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- standards of care with the Academy's library of practice guidelines; and
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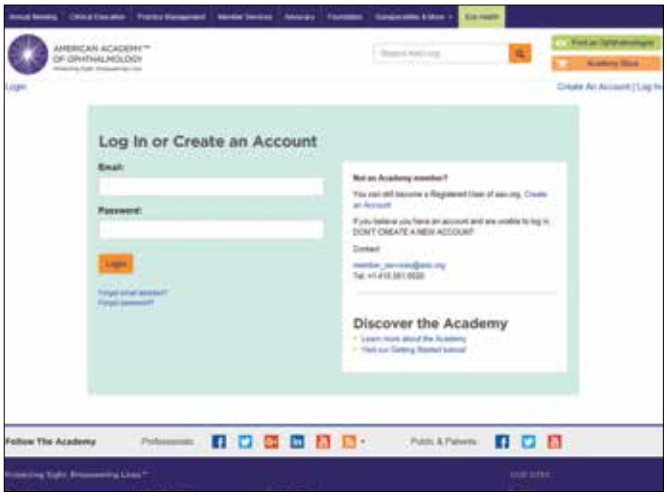
If you have any problems accessing the ONE Network, please contact Laura Khalil at lkhalil@ranzco.edu or on +61 2 9690 1001.Viverbi se none horacte mquit;



RANZCO Leadership Development Program — *advocating equal access to treatment in New Zealand*

Dr Andrew Thompson

The RANZCO Leadership Development Program (LDP) was launched in 2012 as an initiative to build leadership and advocacy skills among RANZCO Fellows. The LDP runs every two years over an 18-month period consisting of sessions and master classes including workshops and talks focusing on personality profiles, leadership, negotiation and management skills, and effective problem-solving and critical thinking. Part of the LDP is to also complete a self-directed project which allows participants to demonstrate and develop their leadership skills and add value to ophthalmology as a profession.

New Zealand ophthalmologist, Dr Andrew Thompson was one of ten Fellows to successfully complete the 2014-2015 RANZCO LDP, graduating at last year's RANZCO Annual Scientific Congress.

Eye2Eye Editor Laura Sefaj spoke to Dr Thompson about his self-directed project and experiences gained from the LDP program.

Q LS: Your self-directed project 'Where you live determines how well you can see' focused on access to Avastin treatments for age-related macular degeneration in New Zealand, tell us more about this project and how you came to this issue.

A AT: The project set out to ascertain patients' equitability of access to Avastin treatment for wet macular degeneration (MD) in each of the 20 District Health Boards (DHB) in New Zealand. New Zealand has the lowest public funding of anti-VEGF drugs of all the OECD countries and it has been known for some time that patient access to Avastin treatment for wet MD in New Zealand has been inequitable. However, the extent of the disparity has not been formally investigated until now.

Avastin funding in New Zealand is determined autonomously by each DHB rather than directly by the Ministry of Health. This has led to huge variance between DHBs funding anywhere from 40 to 140 treatments per 10,000 population.

I work in a provincial practice in New Zealand that is underfunded for Avastin treatment of wet MD. Our practice is not alone in this regard. My colleagues and I constantly have to prioritise patients according to criteria established by ophthalmologists who face the same issue, in an effort to ensure patients get the best visual outcomes possible under the current funding arrangements.

I am also a trustee and board member of Macular Degeneration New Zealand (MDNZ), a charitable organisation charged with increasing awareness and promoting education about MD. The project has provided information useful for MDNZ in their discussions with the New Zealand Government regarding adequate funding and ensuring equitable access for patients to sight saving treatment.

Q LS: What were some of the outcomes of your project?

A AT: Currently DHBs loosely adhere to a standardised intervention rate (SIR) of 40 injections per 10,000 population when planning funded Avastin treatment. Treatment numbers were obtained from each DHB under *Official Information Act* requests and the SIR for each DHB was calculated using census data. This highlighted significant inequity of access to treatment between DHB regions with the most overfunded at 3.3 and the least at 0.3 (adequate funding is represented by a value of 1.0).

Adjusting population for age and ethnicity yielded differences in MD prevalence per DHB ranging between 1 in 7 to 1 in 11. Further analysis gave a population adjusted intervention rate that is far more appropriate than a standardised rate in determining the number of funded treatments required per DHB. With this approach and the current number of treatments funded, there still existed significant inequity of access between DHBs. In other words, where you live determines how well you can see.

Every individual affected by wet MD has the right to equal access to Avastin treatment irrespective of the DHB in which they are domiciled. In order to ensure this, a national planning strategy is required and this can only come from the Ministry of Health. This project only considered access to Avastin for wet MD and did not include other eye conditions that benefit from Avastin. In order to treat other conditions, such as retinal vein occlusion and diabetic macular oedema, additional funding will be required if visual outcomes are to be optimised.

Findings of the project have been disseminated to all DHBs, PHARMAC and the Ministry of Health.

Q LS: What are some of the skills you acquired through the RANZCO LDP and how did you apply these in your project?

A AT: Collaboration and involvement of allied health personnel in the planning of the project were critical in undertaking the project and enabled me to gain the specific information I was looking for in a timely manner.

My presentation skills were improved through experiential learning on the LDP. This was one of the more challenging but most fun aspects of the program, and culminated in the presentation of project findings at the RANZCO 2015 Congress in Wellington.

Q LS: What are some of the ways the program has impacted you?

A AT: I think it is too easy to think of one's attributes and abilities as being inadequate but through the program I developed a stronger belief in myself that I can effectively lead a team.

I gained insight into different personality types, as well as my own (including the good, bad and the ugly aspects), how to involve and motivate different personalities, how different personality types benefit a team and how they react in various circumstances. I realise the importance of effective communication.

I developed skills to manage workshops and meetings more effectively. For example, I have been involved with the University of Health Sciences Faculty in Cambodia developing online examinations and running a strategic development workshop to ensure ongoing development and success of the program.

The skills learnt and developed on the LDP have been extremely useful in the day-to-day running of my practice (and my life), with my involvement in MDNZ and as a College examiner. Following completion of the LDP I took on the role of Chair of Ophthalmic Sciences and enjoy the challenges associated with this.

A significant benefit of participation in the LDP has been maximising relationships and enhancing interactions with people both within and outside the College. This is important in my current roles as Chair of Ophthalmic Sciences and with MDNZ in advocating for patients with macular degeneration to achieve equitable access to anti-VEGF therapy at a national level in New Zealand.

Q LS: How can leadership and advocacy skills benefit ophthalmologists?

A AT: As ophthalmologists we are all responsible for such things as managing people and resources, patient advocacy and teaching trainees and ancillary health personnel. I believe

good leadership skills are important for developing an excellent team through the development of strategic networks, collaboration and utilisation of each team member's expertise to bring about change. Developing skills in these areas can help motivate people and bring about change more effectively.

Q LS: How do you define leadership?

A AT: This is not an easy question to answer succinctly given that leadership has so many different facets. However, I personally believe a leader is someone who moves other people to action. They must be reliable and consistent and be able to inspire and motivate others effectively.

Q LS: What advice would you give to those considering doing the RANZCO LDP?

A AT: As the Nike slogan goes, Just Do It!

The participants of the third RANZCO Leadership Development Program 2016-2017 are:

- Dr Anu Mathew (Vic Branch);
- Dr Clare Fraser (NSW Branch);
- Dr Jenny Danks (NSW Branch);
- Dr Jo Richards (WA Branch);
- Dr Kenneth Chan (NZ Branch);
- Dr Mark Chiang (Qld Branch);
- Dr Shenton Chew (Ophthalmology NZ); and
- Dr Simon Skalicky (ANZGIG).