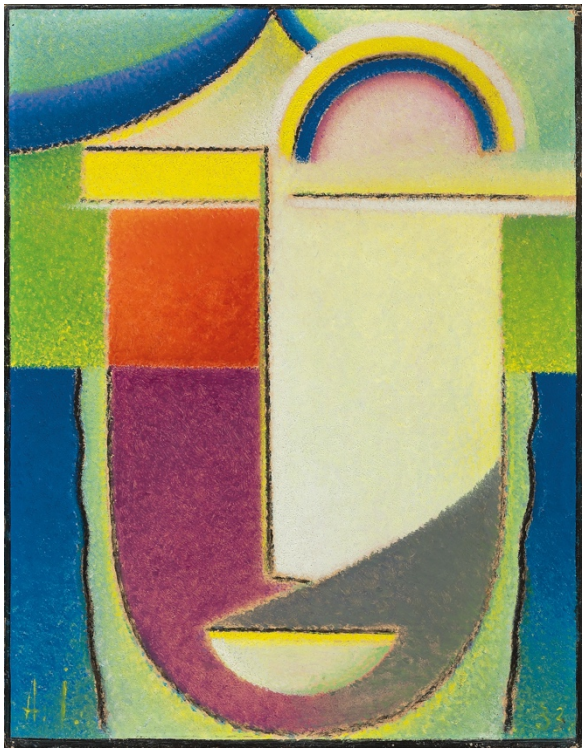
# Leadership Workshop
# 2019 Royal Australasian College of Medical Administrators Conference

*A presentation given by William A. Haseltine*



By William A. Haseltine
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In October 2019, William A. Haseltine presented a workshop on medical management and leadership at the annual Royal Australasian College of Medical Administrators Conference in Adelaide, Australia. He also delivered a keynote speech.

Haseltine's interest in improving human health has taken him from the halls of Harvard Medical School and Harvard School of Public Health, where he served as faculty, to the frontiers of the biotech industry, where he founded more than a dozen companies. Decades of scientific discovery, public health crisis, and technological evolution inform his perspective on global health systems and their impact on society.

In the following text are lessons Haseltine learned after he decided to devote his "third career" to building a philanthropic organization that could spread the benefits of modern medicine around the world.

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There are many services and supports that can help your fellow humans—your fellow Australians, New Zealanders, Tasmanians—that are not currently available to them. The issue is not just access, but quality and affordability. Healthcare has to be high quality, and it has to be affordable in the context of a given country and population. That is why I created a foundation called ACCESS Health International, which operates by the principle that everybody, no matter their age or where they live, has the right to high quality, affordable, accessible healthcare. That is our vision.

Having a vision is one thing. Achieving it is another. I think the approach I have taken, though far from traditional, is more in sync with our times. The idea of medical missionary traveling and treating people overseas, a la Dr. Albert Schweitzer, is certainly admirable in theory, but is ultimately limited in practice. We have come to realize that deploying a vast amount of knowledge and technology into other countries has had, at best, limited reach and impact—at least when it is done in the form of treatment. The exceptions to that rule are vaccine programs, which can sweep through a whole country, or basic public health interventions, like preventing the spread of infectious disease via clean water and sanitation. Compared to dispatching personnel and supplies en masse, influencing government policy is a much more effective way to harness resources. Whether you run a small foundation or even a big foundation, focusing on changing policy is a good way to go.

Another way to increase the access, quality, and affordability of healthcare is to work not only on the technologies, but the systems themselves—also known as health system transformation. You might also call it health system strengthening or health system improvement. Whatever the case, the idea is to find governments and people in the public and the private sector that have the desire to improve and give them the best tools available for effecting the change they seek. For ACCESS Health International, that meant becoming a think tank. We made it our modus operandi to search the world for best practices in global health and in health systems, describe them in ways that were clear, and work with people who want to use them to make a difference.

Influencing national governments like that, I realized, is difficult as a foreigner, especially today. Countries naturally have their pride, but more than that, they have deep, storied suspicions of an ulterior motive. To address that issue, I decided to embed groups of people who were from that country in a country for an extended period of time. Everybody who works for us in India is Indian. Everybody who works for us in China is Chinese. Everybody who works for us in the Philippines is Filipino. Singapore is a little more complicated because it is such a cosmopolitan country, but we still have Singaporeans working for us there.

What we have done over the last ten to twelve years is identify best healthcare practices around the world and, over time, gain the confidence of people working for governments abroad. Some state governments,

like those presiding over Indian states, are quite large. The largest Indian state is home to two hundred twenty million people, and a small Indian state might be bigger than all of Australia. It is important to know where these state governments stand because, as is the case here in Australia, health is a matter of both federal and state jurisdiction. China is another large country where we have to adapt our methods to a distinct government structure and practices. Case by case distinctions aside, we have reached some general conclusions about structured health systems by comparing the United States, England, Scandinavia, the Netherlands, Germany, Canada, and some emerging economies that should be of value no matter where you live.

To catalog those best practices, I myself have written about six books and I am writing a couple more. One is about the Singapore healthcare law that resulted in low costs, high quality, and high impact. Another one is about the incredible Indian ambulance system, or the EMRI, that has so far saved three million lives at no cost to its users. The latest, and the book that I am here to talk about, is *World Class*, which documents the transformation of an American health system called NYU Langone Health. By transforming patient care, research and teaching to be as good as they can be, they achieved a world class standard of care by objective outside measurements.

Let me paint a picture of the thinking that is involved in a transformation of this scale. Healthcare, as a topic and as an industry, can be studied and approached from many different perspectives—sociology, political economy—but resists being confined to just one. It is not a real business because it is structurally unique. One of the differences that is clearest to me, having inhabited the business world, the academic world, and the medical world, is people like you, the fine members of the Royal Australasian College of Medical Administrators. Roles in medical administration and management are qualitatively distinct from most in that run on passion. You do not take this job just to support your family. You take this job because you are passionate about what you do. That is the case no matter where you are in the world. When I was the chief executive officer of a company, maybe twenty or thirty people out of the thousands that worked there had the passion that you have.

When a workforce has passion, they also have the potential to transform things. Under the right management, and in the right organization, you can do wonders, all because you are willing to put in the extra effort that makes the difference. Yet all too often you are embedded in a system that neglects your capacities, your desires, and your deep understanding of the way things should be done.

We see this happening everywhere, and to figure out how to change that I wrote a book called *World Class*. The academic medical center at NYU was a successful enterprise until they fell on hard times. They were on the verge of bankruptcy, and because NYU is a private institution, they could not rely on government support to bail them out. In the national rankings for quality and safety, they ranked in the bottom third. The quality of their research—and consequently their research budgets—had slipped, too. NYU School of Medicine ranked forty out of a hundred twenty academic medical schools across the country.

That was when they decided to turn things around, starting with their leadership. Today, NYU Langone Health is generating close to one billion dollars in surplus that they invest in really interesting ways. They were rated number one in quality and safety in the United States three years in a row, falling only slightly to number two this year. They went from number forty in academic rankings to number three, right behind Harvard and Johns Hopkins. Not to mention they have the highest research dollars per capita of any institution in the United States.

The magnitude of transformation achieved by NYU Langone is made possible by unleashing the capacity of the people employed under the organization. I interviewed more than fifty people to write *World Class*, some of them for many hours and some of them many times. I went three layers down in the organization,

and in a few cases deep dived even further. All that interviewing uncovered some general lessons. The first is if you are going to make a big change, you have to be up against the wall. Prior to near bankruptcy, people at NYU Langone did not have the energy to change. Like most who are lucky enough not to be in dire straits, they were complacent—and none more so than the entrenched management. Neither the board nor the chief executive officer will have the motivation to change.

Which brings me to the second lesson: management is conservative. The first thing the new management at NYU Langone did to ignite change was eject all the old management. On his first day, the new chief executive officer Robert I. Grossman fired the chief operating officer, chief financial officer, and chief executive officer at both the hospital and the medical school. Within the first two years, he also changed thirty of the thirty two department chairs—and then changed two of the thirty he chose. Making a change requires enlisting leaders who are capable of creating and adapting to new conditions. To do that, you need to have the support of your board.

That is the third lesson I want to share. Most people who talk about leadership do not focus on the board, or whatever its equivalent may be for a given institution. When a leader is attempting fundamentally transformative change, however, that leader needs to be protected. Because some board members will be reluctant to leave their comfort zone, a structure must be in place that will encourage change, not inhibit it. In the overall governing body that appoints and sits above the chief executive officer, there need to be strong leaders willing to protect change.

What other changes were made? Something that struck me about their leap in quality and safety ratings was that even though the executive leadership changed, the safety officer stayed the same. This time, she was empowered to actually do her job. Grossman set a goal—being number one—and gave the safety officer the time, attention, and resources she needed to help achieve it.

Grossman did the same thing for the head of the medical education program. In the United States, education programs have to get recertified every five years. For four cycles, the head of education did nothing but rearrange the chairs because he had no power to do more. Grossman, shortly after taking charge, gave him the go ahead to make the program as unique, robust, and impactful as possible—and he took off. He completely reinvigorated and restructured medical education program, creating a three year postgraduate training for medical degrees among other changes. Soon enough, NYU School of Medicine rose to number three in national medical school rankings. That surge was a direct result of new leadership empowering people who were already there and wanted to see their programs excel.

**Female Speaker:** Question, what was your role in this?

**WH:** My role was as an observer. My foundation looks around the world for the best of the best in healthcare, and I found what I thought was the best example of change at a complex health institution. Academic medical centers like NYU Langone have a triple mission of patient care, research and teaching. I observed what they were doing and how they were doing it, and I wrote the book in that vein, as an impartial observer of change and not a participant. Halfway through the process, actually, I became a patient. I developed head and neck cancer, which they treated. Fortunately it was curable, but as a result I can no say that I personally experienced their patient care—not just then, but several times after.

In the book *World Class* there are more management lessons that would be of value to medical administrators. There are also some important lessons on structure, too. The first is, in my opinion, relevant to all medical institutions in advanced and developing countries alike. Based on the example set by NYU Langone and many others around the world, I have observed a common need for what I call distributed care.

In a distributed care system, the hospital is the place of last resort. In a hospital, quality and safety are guaranteed because they only perform complicated procedures that cannot be done elsewhere. The vast majority of procedures are performed in ambulatory care centers, clinics, homes or villages. The impetus to invest in real estate and build big hospitals might have suited the health systems of the fifties and sixties, but in this day and age it is unproductive.

Grossman realized medical technology allows you to do almost all surgeries on an outpatient basis. As a result, NYU Langone performs eighty percent of surgeries outpatient. Outpatient services, in this context, are provided in hundreds of highly sophisticated regional centers spread all throughout New York City. Out of four hundred of these centers, one is devoted to head and neck. One is devoted to oncology, and so on. Sometimes the outpatient centers are stacked in a high rise, but they are not next to the hospital. They are instead distributed across the communities where patients live and work, which makes them significantly more convenient. Outpatient centers are not only cheaper to operate, but also more lucrative, generating ninety five percent of the profit made by NYU Langone each year.

To make healthcare accessible, high quality, and affordable, treat people outside of the hospital. Much of the high costs incurred at hospitals come from treating ailments that should be treated elsewhere. Aging populations, for example, should not be treated in hospitals. If they have to be, they should be transferred to a regional care center or given care at home as soon as possible. The transformative potential of outpatient care was so evident to the leaders at NYU Langone that they went from four outpatient centers to four hundred. Despite their success, other medical institutions have yet to replicate the model. Most in New York are still buying big hospitals. Same in China, where they are building five and ten thousand bed hospitals. In India, they are building entire medical cities. Those outdated structural investments are going to sink them for the next twenty to thirty years.

Another lesson related to structure is the importance of an integrative information system. Using state of the art medical technology and information technology, NYU Langone has built a system that is totally comprehensive and real time. Data on everything from garbage collection and surgery to blood usage and finance is collected and stored in the same database—all without an interface. User friendly dashboards make it easy to relate outcome with cost, relate outcome with procedure, relate outcome with performance, and so on.

With comprehensive, real time data comes total clarity. You can see how many minutes each patient has spent in the emergency department. How many minutes each patient waited to see a doctor. How many minutes each patient had with their doctor. You can see data on mortality and morbidity. These are efficiency measurements, but at the same time they allow you to measure and optimize quality, safety, and cost. The entire staff has the data they need to observe what is happening, ask the right questions, and make the kind of micro changes that lead to macro success.

Building the information system took about four years and about one billion dollars, but there is a lesson to be learned from that as well. Building it by committee or by yourself will never produce the results you need. That takes finding the best systems available, adapting them to specific patient needs, and doing it all under the auspices of a singular vision. If too many people are tasked with designing the system, it will be poorly equipped to serve the demands of a single institution.

So many medical institutions in the United States have introduced electronic recordkeeping and other information systems, only to receive bitter complaints from doctors who believe the technology interferes with the doctor patient relationship. What makes an information system good is its inbuilt capacity to continuously improve—and to encourage its users to improve, too. At NYU Langone, each doctor can see what another doctor is doing because the data is transparent horizontally, not just vertically. The only way for a clinician to really know if they are performing to the best of their ability is by comparing their

outcomes with those of their peers. This is especially true for doctors who treat the same kinds of patients. To be fair, for some specialties it is inherently more difficult to compare quality outcomes than others. With an integrative information system, though, there is at least incentive to try.

Now it is allowed them to do something else. According to the concept of value based medicine, value is calculated by dividing quality, or outcomes times patient satisfaction, by fixed and variable costs. In actuality, however, it is difficult to quantify those variables precisely—and if you do not have exact numbers, you cannot know for certain if you are practicing value based medicine. Evaluation must occur on the relational basis that an information system can provide, which means the entire team needs to be comfortable with transparency. When they are, the "value" in value based medicine functions not just as a collectively held ideal, but a measurable, achievable, data driven outcome. A series of chapters in *World Class* expands on how the same technology used to manage clinicians at NYU Langone is also used to manage research and education. Improvement in all three areas—patient care, research, and teaching—are needed to achieve excellence in an academic medical environment.

Whether we look at India, the Philippines, or the United States, we see emergent medical and information technologies that can be deployed to change the way health systems function. We also see distributed models of care, wherein quality control and information flow are structured to the betterment of value based patient outcomes. These are big structural changes that will face opposition from people who manage big hospitals.

Even Singapore, a small country with a tough government, has struggled to do this for years. The task of creating an integrated healthcare system is entrusted to a high level government committee that, over a span of ten years and counting, has barely made a dent. Despite the lack of progress and strength of opposition, they know they have to persist. Otherwise, the rising costs of healthcare will continue to imperil the future of their country. When the stakes are as high as life and death, diligently pursuing a solution is well worth the risk.

Modern technology allows you to solve these problems. It allows you to deliver high quality care that is accessible, affordable, and patient friendly. That level of health system transformation is achievable, but the question of whether we actually achieve it is another matter entirely. It is ultimately up to people like you, who are in the guts of the organization trying to help even a small piece of it function. Do what you can, as well as you can, to make it work, and do what you can to involve your organizational leaders, your political leaders, and anyone else who has a critical say in the process. I certainly welcome your input and your questions. Thank you very much.