Indigenous eye health inequity and what we can do to improve access and outcomes

Dr. Aryati Yashadhana

The issue

Vision impairment and blindness are three times higher among Indigenous compared to non-Indigenous Australians, with 90% of conditions being preventable or treatable. High prevalence of diabetes among Indigenous adults is associated with a risk of developing vision impairment, and if left untreated, blindness.[1]

What we already knew

Eye care pathways are long and complex, and uptake and completion of primary and tertiary eye care among Indigenous adults remains fragmented. This leads to lost opportunities for prevention and early intervention, and subsequently poor clinical outcomes.[2]

New evidence suggests...

The Patient Experience in Eye Care (PEEC) study[3] drew on evidence from 127 interviews and 12 focus groups with Indigenous adults with diabetes, and clinicians working in eye health and chronic disease (NSW and NT). Critical realist methods were used to identify the 'mechanisms' (root causes) that produced eye health inequity these are; ***economic*** marginalisation, ***linguistic*** marginalisation, and ***cultural*** marginalisation.
Figure 1 shows examples of the different contextual conditions that comprise each mechanism. The PEEC study poses the idea that the health system accepts these forms of marginalisation as normative, which by default demands that Indigenous Australians assimilate into the dominant culture of the health system rather than the system adapting to address 'differences' between.

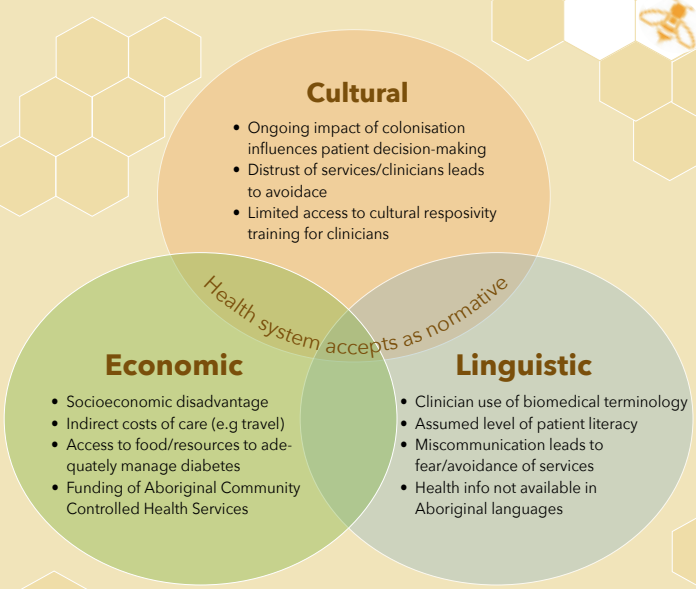

Figure 1: Three types of marginalisation identified as 'mechanisms' that produce eye health inequity

The strength of the evidence in practice

Recognising health systems have a 'culture' of their own, assists in identifying the changes needed to cater to difference in the provision of eye care to Indigenous peoples. Indigenous ways of being, knowing, and doing need to be centred in clinical spaces. Growing the Indigenous health workforce, including cultural liaison officers, coordinators, and interpreters, will also enhance access to eye care services.[4]

Putting it into policy and action

Recommended policy and practice changes:

- Systematic provision of cultural literacy and responsivity training for non-Indigenous clinicians (e.g IAHA framework)
- Increase in funding of non-clinical support including Indigenous Hospital Liaison Officers, Eye Health Coordinators, Aboriginal Health Workers, and interpreters.[4]
- Funding to support Aboriginal Community Controlled Health Services co-manage hospital care
- Review of patient travel schemes and upfront costs in NSW

References
[1] Foreman J, Keel S, Xie J, et al. The National Eye Health Survey 2016, 2016. https://www.cera.org.au/wp-content/uploads/2016/10/National-Eye-Health-Survey_Full-Report_FINAL-V3.pdf
[2] Indigenous Eye Health Unit. Annual Update on the Implementation of the Roadmap to Close the Gap for Vision: Melbourne School of Population Health, The University of Melbourne., 2018.
[3] Yashadhana A, Fields T, Blitner G, Stanley R, Zwi AB. Trust, culture and communication: determinants of eye health and care among Indigenous people with diabetes in Australia. BMJ Global Health 2020; 5(1).
[4] Yashadhana A, Lee L, Massie J, Burnett A. Non-clinical eye care support for Aboriginal and Torres Strait Islander Australians: a systematic review. Medical Journal of Australia 2020, 212 (5).

Suggested citation: Yashadhana, A. Indigenous eye health inequity and what we can do to improve access and outcomes. The Briefing Equity Evidence Report (Issue 2021-no.2), Centre for Health Equity Training, Research & Evaluation (CHETRE), Sydney. Mar 2021. doi: 10.53714/czqh8252