



In Conversation *with*
Tom Closson

Ken Tremblay

Tom Closson's early career includes deep roots in industrial engineering, with meritorious service and induction into the Engineering Hall of Distinction at the University of Toronto. After Closson received his MBA from York University, his career spanned a national consulting practice, many governance roles with national agencies and corporations, leadership with some of Canada's largest academic facilities, including a regional health authority in British Columbia and, since 2008, president and chief executive officer (CEO) of the Ontario Hospital Association. Earlier this year, Closson announced his retirement plans. For Canada, his departure from the corner office leaves a big leadership gap in healthcare as many see Closson as a strong proponent of health system transformation and the evolving role of hospitals. Ken Tremblay spoke with Closson this winter.

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HQ: You are ending your career in health services as CEO of the Ontario Hospital Association. As you reflect on your career, what will colleagues say is your leadership legacy?

TC: First of all, let me correct you by saying I'm not ending my career in health services, I am ending my role at the Ontario Hospital Association. I would like to continue doing some work in healthcare; I just decided that at this stage in my life I don't want to be working full time. Even though I love being CEO of the Ontario Hospital Association, I thought it was time to do something on a part-time basis.

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HQ: What do you think your leadership legacy will be?

TC: That's a really interesting question. I don't normally reflect on that. Instead, I think about what's been important to achieve within the numerous organizations that I've worked for (and I have had the opportunity to work for many organizations). The thing I have tried to focus on is building organizational capacity. My undergraduate degree is in industrial engineering. I was interested in healthcare because I'm interested in systems and how they work; and systems can be within an organization or the entire healthcare field.

In every organization, I have tried to create lasting improvements in the climate, culture and focus of the organization and to create supportive learning environments, to accept people making mistakes. I've tried to focus the organization around long-term results rather than short-term results – meaning, building bench strength in the organization and people who have the ability to make a difference. At the hospital or system level, what attracted me to the job was working within the broader health system to improve the capacity to deliver service. That has been a common theme in every place I have worked.

HQ: As you reflect on your career “to date,” what have been the highs and lows?

TC: The low for me occurred at Sunnybrook when we had a fire at Sunnybrook that killed three of the residents in K-wing. It was started by one of the residents, but two others died of smoke inhalation. It was a low because I couldn't get over thinking about, and I still haven't, what we or I could have done to prevent this from happening in the first place. As CEO, I felt a tremendous sense of accountability for making K-wing a safer environment. Of course, we made it safer after the fire; but for me it was always, why hadn't we done these things before the fire? It makes you want to be proactive about everything [on your watch].

The high point was working at University Health Network (UHN) – a larger organization with over 12,000 people – trying to address staff engagement, which wasn't that great when I first arrived. Scores about working for the organization were very low; one of the reasons I was hired by the board was to improve this. Over the five years I was there, there was rapid improvement in staff engagement because the whole of management was very focused on it. I learned that the most important management people in an organization are the front-line managers, not the CEO.

I spent a lot of time when I first got to UHN talking to front-line managers about how I could make it easier for them to do their job, which in turn allowed them to focus more on improving staff engagement. It really did pay off because I think having people in your organization with a high degree of engagement relates to my comment earlier about building capacity: I don't see how you can build capacity without having

a high degree of staff engagement. It also proved to me that you can actually make a difference in increasing organizational capacity if you set your mind to it.

HQ: Regional health authorities, local health integration networks (LHINs) or virtual network providers: what is your sense of the architecture needed to achieve an integrated health system?

TC: The most important thing is accountability alignment – trying to get the different parts of the system to have their accountabilities in alignment. It's important for the focus to be on a geographical basis and to make sure that all services are included. For example, in Ontario we have a geographical structure. We have some level of accountability alignment between the LHINs, the CCACs [community care access centres], the hospitals and some 2,500 organizations that the LHINs fund. But, we don't include the primary care physicians, specialists, public health, paramedic services – you cannot have an integrated health system without these [providers] included so that you can get the necessary accountability alignment.

Another thing that will help you achieve an integrated health system is having goals and metrics on a geographical basis. Having metrics and targets for different indicators that are publicly reported will cause peer pressure among providers to perform well against their targets. I already mentioned that the funding systems need to be aligned as well, so the way the doctors, hospitals, CCACs are paid need to be in alignment if you want system integration.

The final thing: when I worked in hospitals or health regions, I always turned the organization chart upside down. It's a bit of a gimmick, I suppose; but what I really tried to point out is that by putting the CEO and the board at the bottom and the front-line staff at the top, the structure supports the front line because that's where the interaction with the clients occurs. What's really important here is that management and accountability structures see themselves as supporting actual services on the ground. All of those things together are, for me, what are necessary to achieve an integrated high-performance health system.

HQ: Using the lens of an engineer, tell us what parts of the health system no longer meet the performance specification needed for the 21st century. Is there a specification or outcome that you think that wouldn't meet the standard?

TC: Engineering tends to be based on science, evidence, predictability and doing things in a standardized way. Healthcare is almost the antithesis of that because we've allowed a high degree of fragmentation and variation. Back to my comments earlier, to have an integrated high-performing system, it's necessary to get everything in alignment. Where there is evidence [linked to outcomes], you want people to be following that evidence and you should be monitoring the extent to which they are

following that evidence. Looking at the healthcare system, you find wide variations in the volume of services that are provided to similar people in different parts of this province. [We need] more consistency in the way services are provided, and to provide only those services for which there's evidence to suggest that they add value. The gap between an engineering perspective of the industry and the way we actually provide healthcare is large at the moment. I recognize we're dealing with people, and people are more unique than bridges and roads; but, having said that, a little dose of standardization in the healthcare system would go a long way.

HQ: Ontario hospitals are about to be bound by freedom of information legislation after decades of operating behind closed doors. How do you feel this will improve patient care in Ontario?

TC: First of all, I don't think freedom of information is directly about the improvement of patient care. It's more about public confidence in the system as it focuses on transparency and accountability; it will lead to better performance because of the [resultant] transparency and accountability. If you combine [access to information] with public reporting of performance metrics, over time I think you will see better care for patients.

HQ: You often mention that Ontario's hospitals outperform those in other jurisdictions. Ontario's scale and population might account for some of that difference. What else do you think is at play?

TC: We've analyzed this. I appreciate that Ontario is the biggest province in Canada. Another way to look at it is from the perspective of the urban-rural mix. Ontario looks very good compared with other provinces like British Columbia that have almost exactly the same percentage of urban-rural split (85/15). Comparing Ontario to Alberta, Alberta is 82% urban (just a 3% difference) and yet Alberta spends 24% more per capita on healthcare and 57% more per capita on hospitals than Ontario. Alberta has a very young population, with only 10.4% of the population greater than 65 years compared with 13.5% in Ontario.

Ontario's [relative] performance is, to a large extent, due to leadership in Ontario. I'll suggest that, particularly in the case of hospitals, voluntary governance at the local level combined with a strong CEO leadership have made a big difference in how efficiently our hospitals operate. We have the most efficient hospitals in Canada.

If we look through a lens at what caused that efficiency – Ontario hospitals operate at about 25% lower costs per capita than hospitals in the rest of Canada – the reason is 9% lower hospitalization rates and 10% shorter stays than are seen in the rest of Canada. We also staff at a lower level in terms of paid hours per weighted case. So, we don't admit as many people,

we keep them in a shorter length of time and we staff at a lower level. I don't buy that it's just based on Ontario's scale because Alberta and British Columbia are big enough to be comparable to Ontario. The urban-rural split isn't much different, and yet we perform much better. I put it down to more effective leadership at the local level.

HQ: As the health system transforms and governments seek greater accountability, it's no secret that these are challenging times regarding physicians. What challenges are most germane for medical staff in Ontario hospitals?

TC: I think medical staff need to be more involved in the management of the health system generally and in hospitals specifically. They need to have greater influence on how it evolves. Historically, the medical staff have been outsiders in the healthcare system. In Ontario, physicians are funded separately from the rest of the system, whether in a hospital or the community. Even in community health centres, there is a separate line item for the physicians. They're funded directly by the province as opposed to through any regional or hospital structure. That historical separation has made it a little more difficult to get physicians involved and participating in an integrated way with hospitals and the rest of the system.

We need to have medical staff more integrated into the operation of the health system, and that's why specialists and primary care physicians should be funded through the regional structures, even though their rates should be set across the province, just as the rates for nurses are set provincially. At the hospital level, there needs to be more accountability for physicians – contractual agreements between hospitals and their physicians rather than a privileges model would achieve greater alignment of that accountability. It's a two-way street: as physicians become more integrated into the healthcare system, they will automatically take on more leadership roles within that health system and have more impact on the way the system operates.

HQ: It's no small compliment that people listen to Tom Closson. What three pieces of advice would you give to current and future leaders in healthcare?

TC: First of all, it's important to look at the big picture: to visualize the potential for health system improvements from a broad perspective and to set goals for the whole system that could improve performance both from an efficiency perspective and an outcomes perspective.

The second point would be that it is really important to engage front-line staff and managers in designing the systems to ensure that changes will actually work over the longer term. You'll be able to put something in place that's sustainable because front-line staff and managers are the most knowledgeable about the dynamics of how the system actually works.

The third: restructure the system around the results that you

want to achieve. This is from the adage, form follows function. If you set big goals and engage the front-line staff in terms of the [change] design and implementation, you're going to achieve those goals. It's really important, in terms of driving change, to structure the system around the goals you want to achieve.

HQ: If you were to write a book about your experiences in healthcare, what would be its thesis?

TC: The thesis would be that the Canadian healthcare system is underachieving; we should be able to get the same or better outcomes with significantly lower spending.

HQ: Recently, healthcare leaders – especially CEOs – have been the brunt of concern about public sector compensation, arguably at the expense of the system or relative to executives and other sectors. You've noted that some CEOs manage \$5 million budgets while others manage budgets in the billions. How should the public view this issue?

TC: The position I have been taking is that excellent leaders have a significant positive impact on health system performance. [Conversely,] if the system is underperforming, we need excellent leaders more than ever if we're going to make the changes to Canada's health system; that is, to have it perform better, attract and retain high-quality leaders. In both cases, compensation levels need to be appropriate. Large, complex organizations operating in the billions of dollars need compensation levels much different from small organizations. The important thing here is that we need to attract and retain excellent health leaders if we are going to make necessary changes to health system performance.

HQ: Given your penchant for a national perspective, what are the top three challenges for Canada's healthcare system?

TC: The big challenge, of course, is the constrained funding environment. No province currently feels it can afford the rate at which the cost of healthcare is going up, that is, a 7 or 8% increase per year. The challenge is this: how do you draw that down to a level which is probably more in the 4 or 5% range over the longer term, that is, cut 2–3% from the trend? That would be the first challenge; we cannot continue funding such growth.

The second would be with the issue of provider autonomy. We have built a system where physicians have tremendous autonomy. Their associations promote this autonomy; I see this as a big barrier to change. We need physicians within the system, and excessive autonomy enables them to stay outside the system. There has to be a quid pro quo: physicians need to get much more involved in leadership roles within the system but, at the same time, they have to give up some of their autonomy (as individuals) in order to participate as an integral part of the system.

The third would be government itself – the extent to which government has the courage to make big changes to healthcare.

Whenever you try to make any change in healthcare, there's always some group that's going to come out saying it's a bad idea. The media, doing their job, like to publish what the naysayers have to say. Government has to be willing to move forward on the big, important changes and basically ignore the naysayers.

HQ: You are an engineer by training. What aspects of that background serve you well as a healthcare leader?

TC: Four things have helped me. One is being analytical. I try to approach everything from a problem-solution perspective, understanding the problem and what can be done to address it. Being organized helps me a lot because there is just so much stuff to work on and think about; being organized helps to ensure that I don't become overwhelmed by masses of information. Another is being focused, trying to pick off those things that are going to be important and really focusing on them. Then finally, and maybe this is the most important of all, being persistent. If you have something you want to go after, you have to be persistent – stay with it so that you can see it through [to completion]. Too often, we see people coming up with ideas that never get implemented. Maybe this stems from engineering; Engineers are not flamboyant. They tend to be persistent and a little bit boring. [laughs] They sort of fit into that framework of what you might expect from an engineer.

HQ: Most would agree that we need to spend less on funding hospitals and more on community capacity and wellness or disease prevention, that is, lowering the demand side for expensive hospital-based care. How do you balance what is right for the system if it conflicts with what might be expected by providers such as hospitals?

TC: I actually haven't found that with hospitals – I've been pleasantly surprised. On becoming CEO of the Ontario Hospital Association, representing over 150 hospitals, I thought there might be some pushback from members if I was out there focusing more on getting the entire health system to work better and investing in the community rather than trying to promote greater investment in hospitals. A small percentage of members have indicated that they feel uncomfortable with the association trying to be more systems focused, that our focus should be "get more money for hospitals," but the majority (85–90%) feel we need to focus on better access to care in the community (including primary care), better access to specialists and increased health promotion.

There's a great belief that the real payoff, rather the real leverage, out there is in the community. I'll say it this way: what we should be trying to do at the end of each and every day is minimize the demand for hospital services. That is what our goal should be – to keep people out of hospitals.

HQ: Thank you. **HQ**