Planning for Eye Care - A New Perspective

One of the very first steps in planning for eye care is, knowing where we are - also known as "situation analysis". The way we look at the "situation" influences the direction in which we think, the solutions that we arrive at and the way we prioritize. There are many aspects in understanding the "situation" and in this discussion the focus will be on "causes of blindness and vision impairment".

The conventional way that we look at the causes of blindness has been mostly from a clinical or disease perspective. Every presentation or publication that talks about the causes of blindness always has a table or a pie chart neatly adding to a 100%, listing the clinical conditions responsible with cataract normally at the top. This overwhelming focus on the clinical causes has led to remarkable advancements and discoveries that have significantly improved treatment outcomes in the individuals treated. The most significant improvements have been in the management of cataract and the developments are still continuing at a frenzy pace. We can be certain to see a "doubling" (if one can quantify it that way) of the current technology with sub-millimetre incisions, injectible IOL's, Light Adjustable Lenses (LAL), Multi-focal and accommodating IOLs, elimination of PCO, and so on. Such efforts are on, in all aspects of clinical eye care – glaucoma, diabetic retinopathy, refractive errors, ARMD, artificial corneas, etc. There is also an economic angle to this but it is clinical perspective to the "causes of blindness" that has helped this progress, the extraordinary capacity to innovate and make it work.

Yet millions of people are still blind from the same conditions for which excellent, proven clinical solutions are there for diagnosis, treatment or prevention. At the last count it was 45 million and it is increasing at 2 million a year with most of the backlog and the new cases being in the developing countries. Again influenced by the clinical perspective, several unconventional strategies are being proposed, ranging from improved couching techniques to remote (from the North America and Europe) robot controlled cataract surgery. Anyone working in the field of community eye health will immediately recognize that the issue is not the clinical technique. Thus there is an urgent need for us to develop a paradigm shift in our thinking to identify the real cause of blindness. When we have proven solutions for the clinical condition, if a person continues to remain blind, then the real solution has to lie outside the clinical framework and it is this paradigm shift that we need to make to identify the real causes of blindness. One can conceptualise and group such causes into two dimensions – one relating to the community and the other concerning the health care systems that deliver the eye care services. Though the issues in these areas have been recognised for long, these were considered more as barriers or as areas requiring improvement. These were seen and addressed as enabling or peripheral issues to the core clinical process. If we are serious about making a dent in the prevalence of blindness then these have to take the centre stage as the real causes of blindness.

There are communities in the developed and in the developing countries where excellent eye care services are available at affordable cost with easy access and yet many are needlessly blind with easily preventable or treatable eye conditions. In such areas focus will have to shift from clinical innovation to understanding the community dynamics (e.g. health seeking behaviours) and finding out strategies that would make them give a higher priority to their eye health. Till we take this head on as the primary cause and come up with appropriate solutions and strategies people in such communities will continue to remain blind.

There are other situations again both in the developing and developed world wherein the system or the manner in which the eye care services are managed lead to people remaining blind or visually impaired. For example, the long waiting list in UK or lack of community orientation and motivation amongst the ophthalmologists to serve the community are the main causes of continued blindness. In many situations lack of capacity, inadequate infrastructure, access and the high cost of service keeps the patient away again leading to unnecessary blindness.

Hence it is time for us to develop three distinct perspectives for the causes of blindness and develop methods to quantify them to depict them as pie charts – one giving the Clinical causes, second the Community causes and the third the Health System causes. This would bring out the focus areas to intervene and these would be different in different countries and in provinces/states/districts within the countries. This will show that for the leading "clinical" causes of blindness, almost universally there will be no need to innovate since solutions already exist and the new focus will be on developing appropriate strategies to address the causes of blindness due to community and health system issues. Once we are able to make this paradigm shift in our thinking, appropriate solution will follow and we will be able to make a dent in the blindness.

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