Ophthalmology in Thailand 1997

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Abstract

This article is a brief history of ophthalmology in Thailand after World War II and the National Programmes for the Prevention of Blindness in the past two decades from the late 1970's. Presentation illustrates the efforts of the eye sector in Thailand not only modernizing ophthalmology. However, eye care services in public places has also been made available to all assured with easy accessibility and acceptable quality. The National Blindness Prevention programmes have been forwarded through adoption of primary eye care approach integrating into the national health scheme of primary health care. Avoidable blindness once prevalent in 1980's, has been reduced from 1.1 per cent to 0.3 per cent in twenty years. Eye care networks that came into existence in that period covering the whole country are now once again under realignment for new challenges from unavoidable types of blindness.

Key word : Primary Eye Care, Primary Health Care, Avoidable Blindness, Unavoidable Blindness

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In Thailand, modern ophthalmology can trace back it's origin to the early part of the 1910s when Thai physicians returned home from overseas training in ophthalmology. They began modern eye services in Bangkok, the capital city of the Kingdom of Siam, then known as the Venice of the East. In older days, eye care was with traditional practitioners from India and China. An eye hospital run by a Jewish practitioner was once popular among Bangkok people in the days after the end of the Second World War. However, ophthalmology was a minor discipline in medical circles. The number of ophthalmologists was very limited and accessibility was limited to a small minority in the capital. However, there were prominent leaders in the field of ophthalmology in those days, Prof. Luang Prachakvejasith and Prof. Daeng Kanchanaranya, both were overseas trained and made great contributions to Thai ophthalmology in its early days. The Eye Department of the Red Cross Hospital, Bangkok

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(King Chulalongkorn Memorial University Hospital) and Siriraj Hospital (Mahidol University) were founded by these two leaders. From these two institutions most ophthalmologists were trained. Training, however, followed the British model of house officers for a period of one to two years and training programmes were not very well organised.

The late 1950's and early 1960s are said to be the new beginning of Thai ophthalmology. A new group of young ophthalmologists returned from the USA and Europe. From this group many joined the Eye Departments of Siriraj and King Chulalongkorn Memorial Hospitals, such as Prof. Kobchai Promindaroj, chairman of the Eye Department of King Chulalongkorn Memorial Hospital, while Prof. Chud Usavat, Prof. Banjongsak Namat, Prof. Samran Wangspa delegated a new generation for Siriraj Hospital. The two departments played leading roles in ophthalmology in Thailand for decades until the late 1970's. Chiang Mai University was the third in the country and joined the training programme in the 1960's. Training programmes were gradually improved for both undergraduate as well as postgraduate levels. This was followed by Ramathibodi Hospital, Mahidol University in the late 1970's when it joined the training programme with very modern facilities. The department was chaired by Dr. Uthai Rutnin with Dr. Kazuichi Konyama assisting him. Thus, Thai ophthalmology training programmes reached international standards. By the late 1970's, the three-year residency training programme was introduced. The curriculum was under the supervision of the Thai Medical Board. Trainees were accredited with the Thai Board of Ophthalmology. The training model, largely followed the US model of ophthalmological training.

In the 1980's, all the above institutions had come to individual as well as collective efforts improving themselves toward better eye care for the Thai society. Clinical standards had come to worldwide acceptance. While at home, ophthalmologists were regarded as a very specialist group attracting many medical graduates. However, a review was made for the consumers side for eye care in general in the country. The accessibility to eye care was highly limited to just the city population and those in the vicinity of facilities. Eye care was said to show common patterns among developing countries. It was characterised that quality care was limited to a minority and the poor majority was almost totally neglected. The training programmes were copied exactly from the developed countries, despite the arrival of further groups of new generation ophthalmologists returning home after qualification in the USA. However, old and new generations paid less attention to the rural parts of the country and the silent majority with a multitude of eye problems. Community ophthalmology was far from their professional services.

During the Vietnam War, a number of professionals with a background of American Board joined the home services. Most of them joined training positions in medical schools and contributed to further progress in standards of ophthalmology in Thailand. Dr. Prajak Prajakvej, Dr. Charimet Kanchanaranya Dr. Yanee Jiemchaisri belonged to this generation. In the area of professional organisations, the Ophthalmological and Otolaryngological Society of Thailand was founded in 1955 by a tiny group of ophthalmologists and otolaryngologists with less than 50 members. This Society was separated into the Ophthalmological Society and Otolaryngological Society in 1975. Its activities began with regular meetings twice a year. In time, activities were expanded to interact with overseas guest lecturers visiting Thailand in various specialties of ophthalmology. Veterinary surgical workshops were also introduced. These served as good opportunities for young ophthalmologists to gain access to the latest knowledge in ophthalmic sciences and technology. Opportunities were also opened to the rural professionals who were also encouraged to join. The association gave continuous training to upgrade their status and upon graduation would be on the Thai Board of Ophthalmology.

Apart from the Ophthalmological Society of Thailand, the Royal College of Ophthalmologists of Thailand was established under the policy of the Thai Medical Council. In 1995, the new organisation helped with continuous upgrading of professional status in medical circles which in return benefited the Thai society.

Today, Thailand has 556 practicing ophthalmologists as shown in Table 1. Around 300 are in the Bangkok Metropolitan area and the remainder are in 76 Eye Units of the provincial hospitals of the Ministry of Public Health and University Hospitals in the North, Northeast and South. The country has covered the whole territory with working eye care networks linked to the community at various levels of eye care centres. This success is due to the completion of primary eye care

integration into the national health scheme of primary health care. These achievements are the successful result of the national programmes for prevention of blindness in the past two decades with the goal of "Eye Care For All".

Table 1. Allocation of ophthalmologists* in Thailand.

Location		Number
Working in MoPH Hospitals	Province	183
	Bangkok	38
Working in University Hospitals	Province	26
	Bangkok	77
Working in the Ministry of Defense	Province	5
	Bangkok	45
Working in Government Hospitals	Province	2
(not MoPH)	Bangkok	38
Working in the private sector	Province	38
	Bangkok	104

* These are all the members registered with the Royal College of Ophthalmologists and Ophthalmological Society of Thailand in 1997.
MoPH = Ministry of Public Health

Eye care management programs in Thailand date back to the 1950's. Following the successful implementation of trachoma control activities in Thailand in the 1960's and early 1970's, ophthalmology in Thailand, despite modernization of the overall system was much similar to other developing countries in the region. Characteristics were such that they curbed accessibility among the average population. This issue was not of much concern among ophthalmologists. In addition, being a minor discipline, ophthalmology had always been confronted by disadvantageous health policies and the lack, of support of government authorities. Most facilities were overcrowded by patients and even blindness-threatened cases were given no higher priority. Ophthalmology did not yet have "Eye Care" in a social package for the average population. There were only 22 ophthalmologists working in rural hospitals in 1978.

However, change was to come from a small peer group then working in nameless eye units in provinces, regardless of training background. Their voluntary movement in 1978 had initiated a new tide in the periphery of the country. They banded together and formulated the broad-based national programme for blindness prevention without implicit commitment from health authorities or their high level administrative personnel. The group called themselves "Ophthalmic Cell", a central action group which led the prevention of blindness for two decades. Since then, the national committee has come into existence, and institutional professionals also joined its programmes. All this has led the eye sector in the country to work together under the national banner of blindness prevention and eye health care system development. Thailand is very proud of its successful blindness prevention programme.

Under a plan of human resource development in eye care, all medical schools have helped accelerate production of ophthalmologists who would be posted to the provincial level by increasing three year eye residency training programs. A six-month course for eye nurse practitioners had begun at Ramathibodi University Hospital and later transferred to the newly established Institute of Public Health Ophthalmology, Maharat Nakhon Ratchasima Regional Hospital. The programmes management holds a strong belief on eye care team. Eye care must be delivered through a competent professional group with one ophthalmologist assisted by two well-trained mid-level personnel. In this concept, the ophthalmologist assumes a team leader role. Mid-level personnel training has therefore been an important programme in the national programme. Table 2 shows manpower composition at the different levels in eye facilities.

The national programme set up its horizontal action, integrated approach of primary eye care delivery into the national scheme of primary health care. Training of health workers took place at different levels within local networks of health care. Community members were encouraged to join pre-

Table 2. Manpower in eye care in 1997.

Manpower	Number
Ophthalmologists	556
Ophthalmology residents (under training)	95
Ophthalmic nurses	320
Refraction nurses	87
Orthoptic and low vision nurses	12
Eye beds in the government hospitals	2,188

From 104 questionaire with 94 responses.

vention and promoting eye health in a nation-wide scale. In achieving this, eye care networks as well have come within the framework of primary health care.

Hence, coupled with strengthened tertiary and secondary eye care levels, namely universities, regional and provincial eye centres, networks linked community (primary level) to the upper levels of eye facilities. Accessibility to eye care was thus assured within individual localities and distribute to the whole part of the country. At this point, supporting system of primary health care in the country gave easier integration to the eye sector to carry on its eye programmes. The health sector in this country should be thanked in this regard. In conclusion, primary eye care approach was the fundamental approach of blindness prevention in Thailand. Moreover, this was the model which later many neighbouring regions adopted.

The Thai Journal of Public Health Ophthalmology, a periodical released every six months for more than ten years, acted as a media to communicate among eye health personnel in Thailand as well as for neighbouring countries. This journal contained ophthalmological articles appropriate to community eye care. For ophthalmic and clinical sciences. The Thai Journal of Ophthalmology, produced by The Royal College of Ophthalmologists and The Ophthalmological Society of Thailand served this purpose. In addition, Glaucoma Update, Retina News and Thai Eye Land are circulated regularly among eye professionals within the country.

The National Survey of Blindness and the major causes carried out in a succession of studies revealed that the prevalence of blindness has dropped from 1.14 per cent in 1983, to 0.57 in 1987 and eventually to 0.31 in 1994.

In common with all developing countries, cataract blindness has been of prime concern since the very beginning of the prevention of blindness programme. Yet mass intervention was held till the completion of primary eye care integration. Having fulfilled the completion of community preparations in terms of case-finding and a mass referral system, long awaited intervention began in the mid 1980's against a cataract backlog. The whole process was programmed into the primary eye care framework. It facilitated mass intervention on the extension of a primary health care scheme and complementary input from eye care units nearby in terms of surgical services. This approach proved highly effective as expected, inexpensive and locally sustainable. In this way, cataract programmes were gradually expanded to the whole country.

The operations proved there was no need for heavy financial input from the centre. Self-involvement and self reliance were the key to success. This is a source of great pride for the eye sector of Thailand. The cataract problem was solved by their own efforts. Eventually, it declared great success of the cataract programmes in May 1997 after two decades of consolidated work. Thailand has now an annual capacity to cope with 60,000 new blinding cataract cases approximated each year by a group of ophthalmologists in the rural eye facilities. The cataract output is shown in Tables 4, 5 and 6.

Table 3. The number of ophthalmic nurses (graduated).

Graduated 1979 - 1997 (33 courses)		Graduated
Working in MoPH	Province	377
	Bangkok	13
Working in Nursing Colleges		1
Working in the University Hospitals		45
Working in the Ministry of Defense		12
Working in Laos PDR, Cambodia		28

Table 4. The number of cataracts operated on in Thailand.

Estimated cataract output	1987	1990	1995	1997
MoPH and university Hospitals (73 hospitals)*	23,818	35,000	48,271	62,465
Private hospitals (22 hospitals)0	6,000	10,000	10,349	22,090
Mobile eye units	2,200	4,000	5,000	5,000

* 73 from 113 governmental hospitals

0 22 from approximately 50 private hospitals that have an eye clinic

Table 5. The number of cataracts and IOL implantations in Thailand*

Years	Operation	University Hospitals (7)	Government Hospitals in Bangkok (6)	Provincial Hospitals of MoPH (71)
1993	ICCE	141	7	1,804
	ECCE	1,451	306	8,986
	ECCE c IOL	5,941	2,105	14,582
	PE	13	24	18
	PE c IOL	1,494	1,222	373
	PPL, 2° IOL, Needling	161	50	350
1995	ICCE	93	5	1,371
	ECCE	687	164	6,504
	ECCE c IOL	4,937	1,428	20,882
	PE	405	21	201
	PE c IOL	5,010	2,954	2,700
	PPL, 2° IOL, Needling	234	58	617
1997	ICCE	140	20	791
	ECCE	410	112	2,687
	ECCE c IOL	4,670	2,182	22,457
	PE	432	238	1,263
	PE c IOL	6,562	2,298	14,601
	PPL, 2° IOL, Needling	207	64	882

*From 113 questionnaires with 84 responses.

ICCE = Intracapsular cataract extraction
ECCE = Extracapsular cataract extraction
ECCE c IOL = Extracapsular cataract extraction with intraocular lens implantation
PE = Phacoemulsification
PE c IOL = Phacoemulsification with intraocular lens implantation
PPL = Pars plana lensectomy
2° IOL = Secondary intraocular lens implantation

Table 6. The number of cataract services in Governmental Hospitals in Thailand 1997*.

Institution	Number
Cataract output in (90) MoPH Hospitals	
Outside Bangkok	45,009
Bangkok	4,965
Cataract output in (8) University Hospitals	12,491
Total	62,465

*From 104 questionnaires with 94 responses.

The training of medical officers in cataract surgery and ophthalmic screening nurses was conducted in the secondary and tertiary level at institutions around the country. At the community level, a simple parameter for cataract case finding was provided for community health workers and village health volunteers. The whole process is shown as the mass cataract intervention programme in the context of primary health care.

However, increasing demands are obvious with a population aging and needs multiplying with changes in life style. Continuing efforts, therefore, should be retained and shared equally among all groups of ophthalmologists.

When the Asia Pacific Academy of Ophthalmology (APAO) met for its 8th congress in Bangkok in 1981, it staged a new session of blindness prevention organised in the form of a plenary session. In the past, the session had been a short meeting before the closing ceremony where the national delegates presented brief country reports. However, the highlight of the Bangkok congress was many articles related to blindness prevention from points of preventive and community ophthal-

Table 7. Regular training for doctors.

Training programme	Persons getting trained	Institutes	Duration	Annual output
1. Ophthalmology residency training	Medical graduate	Medical school's Teaching Hospitals (Chulalongkgorn, Siriraj, Ramathibodi, Chiang Mai, Khon Kaen, Rajvithi and Phra Mongkut)	3 years	34
2. Basic eye care for medical officers in community hospitals	General practitioner	Department of Medical Service, MoPH	2 weeks	50
3. Biregional course for PBL and PEC management (SightFirst course) *	Ophthalmic personnel (Ophthalmologist or eye nurse practitioner)	Jointly organised by Lions Clubs International, Sight first project and Department of Medical Services, MoPH	4 weeks	35

* biennially

Table 8. Regular training for nurses.

Training programme	Persons getting trained	Institutes	Duration	Annual output
1. Eye nurse practitioner course	Registered nurses	Institute of Public Health Ophthalmology (IPHO) Maharat Nakhon Ratchasima Regional Hospital	6 months	20
2. Refraction	Eye nurse practitioners	IPHO	2 months	8
3. Orthoptic and low vision nurses	Refraction nurses	IPHO	4 months	6
4. Basic eye care for nurse practitioners in community hospital	Nurse practitioners from community hospitals	IPHO Department of Medical Services, MoPH	1 month	50

Table 9. Additional courses & lectures.

Programme	Persons getting trained	Institutes/lecture	Duration	Attendants
1. Annual meeting in prevention of blindness and eye care management	Ophthalmologist & Eye nurse practitioner	IPHO	3 days	200
2. Annual meeting in Clinical Ophthalmology	Ophthalmologists	Royal College/Society of Ophthalmologists of Thailand	2 days	350
3. Academic lecture (4-5/year)	Ophthalmologists	Visiting lecturers from USA, UK, Japan, Canada, Europe	2 days	150
4. Short course in selected topics in Ophthalmology	Ophthalmologists	Royal College/Society of Ophthalmologists of Thailand	3 days	350

mology. Since then the new tradition has been kept in all the following congresses.

The 8th Congress of APAO in Bangkok in 1981 also opened a new dimension of eye care. Modern ophthalmic knowledge especially in basic and clinical sciences received more attention. Guest and invited speakers from around the world contributed to ophthalmological education in Thailand. Training of eye care personnel for each year is listed in Tables 7, 8 and 9.

Thai programmes of blindness prevention also made a regional contribution in the area of collaborating with its neighbours, including human resources development. Medical graduates from the Laos People's Democratic Republic and Cambodia took short rotation in many university and provincial hospitals. Some took the formal residency programmes in medical schools in Thailand. This kind of collaboration has now extended to nearby countries. They also sent several groups of graduate nurses to the Nurse Practitioner in Eye Care Course, refraction course and orthoptic course held in the Institute of Public Health Ophthalmology, Maharat Nakhon Ratchasima Regional Hospital.

A Biregional Course in Prevention of Blindness and Eye Care Management, funded by Juntendo University at the beginning and presently with support from the Lions Club International Foundation (SightFirst) have been run since 1990. The course has been conducted every two years for ophthalmologists in the region enrolled in blindness prevention. Participants are now invited from Asia-Pacific countries to a four-week course which is a well-known training opportunity, in teaching Public Health Ophthalmology of high standards.

The coming of the new century poses a multitude of problems to the Thai society. Not only in ophthalmology, but more seriously in the care delivery system with regard to relevance and adequacy of eye care. It is imperative for the eye sector to look for a preferable system of eye care suited to the new century. First is the number of ophthalmologists. At the very beginning of the national programmes, a critical issue haunted the management. Manpower to suffice the society, assuring coverage and quality was entirely unknown. None of the models existing even in developed countries could teach us. While a tentative policy of an eye care team with one ophthalmologist in the leader's role and assisted by two well-trained mid-level personnel should be the minimum for a population group of 100,000. This was to serve as the primary target and a tool to solve the problem of unoperated cataract. At present, avoidable blindness has already been solved, Now quality must be upgraded in the view of new challenges. A new policy plan was needed. Thus, the management was again faced with a new challenge.

While social evolution and professional morale began to alter as well with the ceaseless introduction of new technology. Ironically indeed, cataract surgery has increased, however, more to operate on early cases like a phaco-machine. It comes, sometimes, to deep concern regarding professional morale. Only a few operate only on early cases (incipient cataract) and no attention is given to the blinding cataract. In addition, interest has gone to refractive surgery without awareness of the need existing in society.

Apart from blinding cataract, merging threats from blindness of the posterior segment poses a dreadful hazard, whereas, effective measures are not yet known for mass management for most disorders. This is true for diabetic retinopathy, primary open angle glaucoma and many others. Known technology remains not beyond ophthalmic sciences and premature to mass management, while the public is demanding and sophisticated. Obviously, it seems to be at the stage where social cost and resources are hot and sober issues in politics and public health. Yet the eye sector is not too aware of it, but not totally neglecting it. The eye surgical out put in Thailand is listed in Table 10.

Table 10. Eye surgical out put* in governmental hospitals in 1997.

Surgery	Number
Cataracts with IOL	55,398
Cataracts without IOL	7,067
Glaucoma	4,332
Vitreo-retina	3,343
Strabismus	1,520
Trauma	5,725
Keratoplasty	333
Oculoplastic	3,478
Laser	17,996
Minor surgery	44,379

*From 104 questionnaires with 94 responses.

Rehabilitation in Blindness and Low Vision has been offered along with other medical and nursing curriculum but proper action to the community is still lacking and far below the appropriate level. Within the area of Educational Rehabilitation, Thailand had its first special program for the blind established in 1939.

Several reports of the National Statistical Office, between the years 1990-1993 stated that, Thailand has a disabled population of 1,057,010, of which 26.6 per cent was in the educational age range of 0-19 years. However, it was stated in 1993 that only 5.37 per cent of disabled people attended school. At the end of 1995 there were 6,617 students enrolled in 33 special education schools in the Kingdom, while 2,247 were in mainstream programmes. Overall, therefore, 8,864 students were attending school at that time which was only 3.08 per cent of the eligible population of disabled students. Of the 8,864 students attending school in 1995, 10.15 per cent of them were in programmes for the blind.

Vocational Rehabilitation in Thailand has evolved slowly since its establishment by the Department of Social Welfare, Ministry of Interior in 1938. Most Vocational Rehabilitation programmes were conducted under the welfare ready made models in which the disabled must follow with little opportunity to choose what they really needed. Changing the phrase "working for the disabled" to "working with the disabled" has not been used in Thailand for long.

Rehabilitation for the Blind and Low Vision is now getting more attention from national programme policy makers. The next phase of the national plan will place greater weight than previously given to this area. Available rehabilitation and welfare facilities are listed in Table 11.

Recorded in 1995, of the 74 Non-Governmental Organizations (NGO's) that supported the disabled in various ways only 15 of them (21.62%) actively supported education programmes for the disabled and only five worked with the blind.

However, in general now the role of the private sector in eye care is significantly increasing. Every major eye surgery is now being offered in private hospitals. Some private hospitals handle health insurance schemes and some have private funds to give support. Some eye health personnel in the governmental sector are employed on a part-time basis from private services. For national and international non-governmental organizations operating in Thailand, they focus more in extended eye clinics and rehabilitation as shown in Table 12.

When overall review was made on blindness prevention in Thailand, it came to the conclusion that the Thai eye sector has been asked to overhaul once again its structure as well as its mission and role in front of emerging challenges. A new set of action plans is required for the future. It has asked the central action group for early initiative again. The strategies will be that the eye sector, may play a pioneer role within the framework of Non-Communicable Diseases Control Scheme

Table 11. Available rehabilitation and welfare facilities in 1997.

Institutions	Services offered	Capacity
School for the blind in Central (Bangkok), North (Chiang Mai) and South (Surat Thanee)	Institution-based training	378-400 persons /year (total in every school)
Integrated School for the Blind in North (Lampang) and Northeast (Khon Kaen, Roi Ed Nakhon Ratchasima and Maha Sarakham)	Community-based integrated with regular private and government schools	373-400 persons /year
Vocational training centres for the blind (2 for male and 1 for female)	Institution-based training	80-200 persons /year
Total	Education and occupational	1,000 persons /year

Table 12. Non-governmental organizations operating in the country (national & international).

NGO	Supportive activity
Royal Doctor Club	Extended eye clinic
Princess Mother's Medical Volunteers Foundation	Extended eye clinic Regular eye services in border area Eye care for the elderly
Prevention of Blindness Foundation Royal College of Ophthalmologists/Ophthalmological Society of Thailand Fund	Institute of Public Health Ophthalmology Research, academic activities including continuing eye education
Local Provincial Foundation (Lampang, Suranaree, Chaiyaphum)	Extended eye clinic, eye facilities and rehabilitation for the blind
Help Age International	Extended eye clinic for the elderly
CBM, Dark & Light, Helen Keller	Education for the blind
Catholic and Christian Foundation	Vocational training centre for the blind
Lion Clubs International Fund	Sight first cataract campaign project

(NCD). The eye sector, to this end, seems to be well deserved for all aspects. Since it posesses a few good ophthalmologists who are well trained in public health ophthalmology, modern management and health economics with enough mid-level personnel. Their expertise has been proved in blindness control over the past two decades. Eye information systems are working all over the country with adequate trained personnel in health system research. Help comes from the institutions, supporting basic and clinical research control. Thus, ophthalmology in Thailand may bring once again a new model to the region, as they have proved to them in the fight against avoidable blindness.

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จักษุวิทยาในประเทศไทย พ.ศ. 2540

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บทความนี้ทบทวนประวัติจักษุวิทยา และการให้บริการทางตาในประเทศไทยตั้งแต่หลังสงครามโลกครั้งที่ 2 เป็นต้นมา รวมทั้งการเกิดของโครงการป้องกันตาบอดและควบคุมสายตาพิการแห่งชาติ ซึ่งตั้งขึ้นเมื่อปี พ.ศ. 2521 และดำเนินมาอย่างต่อเนื่องด้วยความพยายามของจักษุแพทย์ทุกหน่วยงานที่เกี่ยวข้องทั้งภาครัฐ ภาคเอกชน จักษุแพทย์ในโรงพยาบาลมหาวิทยาลัย จักษุแพทย์ของกระทรวงสาธารณสุข และความร่วมมือจากต่างประเทศ ด้วยศักดิ์ศรีที่เท่าเทียมกัน เพื่อที่จะพัฒนาวงการจักษุวิทยาของไทย ให้ก้าวหน้าเท่าเทียมอารยประเทศ มีความเสมอภาคในทุกกลุ่มชนให้สามารถเข้าถึงบริการได้และครอบคลุมไปเกือบทุกพื้นที่ในประเทศไทย นอกจากการพัฒนาบุคลากรทั้งจักษุแพทย์ พยาบาลเวชปฏิบัติทางตา พยาบาลวัดแว่น และพยาบาลกล้ามเนื้อตาแล้วยังพัฒนาสถานพยาบาลทางตาทุกระดับ ตั้งแต่สถานีอนามัยตำบล โรงพยาบาลชุมชน โรงพยาบาลทั่วไป โรงพยาบาลจังหวัด โรงพยาบาลศูนย์ และโรงพยาบาลมหาวิทยาลัย การสอดแทรกการดูแลรักษาโรคตาเบื้องต้นเข้าไปในงานสาธารณสุขมูลฐานของชาติก็เป็นการปฏิบัติการที่สำคัญและมีคุณประโยชน์อย่างยิ่ง สาเหตุตาบอดซึ่งส่วนใหญ่หลีกเลี่ยงได้ เช่น โรคตาบอดจากการขาดอาหาร โรคติดเชื้อ แผลในกระจกตา และต้อกระจก ซึ่งพบมากจากการสำรวจในปี พ.ศ. 2527 สูงถึง 1.14% ได้ลดเหลือ 0.31% ภายใน 20 ปี เครือข่ายการดูแลรักษาและให้บริการทางตาได้ครอบคลุมทั่วประเทศไทย และโครงการป้องกันตาบอดและควบคุมสายตาพิการของไทยได้เปลี่ยนแผนงานจากโรคตาบอดที่หลีกเลี่ยงได้สู่ปัญหาท้าทายที่เกิดใหม่คือ โรคตาบอดที่หลีกเลี่ยงไม่ได้ ป้องกันได้ยาก รักษาได้ผลไม่ค่อยดี หรือที่เรียกว่าโรคตาในกลุ่มโรคไม่ติดต่อ และการดำเนินงานในทศวรรษต่อไป จะเน้นมากทางด้านป้องกันสาเหตุตาบอดและส่งเสริมสุขภาพตา

คำสำคัญ : การดูแลรักษาโรคตาเบื้องต้น, งานสาธารณสุขมูลฐาน, โรคตาบอดที่หลีกเลี่ยงได้, โรคตาบอดที่หลีกเลี่ยงไม่ได้

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