"A regular eye test is vital if glaucoma is to be detected early and sight loss prevented"
Acknowledgements

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Steve Winyard
RNIB Campaigns Department
Executive summary

Glaucoma is the most common preventable cause of blindness in the UK. Prevalence rises from 1-2 per cent of people aged over 40 to 5 per cent of those aged over 75. In total this represents over half a million people.

Currently there are around 172,000 referrals each year to the Hospital Eye Service (HES) for suspect glaucoma of which one-third are found to be normal, one-third to have glaucoma and one-third remain as suspects requiring long-term review (1). In total at least 300,000 glaucoma patients are seen each year in the hospital setting. These are large numbers and the provision of both primary and secondary eye care to glaucoma patients represents a major investment by the NHS.

However, each year many thousands of people in the UK start to lose their sight due to glaucoma. Overall an estimated 216,000 people have a serious sight problem because of the condition (2,3). Despite the availability of new and effective treatments; despite the best efforts of glaucoma specialists and their teams; and despite the work of optometrists in the community to identify suspects, glaucoma still causes sight loss.

The need to improve glaucoma services has been recognised by professionals working both in the hospital and community setting. This has led to the introduction of a number of innovative schemes aimed at reducing the pressure on Hospital Eye Service (HES) clinics.

There have also been country based initiatives.

In England the Department of Health established the National Eye Care Services Steering Group to develop proposals for the modernisation of NHS eye care services. The Group reported in April 2004 and proposed new care pathways for glaucoma with a significantly greater role for “optometrists with a special interest in glaucoma” managing straightforward glaucoma cases in the community (1). Pilots have been established in East Devon, Birmingham and Peterborough to test the pathway and these are due to report initially in late 2005.

In Scotland new ophthalmology patient pathways, including a glaucoma patient pathway, are currently in the final stages of development as part of the Scottish Executive’s review of eye care services.

In Wales the Welsh Assembly Government and the NHS are in the process of developing protocols on the use of primary care in glaucoma management. Several pilot schemes have been funded with the aim of better managing glaucoma patients between ophthalmology and optometry.

These initiatives are welcome and important. They should help to improve the quality and accessibility of eye care services for people with glaucoma. However, there is a danger of tunnel vision in our approach to “the glaucoma challenge”. Other issues must also be tackled if sight loss due to glaucoma is to be reduced.

Regular eye tests

As new research for this report shows, a sizeable proportion of those at risk of glaucoma are not getting their eyes tested on a regular basis. Nationally around one in five of the over 50s population have not had their eyes tested within the past two years, representing some 3.5 million people. Within the over 50s population fully one half of those of African origin have not had an eye test in the past two years.

All of these people are putting their sight at risk since glaucoma is without symptoms in its early stages. Up to 40 per cent of useful sight can be lost before a person realises. It is therefore vital that governments across the UK fund major public education campaigns to promote the role of eye tests in the early detection of eye disease and the prevention of blindness.

If at risk groups are to be encouraged to get their eyes tested regularly, there is a strong case for the re-introduction of free eye tests for all. It is clear that the system of charges accompanied by a complicated system of exemptions does deter many people. The Scottish Parliament recently took the lead and voted for free eye tests for all – the rest of the UK should follow.
Increasing awareness

While four out of five people have heard of glaucoma, our research indicates that people’s understanding of the condition is very limited. Less than half of this group know of the link with age. Only one in five are aware of the importance of family history and just 4 per cent are aware of the increased risk faced by people of African origin.

There is an urgent need for a co-ordinated strategy to increase knowledge of the condition involving both health providers and patient groups. This strategy would target glaucoma patients and their relatives with the objective of encouraging better long-term engagement with treatment and prevention strategies. It would also seek to get over some key messages to the general public regarding the asymptomatic nature of the condition and therefore the importance of having a regular eye test even when there is nothing wrong with your vision.

Compliance with treatment regimes

There is a need for a concerted effort to improve compliance with treatment regimes. At best three-quarters of glaucoma patients are using the right medication at the right time (4,5). However, the proportion may be much lower than this – possibly as little as one in two. The reasons for this are complex and need to be properly understood. But there can be no doubt that current levels of non-compliance are extremely wasteful, wasteful of people’s sight and wasteful of scarce NHS resources. The problem must be tackled.

Funding

Funding for services for glaucoma patients, both in the community and in the hospital setting, is inadequate. We currently have a system under enormous pressure with dedicated professional staff unable to cope with demand. This translates into a service that does not appear friendly to patients. Indeed, recent qualitative research indicates that patients often feel unwelcome in the eye clinic and that if they ask questions they are “wasting the consultant’s time”. It does not need to be like this but change will only come about if additional resources are made available to allow more time to be spent with patients, listening and answering their questions. RNIB would urge health commissioners across the UK to provide funding for a fully trained Eye Clinic Liaison Officer in every hospital eye department to provide this service.

The case for additional expenditure on glaucoma services is a powerful one. If the condition is detected early in its asymptomatic stage, loss of vision can be prevented. At the moment we are not achieving this – and as a result many thousands of people start to lose their sight unnecessarily. Also, we are failing to help people diagnosed with glaucoma comply with their treatment regime. Again many thousands of people are losing their sight unnecessarily as a result.

The cost of sight loss on this scale is very high both to the individual and to the wider society (6). But properly targeted expenditure to reduce sight loss due to glaucoma would be either cost neutral or may even save the exchequer money. There can be no excuse for not tackling the glaucoma challenge.
most cases a person’s vision recovers completely. However, if treatment is delayed, there will usually be permanent damage to the eye.

What are the main risk factors?

There are several factors that increase the risk of glaucoma and these tend to be cumulative in effect (8).

- **Age** – Chronic glaucoma becomes much more common with increasing age. Rare below the age of 40, prevalence rises from 1-2 per cent in the over 40s to 5 per cent in the over 75s (1).
- **Race** – People of African origin are four times more at risk of developing chronic glaucoma compared to those of European origin. The condition also tends to develop at an earlier age and be more severe. People of Asian origin are at an increased risk of developing acute glaucoma.
- **Family history** – There is a greatly increased risk of developing glaucoma if someone has a close relative (father, mother, brother or sister) with the condition. Free NHS eye examinations are available for such people from the age of 40.
- **Short sight** – People with very short sight (severe myopia) are at an increased risk of developing chronic glaucoma. They too are entitled to a free NHS eye examination.

How is glaucoma detected?

A regular eye test is vital if glaucoma is to be detected early and sight loss prevented. Those over the age of 50, and particularly those in an increased risk group, should have an eye test at least every two years. It is important that the test includes all three of the glaucoma tests:

- **Ophthalmoscopy** – an examination of the back of the eye including the optic nerve by shining a light from a special torch into the eye or by photography
- **Tonometry** – measurement of the pressure in the eye using a special instrument
- **Perimetry** – a check of the visual field using a sequence of spots of light on a screen.
Why is glaucoma still a problem in the UK?

Why is glaucoma still a problem in the UK? Glaucoma accounts for 12 per cent of those registered blind and 9.6 per cent of those registered partially sighted in England and Wales (2). Applying these proportions to the latest figures for registration across the whole of the UK indicates there are around 40,000 people with severe sight loss (either registered blind or partially sighted) due to glaucoma (9).

Many more people however have lost a significant amount of vision due to glaucoma. For example, there are people who have never entered the system and are not receiving any form of treatment. There are also significant numbers of people who have been seen by an ophthalmologist and prescribed eye drops, but for a variety of reasons do not comply with the treatment regime. Across the UK there are around 2 million people with a sight problem (with Snellen visual acuity less than 6/12). Assuming that glaucoma accounts for a similar proportion of this total, as it does for total registrations, gives a figure of 216,000 people with a serious sight problem due to glaucoma. This total includes the 40,000 who are registered as either blind or partially sighted (3).

Given that effective treatments are available for glaucoma, why is it still a major cause of sight loss in the UK? At least four reasons can be identified:

- failure to have a regular eye test
- limited awareness of glaucoma
- restricted access to diagnosis and review
- poor compliance with treatments.

Each of these will be explored in turn.

What treatments are available?

The main treatment for chronic glaucoma (POAG) aims to reduce the pressure in the eyes and so prevent further damage to the optic nerve. Usually the treatment is by means of eye drops. These reduce the amount of fluid being produced by the eye, increase the rate of drainage of fluid from the eye, or both.

There have been major advances in this form of treatment in recent years. The newer drops are far more effective and have fewer side effects than those previously available. However, if the eye drops do not lower the pressure sufficiently, laser or surgical treatments are available.

Acute glaucoma is initially treated with drops and an injection to lower the eye pressure. Once the pressure is down, a laser or surgical procedure is carried out to bypass the blockage in the eye’s drainage system and prevent a recurrence of the problem. These treatments are not painful and are usually done on a day patient basis.

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Failure to have a regular eye test

As the National Eye Care Services Steering Group noted, “Early detection of glaucoma in its asymptomatic stage is important to prevent severe vision loss in later life. Symptoms only occur at a late stage in the disorder and recent large-scale treatment studies suggest that chronic glaucoma satisfies all of Wilson’s criteria for screening. Despite this, no systematic screening schemes for glaucoma have yet been established in the UK and case detection is reliant on high street optometrists who in recent years have expanded their methods of detecting glaucoma” (1).

This is true, but it is not the whole picture. For cases of glaucoma to be detected, people have to go to an optometrist for an eye test in the first place. Are they doing this and, in particular, are the high risk groups having their eyes tested on a regular basis?

In the absence of any recent and comprehensive information on these issues RNIB commissioned a number of questions in the April 2005 Omnimas survey (10). This found that two-thirds of the adult population (aged 16 and over) had had an eye test within the past two years. But the proportion varies significantly with age. Half of the 16–34 age group had been for an eye test within the past two years compared with 86 per cent of the over 65s.

There is also a significant difference between men and women. Overall 73 per cent of women had their eyes tested within the past two years compared with only 59 per cent of men.

As can be seen from table 1, the percentage of the population having a regular eye test also varies considerably between regions and countries.

People living in Scotland are most at risk. Less than six out of ten have had their eyes tested within the past 2 years and one-quarter have either never had an eye test or have left it more than four years since their last test. A similarly low proportion of the population in the South East have had an eye test within the past two years and fully one-third have never been for a test or have gone more than four years without one.

Respondents who had not had an eye test within the past two years were asked why this was. By far the most common response (63 per cent) was “there is nothing wrong with my eye sight”. The next most frequent responses given were “lack of time” (11 per cent) and “not important” (9 per cent). Cost was given as the reason for not getting a sight test by 7 per cent of adults.

Table 1 Frequency of eye test by region and country

<table>
<thead>
<tr>
<th>Region/country</th>
<th>Within past 2 years (per cent)</th>
<th>&gt; 4 years/never (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Anglia</td>
<td>70</td>
<td>13</td>
</tr>
<tr>
<td>East Midlands</td>
<td>77</td>
<td>17</td>
</tr>
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<td>North</td>
<td>66</td>
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<td>South West</td>
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<td>15</td>
</tr>
<tr>
<td>West Midlands</td>
<td>69</td>
<td>21</td>
</tr>
<tr>
<td>Yorks and Humberside</td>
<td>70</td>
<td>20</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>69</td>
<td>21</td>
</tr>
<tr>
<td>Scotland</td>
<td>59</td>
<td>25</td>
</tr>
<tr>
<td>Wales</td>
<td>70</td>
<td>18</td>
</tr>
<tr>
<td>UK</td>
<td>66</td>
<td>21</td>
</tr>
</tbody>
</table>

Limited awareness of glaucoma

The RNIB/Omnimas survey asked respondents whether they had heard of a range of eye conditions, including glaucoma. Cataracts is the best known condition (86 per cent), followed by glaucoma (78 per cent), diabetic retinopathy (50 per cent) and age-related macular degeneration/AMD (29 per cent).

In the case of glaucoma there is higher awareness amongst women (82 per cent) than men (74 per cent). There is also higher awareness amongst older people. For example 90 per cent of those aged 55–64 and 84 per cent of the over 65s have heard of glaucoma compared with 47 per cent of the 16–24 age group.
Table 2 Awareness of glaucoma by region

<table>
<thead>
<tr>
<th>Region/country</th>
<th>Aware of glaucoma (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Anglia</td>
<td>85</td>
</tr>
<tr>
<td>East Midlands</td>
<td>77</td>
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<tr>
<td>North</td>
<td>89</td>
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<td>North West</td>
<td>82</td>
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<td>South East</td>
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<td>South West</td>
<td>87</td>
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<tr>
<td>West Midlands</td>
<td>80</td>
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<td>Yorks and Humberside</td>
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<td>Northern Ireland</td>
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<tr>
<td>Scotland</td>
<td>75</td>
</tr>
<tr>
<td>Wales</td>
<td>84</td>
</tr>
<tr>
<td>UK</td>
<td>78</td>
</tr>
</tbody>
</table>

There is substantial variation across the UK in awareness of glaucoma, ranging from a low of 71 per cent in the South East to a high of 89 per cent in the North.

A far higher proportion of those who have had their eyes tested within the past two years have heard of glaucoma (85 per cent) compared with those who had not (63 per cent). This is both welcome and unsurprising given that a routine eye test by an optometrist should include at least one of the glaucoma tests.

While overall awareness of glaucoma is relatively high, further questions were asked to establish the extent of people’s understanding of the condition. Respondents who had heard of glaucoma were asked the following four questions.

- “Who is more likely to develop the condition?” The most frequent response was “people over 60” (43 per cent), followed by “those with a close relative with glaucoma” (18 per cent) and “diabetics” (13 per cent). People of African origin were mentioned by 4 per cent of respondents, Asian people by 2 per cent and “all ethnic minority groups” by 2 per cent. One-third of those who have heard of glaucoma were unable to say who is more likely to develop the condition. Replies ranged from a simple “don’t know” (23 per cent), to “no one/anyone” (5 per cent) and “other people” (4 per cent).

- “How does the condition affect vision if left untreated?” Just over three-quarters (76 per cent) replied either “blindness” or “large loss of sight”. Only 2 per cent mentioned “tunnel/narrow/decreased field of vision” and another 2 per cent “blurred/distorted vision”. One in five respondents (19 per cent) replied “don’t know”, 4 per cent “there would be a small loss of sight” and 3 per cent “you would need to wear glasses”.

- “What are the symptoms?” The most common response was “don’t know” (45 per cent), followed by “blurred vision” (36 per cent) and “trouble focusing” (12 per cent). Only 3 per cent of respondents stated “no symptoms” which is correct for the early stages of the disease.

- “How is glaucoma usually treated?” For this question respondents were able to choose one or more options from “with glasses” (7 per cent), “by resting eyes” (2 per cent), “with eye drops” (32 per cent), “by surgery/an operation” (41 per cent), “it’s not treatable” (5 per cent), and “don’t know” (29 per cent).

This indicates that whilst general awareness of glaucoma is high, very few people have a real understanding of the condition.

The African and African-Caribbean survey

People of African origin have a four times increased risk of glaucoma compared to people of European origin. Also the condition tends to come at an earlier age and be more severe. It is therefore vital that they monitor the health of their eyes and have a regular eye test.
Is this the case? Are people of African origin getting their eyes tested regularly and are they aware of the higher risks they face from glaucoma? To answer these questions, RNIB placed a number of questions in the Ethnibus survey that collects information from a representative national sample of people from African and African-Caribbean backgrounds. Our data comes from the April 2005 wave (11).

Overall rather less than half of all respondents (44 per cent) had been for an eye test within the past two years. This is markedly lower than the national average (66 per cent). Among those aged 45-54 the proportion rose to 62 per cent. However in the over 55s it was just 38 per cent – less than half the national average for this age group. Also of concern is the fact that approaching one in five (18 per cent) of these respondents had never had an eye test. Again, this is more than twice the national average (7 per cent).

Respondents of African origin who had not had an eye test within the past two years were asked why this was. As with the general UK population, by far the most common response was “there is nothing wrong with my sight” (44 per cent). Next came “lack of time” (20 per cent), followed by “cost” (17 per cent).

That cost is given as the main reason for not having an eye test by one in six people of African origin is of real concern. It suggests that many people are not aware of their entitlement to free eye tests. Nearly half of those not in employment gave cost as the reason for not having an eye test. However in virtually all cases they would be eligible for a free NHS test.

Another question placed by RNIB in the Ethnibus survey confirms that there is only a very limited knowledge of who is entitled to a free eye test amongst the African and African-Caribbean population. When asked about which groups are eligible one-quarter of respondents said they didn’t know. “People over 60” were mentioned by 21 per cent of the sample, while only 9 per cent mentioned “people on benefits”. “People over 40 with a close relative with glaucoma” were mentioned by just 2 per cent of respondents, while a similar proportion mentioned “people with glaucoma”. All these groups are entitled to free eye tests.

RNIB asked respondents which of a range of eye conditions they had heard of. Best known was glaucoma, mentioned by just under half (48 per cent) of the sample. Next came cataracts (17 per cent). In both cases these awareness levels are much lower than the national average (78 per cent glaucoma and 86 per cent cataracts).

Those respondents who had heard of glaucoma were asked which groups in the population did they think are more likely to develop the condition. Just over one-quarter (26 per cent) mentioned people of African origin, followed by “people over 60” (17 per cent). “People who are short sighted” and “People over 40” were mentioned by one in ten of respondents.

To understand how much people who said they had heard of glaucoma actually know about the condition, this group was asked four further questions.

- “How does glaucoma affect your vision if left untreated?” By far the most common response was “blindness” mentioned by 48 per cent, followed by “large loss of sight” mentioned by a further 26 per cent of the group. One in ten said there would be a small loss of sight and a similar number said they did not know what the impact on vision would be.

- “What would the symptoms be/how would you know if you had glaucoma?” Four out of ten said that they did not know, whilst a similar number responded “blurred vision”. Fifteen per cent said “you see spots”. Just five per cent of respondents replied “you would not know” – correct for the early stages of the disease.

- “How is glaucoma usually treated?” By far the most frequent response was “by surgery” (58 per cent). Eye drops were mentioned by one in five respondents (19 per cent) while 8 per cent said that the condition is not treatable. One in seven respondents who had heard of glaucoma (14.2 per cent) said that they did not know how it is treated.

- “How difficult do you think it is to treat glaucoma?” Fully 82 per cent responded that it is either “difficult” or “very difficult” to treat the condition. This is in sharp contrast to the population as a whole, just over one-quarter (26 per cent) of whom think that it is “difficult” or “very difficult” to treat.
Restricted access to diagnosis and review

The problem of restricted access to diagnosis and review is well recognised. It was referred to by the National Eye Care Services Steering Group in the following terms:

“As a result of the relatively low number of ophthalmologists working in the HES and the tendency for HES outpatient clinics to gradually expand their number of glaucoma patients and suspects, waiting times for initial assessment remain a problem in many areas” (1).

To reduce the pressures of numbers in hospital eye clinics due to glaucoma, a number of local schemes have been put in place that seek to utilise the expertise of optometrists. For example, in Manchester there is a “super optometrists in the community” programme that seeks to reduce the number of referrals in to the HES. A different approach has been adopted in Nottingham. Here the objective has been to increase the capacity of the HES through an in-house optometrist’s scheme.

Some progress has been made in reducing the waiting times for initial assessment of glaucoma patients and suspects, but this has not been without problems. Crucially, the pressure on Hospital Trusts to reduce waiting times for new patients has meant that appointments for review are often cancelled. As a result patients are known to have lost vision unnecessarily and will, in some cases, have stopped medication altogether. It is important that the Department of Health collects data to monitor this problem.

New glaucoma pathways and an increased role for optometrists in assessment and the on-going management of glaucoma cases will help. But there can be no doubt that both primary and secondary eye care is badly under-funded. With the welcome exception of the £70million funding for the “Action on Cataracts” initiative and £4million to fund the eyecare pathway pilots, the sector has not been a priority within overall NHS expenditure plans. This must change. Not only because many people are losing their sight unnecessarily, but also because demand for eye care is set to rise by 35 per cent by the year 2020 (1).

Poor compliance with treatments

It has long been recognised that there is considerable non-compliance with treatment regimes amongst people with glaucoma and ocular hypertension. It is difficult to measure precisely the extent of the problem but a number of studies indicate degrees of non-compliance varying between 25 and 50 per cent (4,5). Certainly there can be no doubt compliance is an important issue that needs to be addressed. When people stop taking their eye drops, or only take them intermittently, they inevitably risk further damage to their sight.

The reasons for non-compliance are many and vary between different groups in the population. Most important appear to be situational/environmental factors (eg being away from home or a change in routine) and those related to the medication regime (eg side effects or complexity with different drops to be taken at different intervals) (12).

The patient’s understanding of the disease is also important. Given that glaucoma is asymptomatic, it is often hard for the patient to believe that there is anything seriously wrong with their sight. It is also hard to appreciate that the disease is life-long; that you have to keep taking the medication but there will be no cure and no obvious improvement.

Another factor that is important in compliance is the quality of the relationship between the patient and the doctor. Recent qualitative research (13) suggests that whilst consultant ophthalmologists are seen as authoritative and are well respected, they can come over as “patronising” and “intimidating”. They often give the impression that they are extremely busy and patients feel they do not encourage questions or discussion. All of this inhibits the giving and receiving of information. In contrast, optometrists are generally seen as easy to talk to and very willing to answer questions. Patients feel much more comfortable with the optometrist. This may in part be due to a good relationship having been established over a number of years. Interestingly, optometrists are seen as having great expertise and state-of-the-art equipment.

It is clearly important that compliance messages are continually reinforced. Glaucoma is a life-long condition and patients need to be reviewed on a regular basis, feel supported and able to seek advice when needed.
Moving forward on glaucoma

In late 2002 the Department of Health established the National Eye Care Services Steering Group to develop proposals for the modernisation of NHS eyecare services in England. As its first priority, the Steering Group sought to develop model care pathways for cataract, glaucoma, low vision and age-related macular degeneration (AMD). The Steering Group reported in April 2004 and proposed for glaucoma care that:

- community optometrists are encouraged to conform to College guidelines for referral of glaucoma suspects, with appropriate funding
- Hospital Eye Services (HES) are encouraged to utilise optometrists to assist in glaucoma care within the HES
- refinement of optometric referrals in the community is established using Ophthalmic Medical Practitioners (OMPs) and optometrists with a special interest in glaucoma
- community care of “straightforward” glaucoma cases by OMPs and optometrists with a special interest in glaucoma is established
- funding is agreed.

In addition the Steering Group recommended that a number of new pilots be set up to test the new care pathway for glaucoma using optometrists with a special interest. These pilots have subsequently been established in Birmingham, East Devon and Peterborough. They are expected to report early findings in the second half of 2005.

In Scotland new Ophthalmology Patient Pathways, including a glaucoma patient pathway, are currently in the final stages of development. These have been developed by a multidisciplinary group as part of the Scottish Executive’s review of eyecare services.

In Wales, the Welsh Assembly Government and the NHS are in the process of developing protocols on the use of primary care in glaucoma management and issues in respect of referrals. Several pilot schemes have been funded with the aim of better managing glaucoma patients between ophthalmology and optometry.

All of this work is welcome and important. However, other issues need to be tackled if sight loss due to glaucoma is to be further reduced.

Getting a regular eye test

As we have seen, far too many people in “at risk” groups are not getting their eyes tested on a regular basis. Nationally around one in five of the over 50s have not had an eye test within the past two years, representing some 3.5 million people. Within the over 50s African and African-Caribbean population the proportion is as low as one in two.

Given the asymptomatic nature of glaucoma, it is vitally important that people do have their eyes tested, even when they believe “nothing is wrong”. To this end RNIB calls for:

- a major public education campaign to promote the role of eye tests in the early detection of eye disease and the prevention of blindness.

It is also clear that few people understand the complicated exemption categories for free NHS eye tests. Many people of African origin are currently deterred from having their eyes tested on grounds of cost, unaware of their entitlement to a free NHS test. To tackle this problem RNIB calls for:

- the re-introduction of free eye tests for the whole population.

In Scotland, legislation is currently going through Parliament that will deliver free eye tests for all by 2007. This is welcome and the rest of the UK should follow Scotland’s lead. A useful step in this direction would be to bring the age limit for free eye tests down from 60 to 50. It is after 50 that the incidence of eye disease increases sharply and a bi-annual test becomes really important.
As argued above, there is an urgent need for a public education campaign to promote the role of eye tests in the early detection of eye disease. Glaucoma should feature strongly in this. Most people are unaware of the lack of symptoms in its early stages.

Improved compliance

There needs to be a concerted effort to improve compliance with treatment regimes. At best three-quarters of glaucoma patients are using the right medication at the right times. However, the proportion may well be much lower than this. Non-compliance on this scale is extremely wasteful. It is wasteful of people's sight as they come off medication and lose useful vision. It is wasteful in terms of public expenditure – glaucoma medications currently cost in excess of £100million per year and if these are not being used properly this is literally money down the drain. It is also wasteful in terms of scarce staff time – the hours spent by optometrists, GPs, ophthalmic nurses, Registrars and Consultants in assessing non-compliant patients.

A higher priority for eye health

Ninety per cent of people when asked say that sight is the sense they most fear losing (14). Yet this is not reflected in current NHS spending priorities. We currently have an eye care system under enormous pressure, with dedicated professional staff unable to cope effectively with demand. With the welcome exception of the £70million for the “Action on Cataracts” initiative and the £4million made available for eye care pathway pilots, eye health has not been a noticeable beneficiary of the recent rapid growth in NHS expenditure.

This needs to change. Overall much more needs to be spent on services for glaucoma patients, both in the community and hospital settings. In particular RNIB calls for funding for an “Action on Glaucoma” initiative covering:

- refinement of optometric referrals in the community using “optometrists with a special interest in glaucoma” and Ophthalmic Medical Practitioners (OMPs)
References

8. RNIB and Royal College of Ophthalmologists, Understanding Glaucoma, 2004, London, RNIB.


Other RNIB campaign reports

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ISBN 1 85878 629 0, 2004, £5.00
Print PR 12043P ■ Braille PR 12043B ■ Tape PR 12043T ■ Disk PR 12043D

21 Travellers' tales: making journeys safer for blind and partially sighted people
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