

Laser-focused on improving vision

Advances in laser eye surgery have made it safer and more accurate, says AMA (WA)'s Ophthalmology Representative **Dr Rob Paul**



Dr Rob Paul performs laser eye surgery.

There's something else certain in life beyond the well-known saying of "death and taxes", according to Perth ophthalmologist Rob Paul – and that's presbyopia, which forces people to wear reading glasses, or multifocals, when they hit their forties.

"It's a natural part of ageing that affects the eye's ability to focus up close because the lens of the eye no longer zooms in and out like it used to when you were younger," Dr Paul explains.

"Traditionally, for somebody who came to me with short-sightedness or long-sightedness and wanted the best of both worlds – not just distance but also reading – we'd have to set one eye for distance and one eye for near.

"The problem with that is people would lose their three-dimensional vision and sometimes they can't adapt to it. It put them out of whack a little bit and gave them an imbalanced type of visual feel. Only 70% of people really liked that setup."

The latest advances in laser eye treatments mean this problem can now be overcome by using two state-of-the-art pieces of software called PRESBYOND and PresbyMAX.

"It's been a real godsend," says Dr Paul, "because it really allows for a much more accepting type of treatment post-operatively, where you've got over 90% patient satisfaction as opposed to 70% with the old traditional ways.

"It essentially creates more blended vision. It sets one eye for more distance and computer work, which is the dominant eye; and it sets the other eye for more reading and computer work. So, the intermediate vision is actually very good, and what we find is the eye that was set for reading still sees very well into the distance, so patients have fewer complaints in terms of imbalances or three-dimensional assessment problems.

"The two treatments change the spherical aberrations that occur naturally in the cornea. And what that basically does is, instead of giving you a set point, it allows an increased depth of focus; so it produces multiple points of vision. PresbyMAX creates a multifocal cornea and PRESBYOND creates a blended or increased depth of focus zone by changing the aberrations on the cornea.

"In patients who are very long-sighted, we tend to go with PresbyMAX. But for the vast majority, 90% of people, PRESBYOND treatment is more suitable and the far more popular procedure."

Technology has come a very long way from two decades ago when the standard form of laser eye surgery, LASIK (laser-assisted in situ keratomileusis), used a blade to cut a flap in the cornea to correct refractive errors such as short-sightedness or long-sightedness.

"That was quite uncomfortable and, as you can imagine, a little bit barbaric when we think about the bladeless surgery we do now," Dr Paul says.

"The other advance is that the blade used to take several minutes to get set up and to cut the flap. It's now done with a laser that takes only eight seconds to create that flap.

"This minimises the risk of complications because if the laser doesn't work the first time, it can be done automatically immediately afterwards. Whereas if you had a problem with the blade type of treatment, you'd have to cancel the surgery or delay it. So safety, accuracy and efficiency have been the real points of improvement in terms of laser eye surgery."

Over the past few years, another advance has been a switch from creating flaps to perform laser eye surgery to something called SMILE (small incision lenticule extraction).

"This has been a major change in the way we do things because it's essentially the closest thing to what's called 'keyhole' laser," Dr Paul says.

"Basically the laser performs a circular cut in the cornea, and we then remove that tissue through a 3mm incision, so there's no flap. The benefit of that is you don't have to worry about the flap dislodging, which can happen after laser eye surgery with LASIK if you have some significant trauma to the eye.

"One of the major side-effects of laser eye surgery is dryness, from one to three months – but with SMILE, because we're not cutting a large flap on the cornea, there's much less dry eye. The other really important benefit of SMILE is that biomechanically the eye is a lot stronger because you're not cutting into the deeper layers of the cornea and weakening the eye as much as you would with the laser flap."

Dr Paul says the recovery rates from laser eye surgery are two days for LASIK and one day for SMILE; and 98% of patients leave with 20/20 vision.

"On day one, we see probably around that mark, but by about three months it's close to 99%. It keeps improving on a sort of a logarithmic scale," he says.

With short-sighted laser treatments, whether with LASIK or SMILE, people can expect about 15 to 20 years of good vision.

"The problem is in those patients with presbyopia, where it tends to wear off after about eight years, but then it can be done again," Dr Paul says.

"People think it can only be done once, but that's not

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KEY FACTS

- **The recovery rates from laser eye surgery are two days for LASIK and one day for SMILE, and 98% of patients leave with 20/20 vision.**
- **With short-sighted laser treatments, whether with LASIK or SMILE, people can expect about 15 to 20 years of good vision.**
- **In patients with presbyopia, the treatment tends to wear off after about eight years, but then it can be done again.**
- **The FLACS cataract surgery procedure creates computer-generated cuts to the eye and breaks up the cataract that was traditionally done manually – this makes for more accurate results.**

true. For example, if somebody who's been treated with PRESBYOND or PresbyMAX comes back eight years later and says, 'My reading's worn off', then the treatment can be done again.

"There's only a 10% chance of it wearing off for distance, and that's usually for people with very high degrees of short-sightedness."

Dr Paul says the other major advance in the past 10 years has been the use of lasers in cataract surgery.

"We now use a laser to create computer-generated cuts to the eye and break up the cataract that was traditionally done manually, and this makes for more accurate results," he says.

The procedure is called FLACS (femtosecond laser-assisted cataract surgery) and it now takes about 20-30 seconds to complete half the operation, which previously would have taken several minutes.

"The critical steps are done with the laser," Dr Paul says, "and if you get the critical steps right in cataract surgery, everything else flows from there." ■



Specialist fees

“When Church and State need to separate”

Dr Rob Paul
AMA (WA) Ophthalmology Representative

In 2025, the Grattan Institute called on the Federal Government to combat “extreme” specialist fees. The Institute found that an initial consultation with a cardiologist or endocrinologist can cost up to \$370, and up to \$670 for a psychiatrist. The Government was advised to claw back public subsidies from specialists who charge “extreme” fees.

On average, patients' bills for specialist appointments add up to \$300 a year. This excludes people who were bulk billed for every appointment, but that's relatively rare: patients pay out-of-pocket costs for two-thirds of appointments with a specialist doctor.

“Increasing GP costs make national headlines, but specialist fees have risen even more – by 73% since 2010,” the Grattan report asserts. The report attracted pushbacks from doctors, with the latest coming from the nation's ophthalmologists.

I agree with Australian Society of Ophthalmologists (ASO) President Peter Sumich who says the Grattan report is good, but it draws many wrong conclusions. Firstly, that bottlenecks in specialist training are caused by the Colleges. It is the public hospitals that pay for trainees and mentors, and that purse is controlled by governments, not Colleges. The College committees only select the trainees for the places deemed funded and available.

The second issue involves the Medicare rebate. Specialists have blamed out-of-pocket costs on what they see as the inadequate Medicare rebate not keeping pace with the cost of doing business. Grattan said overcharging specialists should have the rebate totally withdrawn.

The ASO says the Medicare rebate is out of date. “It has no meaning in the commercial world,” Dr Sumich said. “It's been frozen, cut, and has never kept up with inflation or average wages. Therefore, as a metric of a medical service, it is unreferenced and meaningless.” He added that specialist fees reflect real-world costs – wages, insurance, rent, medical technology, and more – and rejected “the implied threat” to remove patient rebates.

Indeed, Medicare rebates since 2010 have failed to keep pace with inflation, growing only 0.5% to 1% annually, with a five-year freeze from 2013 to 2018. The Federal Government increased bulk-billing incentives for GPs in 2023/24 after prior prolonged underinvestment, but clearly this is not enough to right the wrongs of the past or to pay adequate respect to the difficulties faced by GPs in running a practice. Inflation, in contrast, has grown annually at a rate of 2.5-2.6% since 2010.

“The Medicare rebate belongs to the patient, not the doctor. If it is withdrawn by the Government, then specialists would go the way of dentists and charge their own fees regardless,” Dr Sumich warned. “Most patients would be furious if the rebate was withdrawn.”

And so, the debate comes back to the consumer, paying more and doubting they're receiving value for the money they spend on their health.

Australian ophthalmologists still remember 2009, when then Health Minister Nicola Roxon threatened to halve the Cataract Medicare Fee. But after an ASO-led public campaign titled “Grandma's not happy” and significant voter backlash, she backed down to a 12% cut. For a few months though, patients were out of pocket on average \$600 even though they had private health insurance.

Earlier this year, a day after introducing legislation to publish specialist fees on the Medical Costs Finder (MCF) website, Health Minister Mark Butler said he was considering direct fee regulation of specialists to counter what he described as “spiralling out-of-pocket costs for medical services”.

The Australian Constitution explicitly disallows laws that result in the practical compulsion of doctors to provide a service in a particular way. It seems unfathomable that our noble profession could be subject to government-regulated, mandated policy.

“While change is inevitable, our profession should not be further regulated and be blamed as a contributor to the cost-of-living crisis, otherwise Church and State may fully separate.”

Federal President Dr Danielle McMullen has reiterated that the AMA rightly believes “doctors should charge a fee that meets the cost of delivering their care”. She also notes that people are being forced into the private sector because of inadequate public sector options and delays.

If this legislation is passed, one can envisage some practitioners will run fully private clinics, with patients bearing the consequences. Personally, I would be browsing over and implementing my AMA fee handbook recommendations if this occurred.

While controversial, my question is, should the Government be fighting the cost-of-living crisis by attacking healthcare, or by not spending \$300 billion plus on AUKUS submarines or a Tasmanian stadium? (Conflict of interest declaration: My Freo Dockers don't need any more threats to a premiership.)

While the MCF will empower patients to make informed decisions on their healthcare, should not the same transparency apply to private health insurers? Patients deserve to know what private health insurers are doing with their premium dollars, such as how much goes towards the hospital bed, the cost of prostheses, and how much goes to those who deliver care.

On a positive note, at least the legislation seeks to stamp out product "phoenixing", where insurers close an existing policy and reopen a near-identical product at a significantly higher price. While change is inevitable, our profession should not be further regulated and be blamed as a contributor to the cost-of-living crisis, otherwise Church and State may fully separate.

Optometry prescribing rights

Optometrists with a 'scheduled medicines endorsement' on their registration can prescribe a range of topical medications (eye drops) to treat conditions such as infections, inflammations and glaucoma. As of March 2025, approximately 79.2% of registered Australian optometrists held this endorsement.

The Optometry Board of Australia has proposed to increase endorsed optometrists' scope of practice to include oral medications such as antibiotics for bacterial infections; antihistamines for allergic eye disease; antiviral medications such as aciclovir, famciclovir and valaciclovir; and acetazolamide (Diamox) for emergency treatment of angle closure glaucoma.

No extra training would be required. The proposal is designed to reduce waiting times for seeing either a GP or ophthalmologist, and provide patients with greater access to care, especially in rural settings. Federal AMA Vice-President A/Prof Julian Rait warned the proposed changes risk fragmenting patient care and creating confusion about who is responsible for a patient's overall medication regime.

"Expanding prescribing rights without robust evidence and safeguards undermines the integrity of Australia's healthcare system," A/Prof Rait said. "We need a clear distinction between medical and non-medical roles to

ensure prescribing remains the responsibility of those with appropriate training and accountability."

Australia's healthcare system currently ranks first overall among comparable countries, according to the Commonwealth Fund Report 2024, as well as coming first for equity and health outcomes. A/Prof Rait said the AMA supported collaborative care models where non-medical prescribers operate in tightly defined scopes under appropriate clinical governance.

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"The AMA believes optometrists should not be permitted to prescribe beyond topical agents under current arrangements," he said. "We support a medically led model of care that prioritises patient safety over piecemeal expansion of prescribing rights."

The concern amongst ophthalmologists is that some oral medications have serious side effects including death. (Diamox can cause aplastic anaemia or sulpha allergy anaphylaxis.) Drug interactions are another concern; and without knowledge of systemic interactions, this is a recipe for disaster. The oral medications will not be PBS-funded either, so there are no savings from that end.

The other concern is, will this be a conduit to prescribing even more potent drugs like oral steroid? State legislation is already facilitating pharmacists to act as pseudo-GPs under the guise of freeing up general practice workloads.

The role of allied health in medical management should be limited, otherwise what is the point of our rigorous medical school and post-graduate training? This is not a protectionist opinion, but one that follows our Hippocratic oath of 'First do no harm' – something Government and allied health are not bound by. ■