



# Completing the Pathway: From Patient Referral to Care - UK



International  
Federation on  
Ageing





## Overview of United Kingdom's Health System

The United Kingdom (UK) operates on a mixed health system, with the publicly funded National Health Service (NHS) playing a dominant role over the private sector.<sup>(1,2)</sup> The UK's devolved healthcare system involves each of its four nations, England, Scotland, Wales, and Northern Ireland, managing healthcare independently under a shared commitment to universal coverage. Although all four UK nations provide publicly funded, free-at-point-of-use healthcare, their systems differ in governance, organization, and emphasis. In England, the NHS has moved toward greater local autonomy and patient choice, particularly via the establishment of 42 Integrated Care Systems (ICSs) in 2022 to coordinate planning and delivery of services locally.<sup>(3-5)</sup> In Scotland, services are managed via regional health boards and special NHS boards under a centrally supervised public system, with strong focus on equity and integration.<sup>(4-6)</sup> Wales similarly delivers services through local health boards, with strong emphasis on public health, collaboration, and reducing health inequalities.<sup>(5-7)</sup> In Northern Ireland, Health and Social Care (HSC) uniquely merges health and social services under one structure since the early 1970s.<sup>(3-5,7,8)</sup>



The NHS provides free healthcare to all UK citizens and is accessible to anyone in the UK. However, most non-UK citizens planning to stay for more than six months must pay an additional fee, known as the Immigration Health Surcharge, to access NHS services.<sup>(9)</sup> Health services including general practitioners, consultants, dentistry, hospital services, pharmacy services, mental health services, pregnancy services, home care and care homes, are provided by the NHS. (10) However, to more quickly access elective procedures, private hospital care, or services not routinely offered by the NHS (e.g., physiotherapy, counselling, alternative therapies), individuals or employers can purchase private or voluntary health insurance (VHI). Approximately 2 million people access employer-paid private medical insurance, and 1 million people access independently purchased plans, which is predominantly concentrated in London and the Southeast of England (accounting for >50% of VHI spending).<sup>(11)</sup>

In the UK, age-related vision challenges persist as a significant public health issue whereby approximately 2 million people live with sight loss with the majority being over 65 years of age.<sup>(12)</sup> Trends indicate that the number of people with the following eye conditions will continue to increase in the UK over the next ten years: late AMD by 24.4%, primary open-angle glaucoma by 15.9%, and vision impairing cataracts by 16.7%.<sup>(13)</sup>

In the UK, vision care follows a mixed model where some services are publicly funded under the NHS, and others require out of pocket payment or private insurance. Scotland is the only UK country with free universal NHS funded eye examinations for all residents, with routine exams offered every two

years (more frequently for those with high risk).<sup>(14-17)</sup> Whereas England, Wales and Northern Ireland only provide free eye exams to those who are eligible based on age (under 16 years, aged 16–18 and in full-time education, and aged 60 or over), economic factors, and/or diagnosis of conditions, including diabetes and glaucoma.<sup>(18-21)</sup> The NHS also covers treatment for many eye diseases and emergencies, including cataracts, glaucoma, diabetic retinopathy, AMD, and urgent vision issues. However, access to newer technologies or premium options may be limited. Eligible individuals may receive optical vouchers to help with glasses or contact lenses; others must pay privately or use insurance for additional services.<sup>(22-25)</sup> Notably, as in other vision health systems, private insurance can provide individuals to faster access via private clinics as well as access to second opinions.

## 1. Campaigns and patient education

Several campaigns in the UK promote vision health and eye care awareness, often led by organizations like the Eye Health UK and Sight Research UK.<sup>(26,27)</sup> For instance, the Eye Health UK in partnership with optometrist associations and local public health authorities, conduct the National Eye Health Week which aims to encourage people to complete regular eye tests, promotes good eye health habits, and highlights prevention and early detection of eye disease.<sup>(28)</sup>

To address challenges at the policy and program level, several initiatives are currently being developed and implemented across the UK. One example is an initiative by the Association of Optometrists (AOP), which utilises an online resource to address policy challenges in eye care for older people.<sup>(29)</sup>

## 2. First point-of-care to screening

As diabetic retinopathy remains one of the leading causes of blindness in the UK, the national diabetic eye screening programs represent a key public health initiative aimed at preventing avoidable vision loss. The NHS operates this program to detect retinal changes in individuals with diabetes, with each nation within the UK managing its own screening system. Screening is conducted using retinal imaging and occurs annually for people aged 12 and over who have any type of diabetes<sup>(30)</sup> Following the review of retinal photographs, the degree of retinal damage is assessed, and the appropriate next steps are determined. Based on the findings, one of the following pathways is recommended:



1. If no signs of retinal damage are detected, routine screening is scheduled in one to two years.
2. If there is evidence of minor changes, repeat screening is advised within one year or sooner.
3. If there is presence of sight-threatening damage, the individual will be referred to a retinal specialist for further assessment and treatment.<sup>(31)</sup>

In addition, for those not eligible for such screening, community optometrists and ophthalmic opticians (also known as opticians) are often the first professionals consulted, either directly or via a referral from a general practitioner. They will perform routine sight tests, eye health checks, and refractions (for glasses/contact lenses) and can detect signs of eye disease (e.g., glaucoma, cataracts, macular degeneration). Some optometrists, called independent prescribers, who have additional qualifications, can also manage some minor eye conditions. All optometrists can provide services

including urgent and/or emergency care, glaucoma triage and cataract care.<sup>(32,33)</sup> It is important to note that optometrists can only refer patients if they detect issues with general eye health and cannot formally diagnose.

General practitioners may support identification and access to vision health pathways by identifying vision-related symptoms (e.g., headaches, neurological signs). Additionally, eye emergencies and eye casualty telephone triage lines can support individuals access urgent eye care as needed.<sup>(34)</sup>

### 3. Referral to specialist and treatment

If an eye condition is suspected, individuals may be referred to an orthoptist in certain cases; however, referral is more commonly made to an ophthalmologist for further investigation and treatment.<sup>(35)</sup> Orthoptists are qualified to identify and treat certain eye conditions, including eye movement disorders, strabismus (squint), and binocular vision problems. Ophthalmologists are specialized professionals who diagnose, treat and monitor conditions related to eyes through medication and surgery.<sup>(33)</sup> Once patients meet the ophthalmologist, they will perform tests to address patient concerns and diagnose conditions. Following a confirmed diagnosis from the ophthalmologist, a treatment plan will be created and implemented.<sup>(36)</sup>

In England specifically, local eye health networks (LEHNs) were established by NHS England to improve integration and delivery of eye health services. They are multi-professional groups, including optometrists, ophthalmologists, public health representatives, and patient representatives, across every NHS Area Team (AT) in England which identify, diagnose, and treat a range of eye conditions.<sup>(37)</sup> Similarly, Minor Eye Conditions Service (MECS) is an NHS-commissioned community service in parts of the UK that allows patients with urgent or minor eye problems to be seen by an accredited optometrist in a high street optician's practice, instead of going to a GP or hospital.<sup>(38)</sup>

### Barriers throughout the pathway

- There is a limited awareness or understanding of eye health as well as available resources. The lack of consistent and comprehensive patient awareness programming in the UK contributes to this challenge.
- Many patients experience long delays, especially for secondary/tertiary care (e.g. hospital eye clinics) and follow up care is particularly affected. Delays in care can contribute to worsening vision outcomes and, in some cases, permanent sight loss.<sup>(39)</sup>
- The structure of vision care is seen by many patients as confusing and fragmented, especially between primary care (optometrists), hospital/secondary care, and social support. Lack of clear information, poor communication, and unclear pathways can discourage or delay care seeking.<sup>(40)</sup>
- In England, Wales, and Northern Ireland, adults aged 18–59 must pay for eye exams unless they meet specific criteria (e.g. low income, medical conditions), which inevitably creates health inequalities and barriers to accessing eye care.
- NHS eye care services are experiencing growing demand, particularly for age-related conditions like cataracts and macular degeneration. Therefore, there are bottlenecks in ophthalmology, with long waiting lists for outpatient appointments and surgeries. Some geographical areas experience shortages of optometrists or ophthalmologists, particularly outside major urban centres.<sup>(41,42)</sup>

- In vision care, a lack of workforce capacity and data science expertise, limited data-linkage, and long delays and high costs in accessing data prevent the routine use of data for service planning and quality improvement.<sup>(11)</sup>

## Acknowledgement

The International Federation on Ageing (IFA) extends its sincere gratitude to Dr. Stella Hornby, Ophthalmologist at the Oxford Eye Hospital, for her expert insights and contributions, which informed the development of this note and the referral pathway infographic.

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