S Afr Optom 2009 **68**(3) 95-96

From the Editor's Desk September 2008

Yet again the effective institution of a period of community service following graduation of optometry students has been postponed or delayed. In this latest instance, the global economic state and local difficulties such as the necessity to rapidly and significantly improve remuneration for professionals such as doctors, dentists, nurses and others in especially the public health care sector has resulted in there being little or no financial support or willingness to properly establish this component of the clinical and theoretical education of young optometric graduates. The graduates thus lose out and, even more profoundly, the poorer communities in this country also do not benefit from wider and more adequate eye and vision care services. It appears that the emphasis in health care in South Africa will continue to have other and more urgent priorities that will mean that a community period of further training and experience for optometrists will probably not occur soon. Perhaps it is now long overdue that the optometric profession in this country found other means to provide such an educational experience to young graduates. In some parts of the world, recent optometric graduates cannot register with their health care authorities until they have completed a period of primarily clinical training under the supervision of more experienced practitioners. Often such training can take place in private optometric practices for some part of the total period concerned. While this might not always be ideal, it at the very least gets the ball rolling and with a little creativity it should be possible to provide eye and vision care at reduced costs within the private health sector to the less economically active or wealthy sections of the population. With possible changes in terms of National Health Insurance (NIH) to be implemented in South Africa in the near to intermediate future it should also be possible to incorporate a private practice based component to provide more specifically primary or community health care services in the eye and vision arenas. Also, this does not exclude the expansion of the public sector impact and involvement of optometry but that process is likely to be slow in terms of actual implementation given economic and other issues. So, getting a private sector based approach started and working until other alternatives become available would seem to be sensible and indeed urgent. This period of community service within the private health sector would not necessarily need to be a full year and could, for example, be for a period of 3-6 months and later university based education (for an additional period of, say, 3-6 months could be provided). If and when public health care facilities become available then a similar period within such an environment could also be included. Thus, each optometric graduate might eventu-

ally spend four months under supervision in each of these sectors or clinical environments before registering as a fully qualified optometrist with the HPCSA. Graduates might also perhaps earn a small allowance or remuneration during some parts of this training, for example, in the private and possibly the university based periods of training. The immediate impact on public health and potential costs in terms of optometry could thus be significantly reduced and may become a lot more manageable and some type of true and wider community-based service could be more easily implemented and hopefully expanded over time as economic prospects improved. This approach is also not dissimilar to that used with other non-medical professions so as to ensure that graduates are sufficiently strong both in terms of their more theoretical education as well as more particularly regarding work-related skills, or in our case clinical training and activities.

Alan Rubin
Editor
Department of Optometry
University of Johannesburg