GUEST EDITORIAL

R. D. Thulasiraj, M.B.A.,

Executive Director, Lions Aravind Institute of Community Ophthalmology, Madurai.

Community Ophthalmology in the 21st Century

The concept of Community Ophthalmology came into sharp focus during the last three decades of the 20th century. This focus was brought about by events like the inclusion of "Control of blindness" as one of the priority actions in the "Twenty-Point Programme" launched by Mrs. Indira Gandhi and with the launch of the National Programme for Control of Blindness. As we move into the 21st century, we are at crossroads and there is a need to define the need and the role of Community Ophthalmology. In addition, the issues facing the health system and providers of eye care at the beginning of the 21st century are vastly different from those early in the 20th century. At a very broad level, there is the philosophical issue of whether we ought to move towards strengthening the community ophthalmology or engineer a complete paradigm shift that ensures eye care to all and thus work towards dispensing with community ophthalmology. Afterall in developed countries in North America and Europe there is no such entity as community ophthalmology.

The answer to the above question would first require that we define community ophthalmology. Initially community ophthalmology became synonymous with outreach work, free services, school screening etc. In the more recent years those involved in these activities also become involved in population based epidemiologic studies as well as in policy formulation at State, Regional and National levels. Thus Community Ophthalmology has now come to include all of the above.

Community oriented initiatives will be required in all fields when all potential beneficiaries are not covered by the existing service delivery system, whether it is in the field of literacy, immunisation or eye care. From this perspective, community ophthalmology will need to be in place till such time as there is universal access, availability and affordability of eye care services through fixed facilities.

This requires a reflection on where we are and where we ought to be in eye care. Today, nationwide it is estimated that there are over 12,000 formally trained ophthalmologists with reasonable infra - structure to handle secondary level care. Systems for primary eye care and infrastructure for tertiary eye care are not well developed. The Government programme has been decentralised to the district level during the last decade and the whole cataract programme has been significantly strengthened through the World Bank assistance for control of cataract blindness, but technical, logistical and funding problems impair its effectiveness and blindness continues to be at unacceptably high levels. Between the States of India, there is high disparity both in the coverage of service as well as in the quality of eye care. For instance the level of cataract service measured by the number of surgeries per million people varies from a high of 8,000 in Gujarat to a low of less than 1,000 in Bihar with Tamilnadu being around 6,000. A lot needs to be done even for basic services like refraction, where it is estimated that less than 10% of those who need spectacles are actually

wearing them. The current eye care services are inadequate in reaching women and those living in the rural areas.

In tertiary care areas like Retina Vitreous services, Glaucoma and Paediatric Ophthalmology the services are highly inadequate and as a result a lot of the patients with these conditions often present themselves at end stages. In the coming two decades we are going to witness a demographic transition that will result in the doubling of the elderly population and a steep increase in the life-style diseases like hypertension, diabetes, etc. These will have a direct impact on the need for tertiary care services. Fortunately in Tamilnadu the overall trend of eye care services is encouraging and it is in the right direction. In Tamilnadu there is an increasing focus on quality, the number of patients treated and in the development of specialty care.

The major providers of eye care can be grouped as Government, voluntary sector and the private sector. Traditionally and to a larger extent even now the Government services essentially attract the poor patients, while the voluntary sector aims its services both to the poor and to some extent to the middle income group, while the private sector has a strong focus on the middle and higher income groups. We are currently witnessing a transition dynamics brought about by the necessity of cost recovery, patient awareness and technological advancements. As the workload is growing (it has tripled in the last decade), the Government as well as the voluntary sector is under increasing pressure to meet the costs. They are required to go in for cost recovery mechanisms such as attracting paying patients. The Government is contemplating user fees as a key strategy towards enhancing their capability to improve both the quality as well as the coverage of health care services. The voluntary sector which depends on International NGOs now find themselves receiving lesser and lesser support for operating expenses and they are also looking at differential price mechanism and other strategies to become self-sufficient through user fees. The private practitioner has also recognised that increasing their clientele is dependant on the goodwill of the community .This is leading to some charity work and aggressive pricing to increase the market segment by the private sector. This transition, over a period of time will lead to a situation where all the three providers would be providing service to the entire spectrum in the community covering the rich as well as the poor. This fusion, in addition to offering more choice to patients will result in overall increase in the equity , quality of care, technology and the manner in which the care is delivered.

In addition to this market dynamics the global initiative "Vision 2020 -The Right to Sight" also offers an excellent framework for all eye care providers to co - ordinate their actions in order to enhance the level of eye care service. All these initiatives, if done well and effectively, can easily lead to a situation within the next two decades in which every single individual who needs any form of eye care is able to access it and get the services conveniently and at a price that he or she can afford. The very poor would have easy access to places that offer free care while the rich will have places that suit their demanding requirements. This situation will place us far ahead of countries like USA and UK in the delivery of eye care service. When this is reached we will truly have community ophthalmology in place and paradoxically we wouldn't need any community ophthalmology, as we understand it now.