Optometry Australia

Optometry Board of Australia Public Consultation Submission Guide

September 2025

About the Submission Guide

This guide has been prepared to help you submit a response to the **Optometry Board of Australia** (the Board) public consultation on the *Registration standard: Endorsement for scheduled medicines and Guidelines for use of scheduled medicines*.

Please finalise your submission as a Word document (not PDF) using the template on the *Board consultation page*, and email to *optomconsultation@ahpra.gov.au*, with the subject '**Public consultation on the review of Endorsement for scheduled medicines**'.

Context

Changes to the therapeutic regulations for optometrists are imperative to meet the increasing eyecare needs of the population, benefit the healthcare system, and contemporise the scope of the profession in Australia. Over the last decade, **Optometry Australia** (OA) has consistently advocated for changes to the endorsement and guidelines that govern medicines prescribing by optometrists in Australia.

International experience has shown oral prescribing by optometrists to be extremely safe and effective. Optometry Australia therefore strongly supports the proposed removal of the word "topical" from the guidelines – enabling prescribing of oral medications by optometrists for the purposes of the practice of optometry.

However, the Board has proposed to maintain a scheduled list of 'approved' medicines on the Board website – a suggestion which we believe places undue and unnecessary restrictions on practitioners and may preclude patients from receiving the best medicines available for their condition. Optometry Australia therefore disagrees with reference to this list in the standards and guidelines and instead advocates for optometrists being able to prescribe for the purposes of practising optometry[1], without being limited by a restrictive list.

We further note commentary from the profession regarding workforce pressures and pay inequity. These concerns are very real, and OA continues to call on employers to align with our *Position Statement on Workforce Conditions* and lead meaningful change across the sector. At the same time, reforms like oral prescribing are about professional recognition – ensuring optometrists can practise to their full capacity.

Optometrists will always have full clinical autonomy to decide what's right for their patients, and Optometry Australia will continue to champion both: an empowered profession practising to its full scope, and better conditions for every optometrist.

Increasing prescribing scope will not only be of benefit to patients, it will also assist in building awareness of the crucial role of optometrists in eye care amongst the public and other health practitioners. This consultation is a once in a generation opportunity to meaningfully improve access to eyecare for Australians, and to ensure the alignment of Australian scope of practice with our overseas colleagues, including in New Zealand.

Overarching Advice

This guide will suggest how you might like to respond in alignment with Optometry Australia's researched advocacy.

The mainstays of your response should include thoughts about:

Patient Care

Oral prescribing ensures timely, convenient, and effective treatment. It prevents harm caused by delays and reduces unnecessary costs for patients.

System Efficiency

By prescribing oral medicines, optometrists reduce the demand on GPs and ophthalmologists, freeing them to focus on complex and surgical cases.

Access

Optometrists are more geographically accessible than ophthalmologists, especially in rural and regional communities. They frequently provide bulk-billed services and urgent same-day appointments.

Scheduled Medicines List

A scheduled medicine list may delay access to contemporary evidence-based treatments, complicate prescribing during drug shortages, and create unnecessary barriers for patients and practitioners.

Safety

International evidence is clear. In New Zealand, more than a decade of optometrist oral prescribing without a list of scheduled medicines has resulted in no adverse outcomes or complaints. The UK and USA also demonstrate safety, with no increase in malpractice claims or patient harm.

Evidence

it is helpful to include evidence to substantiate your views. In addition to this submission guide, *Optometry Australia's Position Statement on the Use of Medicines by Optometrists* and the *HT Analysts Report on the Value of Optometrist Prescribing* are valuable resources.

Case Studies

Members should include patient examples where oral prescribing would benefit their patients, and also where prescribing restrictions delayed or prevented treatment. For example, delays in adding Nepafenac (Illevro) and Loteprednol to the topical medicines schedule left patients without timely access to safer or more effective treatments.

Draft response to consultation questions for consideration

Question 1:

Which option do you prefer? (Option 1: status quo; Option 2: proposed changes)

I support the Board's proposal to expand the scope of prescribing for endorsed optometrists to include oral medicines used for common eye conditions, however I have concerns about the proposal to maintain a restrictive list of approved medicines. As such, I prefer option 2 but with amendments as described in question 8 below.

I support the proposed changes to remove specific reference to the word 'topical' for the following reasons:

- This change is in the best interests of patients, and has the potential to prevent significant detriment to vision and eye health through prompt treatment of common ocular conditions by the primary providers of eyecare in Australia
- This change has proven safety and efficacy from the experience of overseas optometrists, who have practised with oral prescribing for many years with no adverse outcomes[1-5].
- It is within optometrists' knowledge and expertise[6].
- It improves patient care through optimised continuity of care and reduced delays in obtaining the necessary treatment.
- It reduces the burden upon ophthalmology, a workforce with restricted capacity, inadequate geographic distribution, and advanced skill sets in other areas that are dramatically needed (e.g., eye surgeries).
- It reduces costs to the patient through fewer appointments and less time off work.
- It reduces costs to the health system through reduced GP and specialist visits[7].
- It increases equitable access to care, as optometrist services are widely available throughout the country, typically allow for urgent same day appointments, and have high rates of bulk billing.
- By allowing oral prescribing, the proposed changes take a step forward in aligning the scope of practice of Australian optometrists with their international counterparts, which is welcome because scope advancements in optometry have been shown to align with better eye health outcomes for the population. However, retaining reference to approved lists of scheduled medicines is misaligned with our New Zealand counterparts, and other Australian health professions such as nurse practitioners and midwives.

Question 2:

Do the proposed updates have specific impact on Aboriginal and Torres Strait Islander Peoples? If yes, please describe.

Please refer to responses provided by First Nations-led organisations and Optometry Australia's Advisory Group on Aboriginal and/or Torres Strait Islander Eye Health. I respect the input of this group and will continue to practise in a culturally safe way when enacting the changes to therapeutic prescribing guidelines.

OR

Aboriginal and Torres Strait Islander Peoples experience multiple barriers to eye care [8, 9], and whilst the revised standard cannot address all these issues, I support Optometry Australia's view that allowing oral prescribing by optometrists will benefit this population in the following ways:

- Improved access to timely comprehensive eye care services/treatment.
- Reduced complexity and fragmentation across the referral/treatment pathways.
- Reduced wait times, costs, and visits or appointments for eye care services/treatments.
- Improved collaborative care through oral prescribing, eliminating this demand on ophthalmology time and therefore reducing waitlists for other crucial ophthalmology services such as cataract and diabetic eye disease treatments[8].

Further, the inclusion of a scheduled list of medicines may mean that access to the right medicine at the right time might be impeded by medicine shortages or supply issues – this may disproportionately impact Aboriginal and Torres Strait Islander Peoples, particularly those living in remote Australia[10].

The restriction of evidence- based contemporary practice imposed by a list is contrary to several consultations and reviews which have highlighted the importance of improving access to, and quality of, eyecare for Aboriginal and Torres Strait Islander populations.

Question 3:

Can you think of any unintended consequences from the proposal that haven't been addressed by the Board? If so, please describe them and provide evidence if possible.

I welcome the amendment of the endorsement to state that therapeutically endorsed optometrists are qualified to administer, obtain, possess, prescribe, supply and/or use Schedule 2, 3 or 4 medicines for the purposes of the practice of optometry.

However, I am concerned that the publication of an 'approved' medicine list on the Board's website will create confusion amongst practitioners, and cause delays in access to the best treatments for patients. Whilst the Board has proposed that the list can be reviewed in consultation with stakeholders and updated annually, I hold concern that this creates additional regulatory and administrative burden, and risks delaying access to new or alternative scheduled medicines for optometrist prescribing in the interim.

There is also a lack of clarity around how the list will be enforced, and the process and timing involved to make amendments to the list, including when these are urgent in the event of medicine shortages.

The Board has correctly identified that more "person-centred collaborative practice models", and "more up-to-date medicines for optometrist prescribing" are required, but retaining a scheduled list on the website does not allow for this. The Board provides a wealth of evidence enabling endorsed optometrists to prescribe scheduled medicines for the purposes of the practice of optometry is low risk, but proceeds to maintain an approved list without explaining why it is needed, and ignore its downside impacts in terms of patient access and restricting optometry practice. The reference which is made by the Board regarding restricted schedule 4 and schedule 8 not being within optometrist scope would suffice as guidance for optometrist prescribing.

Question 4:

Do you have any other comments?

Individuals to update this section:

To demonstrate support for the proposed changes which enable optometrist oral prescribing, please provide in your submission a case study of a patient who could have benefited from oral prescribing, detailing:

- the delays, impediments to treatment, and costs that the patient faced as a result of your restricted practice
- how improved management would be possible if this change to enable oral prescribing is implemented.

You may wish to mention that current restrictions on your prescribing are incongruous with The Trans-Tasman Mutual Recognition Act 1997, and that you could currently provide this service to your patients if you relocated to New Zealand.

Question 5:

Is there anything that needs to be changed, added or removed in the proposed draft standard and guidelines? Please provide details.

For the reasons outlined elsewhere within this submission, I ask the Board to remove the following section of the Draft Registration standard: Endorsement for scheduled medicines:

"Approved list of scheduled medicines: The approved list of Schedule 2, 3 or 4 medicines for the purposes of the practice of optometry is published by the Board. You are expected to be familiar with the list."

I further propose that the following section of Guidelines for the use of scheduled medicines be removed:

"Medicine list for endorsed optometrists: The national approved list of Schedule 2, 3 or 4 medicines that endorsed optometrists are qualified to administer, obtain, possess, prescribe, supply and/or use for the purposes of the practice of optometry, is published on the Board's website. You are expected to be familiar with this list."

The following change to the standard is supported and welcomed:

"Wording to appear on the Register of optometrists: Endorsed as qualified to administer, obtain, possess, prescribe, supply and/or use Schedule 2, 3 or 4 medicines for the purposes of the practice of optometry."

Regarding recency of practice, I believe that all clinical practice as an endorsed optometrist enhances ability to prescribe medicines safely and effectively as required. I note that it is unclear how "recent experience in this scope of practice" is defined or quantified and encourage the Board to consider that whilst CPD requirements should differ to non-endorsed optometrists, endorsed practitioners should not face more arduous or unclear obligations around recency of practice. I therefore encourage the Board to reconsider the below language, to ensure clarity:

"During the registration period have recent experience in this scope of practice that meets the Board's Registration standard: Recency of practice"

Finally, I welcome the inclusion of the following language regarding the care of patients with chronic glaucoma: "*informed by the best available evidence and QUM principles*". This enables me, as a clinician, to respect individual patient treatment and management preferences.

Question 6:

Would the proposed updates result in any adverse cost implications for practitioners, consumers or other stakeholders? If yes, please describe.

I do not believe that there will be adverse cost implications for practitioners as a result of this proposal. I am also aware that oral prescribing by optometrists who are members of Optometry Australia will have no negative impact upon their existing Professional Indemnity Insurance arrangements.

As a practitioner who relies upon the important work performed by the Optometry Board of Australia, I am concerned about the cost implications of maintaining and regularly updating a restrictive lists of medicines to be published on the website, due to the unclear and potentially burdensome regulatory input required.

I do not believe that there will be adverse cost implications for consumers and stakeholders as a result of implementation of this proposal. In fact, I believe that enabling optometrists to prescribe oral medications for the purposes of the practice of optometry will have a positive effect, reducing costs to both the patient and the health system associated with additional GP and specialist visits[7].

Question 7:

Would the proposed updates result in any potential positive or negative unintended effects for members of the community at risk of experiencing poorer health outcomes? If so, please describe them.

It has been established that some sections of the population experience disproportionately poorer eye health outcomes due to access and cost barriers to timely and effective eye care. I would contend that the positive effects of the proposed updates will be more pronounced for those community members who are most at risk of experiencing poorer health outcomes because:

- One of the primary benefits of the proposed updates is that they mean that patients will no longer need to have an appointment with a general practitioner or ophthalmologist to receive an oral medication for an ocular condition within the scope of my practice and expertise.

- ABS Patient Experiences Survey (November 2024) shows that a significantly higher percentage of Australians living in areas of most socio-economic disadvantage wait longer than acceptable for a GP appointment than those living in areas of least socio-economic disadvantage (30.3% compared to 24.3%), and similar inequity applied for outer regional, remote or very remote areas compared with those living in major cities (36.3% compared to 26.0%)[11] During 2023-24, some 46 per cent of Australians waited more than 24 hours for an urgent general practice appointment.

- Oral prescribing by optometrists will allow for greater access to urgent ocular care in rural and remote settings and other locations where lengthy waits to see GPs or ophthalmologists limit or disincentivise access to care [12, 13]

- Supporting patients from diverse backgrounds to overcome healthcare barriers by improving access to follow-up appointments has been shown to significantly improve eyecare outcomes[14]. Oral prescribing by optometrists will help facilitate this.

Question 8:

Do you have any feedback about the proposed draft medicine lists?

The Board's proposal to remove reference to the list within the endorsement appendix but refer to a list on the website in the standards and guidelines is confusing and creates several significant barriers to patient care and practitioner guidance. I encourage the Board to instead consider an exclusion of restricted schedule 4 and schedule 8 medicines, which would suffice to ensure rigorous consumer safety and adequate practitioner guidance.

Question 8 continued:

Individuals to update this section:

In support of your opposition to an approved list of medicines, it would be helpful to provide in your submission a case study of a patient whose treatment was compromised due to the restrictive nature of the scheduled list of medicines in the current therapeutic prescribing guidelines, detailing:

- how the patient could have benefited from prescription of an alternative medicine
- the delays and costs they faced as a result of your restricted practice
- how improved management would be possible moving forward if the changes to the guidelines included removal of reference to a list of approved medicines

You may also wish to mention the following pertinent points:

- A restrictive list of scheduled medicines places unnecessary burdens upon patients and optometrists, as the best evidence-based treatment for the patient may not be approved, especially in times of drug shortages.
- Unnecessary restrictions on patient access, such as those that occur through the enforcement of a specified list, run contrary to the core objectives of the National Medicines Policy. These patient access issues are likely to be greater in regional and disadvantaged communities that do not have ready access to other health professionals. The list also creates a barrier to optometrists providing care in line with the Quality Use of Medicines guidelines, as the best treatments, despite having proven safety and efficacy and TGA approval, are not made available to the treating practitioner.
- A scheduled list is out of kilter with other health professions, like nurse practitioners and midwives, who are able to prescribe in accordance with their scope without a list.
- In addition, the list undermines the clinical expertise of optometrists, by placing undue and unnecessary restrictions on their therapeutic judgement and management of patients' conditions. It creates confusion and lack of clarity in prescribing due to differences between state and territory medicines and poisons legislation.
- The removal of a scheduled list is the most effective way of ensuring that patients can access the right care at the right time, with greater ease, choice and empowerment over the management of their condition.

Question 9:

Can you identify any other potential regulatory impacts that the Board needs to consider?

It is unclear how the process of approving new medicines for optometrist prescribing will be expedited by the list appearing on the Board website instead of within the endorsement appendices. In the past, there have been lengthy delays due to the bureaucratic processes involved in adding new or replacement medicines to the approved list. For example, the addition of Nepafenac to the list is welcomed, but the request for this medicine was submitted to the Board in 2020.

The impact of maintaining an approved list of medicines is considerably more arduous for the Board to monitor and update in comparison to entrusting practitioners to prescribe medicines within scope for the purpose of practicing optometry. Most importantly, it means that patients are denied access to treatment if a medicine on the list is unavailable and there is no alternative on the list. Therefore, I further encourage the Board to execute changes to the schedule and guidelines with removal of any reference to a list.

References

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