK, it is also true that these highly trained individuals are not necessarily effectively deployed. We have been seeing large volumes of patients with pathology in our traditionally under resourced and inefficient hospital settings. In an ophthalmologist- led community eye service, which is assisted by optometrists, GPSIs or ophthalmic technicians, we will be able not only to increase capacity but also to reassure ophthalmic patients that their care is not compromised due to the lack of broad expertise and knowledge of practitioners.

National Tariffs and payment by results

The most important challenge that we will face over the next two years, when PBR is fully implemented for outpatient and surgical activities, is to ensure that the national tariffs reflect the complexity of our workloads. This is important for all ophthalmologists, whether practicing in state owned hospitals, or their own community facilities. The financial viability of departments will depend on being paid adequately for the work that is delivered. To this end the Association of Ophthalmologists (AOO) will work with other ophthalmic organisations to find a way to help the Department of Health determine national tariffs for ophthalmic patients. These tariffs have to be based on agreed care pathways for patients and also reflect the complexity of cases. Regional cost differences need to be taken into account.

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Comprehensive services versus cherry picking

When ISTCs were introduced, the concept was met by some hostility from UK ophthalmologists. Although the ISTCs have contributed very little in terms of increased capacity to Cataract Surgery services, they have undoubtedly introduced market forces into UK healthcare. This, combined with centrally driven targets, has resulted in reduced waiting times for cataract patients. As the government is committed to embed the introduction of multiple providers by expanding the numbers of ISTCs, in the ISTC wave two programme, we need to register our persistent concerns. The AOO have two main anxieties, not about the general policies, but about the practicalities of their implementation: firstly the comprehensiveness of service regardless of the provider, and secondly the training of the next generation of UK ophthalmologists.

- **Comprehensiveness of service:**

The government has allowed some providers to cherry pick parts of ophthalmic services such as Cataract Surgery. Even within a cataract service, some providers only prefer straightforward cases. One can envisage that in each geographic area there will be a handful of providers, each covering a comprehensive range of services. The less welcome alternative is for some organisations to cherry pick isolated surgical procedures, and to leave the rest to other units. This is the recipe for creating resentment among those ophthalmologists who not only have to pick up the unattractive services, but also deal with the complications of other providers. This approach in the longer-term will fail.

- **Training of tomorrow's UK ophthalmologists:**

Training needs to be appropriately costed and reflected in PBR for providers who wish to undertake training of juniors. There is an opportunity cost in training; it is natural that surgical procedures are more time-consuming, and outcomes are worse, when junior surgeons are developing their skills. Healthcare provision is changing rapidly. These changes can be regarded as a threat, but they may present real opportunities for patients and for us.

It is hoped that the AOO will provide a role complementary to that of the Royal College of Ophthalmologists (RCOphth) in steering the government in a direction that, in the long term, is most beneficial to both patients and the profession. In the Spring meeting of the AOO, which was attended by more than a hundred ophthalmologists, we discussed areas of healthcare policy changes relevant to Ophthalmology. It is anticipated that there will be regular meetings and we welcome suggestions about content and format of these meetings.

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