

In Conversation with

# Mark Hundert

National Director (Retired)  
Hay Group

**Ken Tremblay**

**A**ny scan of issues and challenges across healthcare's landscape reveals the contributions by consultancy, be they policy frameworks, analytics, novel perspectives or paradigm-shifting solution sets. Over the past forty years, a central figure in Canada's journey has been Mark Hundert, recently retired National Director for Healthcare Consulting at the Hay Group. With a career focused exclusively on the healthcare sector, he specialized in the planning, analysis, improvement, management and governance of healthcare services for hundreds of clients across North America.

Prior to joining Hay Group, Mr. Hundert was the Principal of Hundert & Associates, National Director of Health Care and Social Services consulting for Peat Marwick (Peat Marwick Medicus) and President of Medicus Canada.

He received a BSc in Industrial Engineering from the University of Toronto and an MS in Operations Research from Northwestern University. A long-time member of the Canadian College of Health Leaders (CCHE), the Canadian Association of Management Consultants (CMC-Canada) and Professional Engineers Ontario (PEng), he has served on the Boards of Holland Bloorview Kids Rehabilitation Hospital and Anaphylaxis Canada and been active with Cancer Care Ontario, the Toronto Board of Trade and several editorial boards. In 2008, Mark received the Engineering Medal for Management from the Ontario Society of Professional Engineers and Professional Engineers Ontario, and most recently was elected a Fellow of the Canadian Academy of Engineering. Ken Tremblay spoke with Mark this summer.

**HQ: They say that you're supposed to retire to something rather than from something? What has been your experience?**

MH: It's *from* something: from advising, consulting and disturbing the healthcare system.

**HQ: Your career spans four decades of challenges and change? On reflection, what were the highs and lows?**

MH: The highs were the people I got to meet and got to work with. A high was some of the restructuring we did with [Ontario's] DHCs and the then government, particularly the introduction of workload measurement and metrics into management processes within healthcare in Canada. The lows were all the arguments I lost, perhaps the world would be a better place had I won them.

**HQ: Is there a "Canadian healthcare system"? What term is more accurate: pan-Canadian or trans-Provincial?**

MH: There are a series of provincial systems. I don't think there's an actual system. And even within provinces, especially bigger provinces such as British Columbia, Ontario and Quebec, they really function more locally than provincially. I have generally tried to avoid "pan-Canadian." I like addressing the needs of communities. Canada is not one community: it's a collection of [individual] communities with separate and distinct needs.

**HQ: Rationalization, restructuring, integration, patient-centred care, among other interventions, have exacted their impact on healthcare. What approaches, in your opinion, have been the successes and failures in shaping healthcare for the twenty-first century? Is there a "next big thing"?**

MH: [laughs] That's a lot of questions! The approach that has been the most useful is the consolidation of services, mostly for consistency in quality. We have not done enough of it, but where we have, it has worked.

**HQ: Is that economies of scale or critical mass for excellence?**

MH: Yes: qualities of scale and economies of scale noting that primary care is a local activity while secondary and tertiary need not be. What we continually don't seem to achieve is the

integration of service, particularly primary care. In Ontario, I think we're on primary care reform number 17 and we still cannot seem to get it right. The future and strength of the health system will recognize that the key to health and health-care is strengthening the quality, competence and capabilities of primary care providers.

**HQ: Is there any policy or direction you think of as an abject failure?**

MH: Well, I never failed [laugh], but the system has! In the early '90s, we were hired to help plan for the implementation of an integrated healthcare system focusing on populations, population health and primary care in northwest Ontario. When the government changed, the [new] government killed the project. So, we started with an integrated health-care system in Thunder Bay but it never went anywhere. Had that [concept] proceeded with Canada's single-payer system, I would argue that we would have had a dramatically different and much more effective healthcare system in Ontario and perhaps Canada. But for a lot of reasons beyond my understanding, the government decided they didn't want to do that.

**HQ: The next big thing?**

MH: Probably artificial intelligence (AI). In terms of what's going to make a big difference, that's what it'll be. We're not able to deal with important policy things because the Premier's office in every province keeps screwing it up.

**HQ: One cannot look to the future without an understanding of the contributions of e-health – from clinical transactions, to reimbursement and performance management to meta-data underpinning population health and policy debate. What is your take on Canada's journey with investments in the knowledge economy?**

MH: It's been pretty good. We have really focused on disseminating best practices to providers so that evidenced-based innovation can become practice. We could do a better job of reinforcing best practices through technologies that prevent interventions that are contra-indicated by the literature. But as I said, AI and e-health will help with that future [state] if we continue to invest in them.

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**HQ: Central to healthcare's performance is attention to people – from directors in governance to the professions and those who contribute behind the scenes. Concurrently, healthcare has morphed into a "knowledge industry," where workplace expectations are much different: lifelong learning, engagement, succession planning, reward and recognition, etc. What do you say to today's leaders about investing in people?**

MH: We deliver healthcare through people. You cannot invest too much in your people and you have to reinforce their importance to the system. You have to give them the freedom to innovate and, especially as professionals, to deliver their professional services in a way that makes sense and meets their standards over time. People are critical; we need to invest in their learning and their understanding of what organizations and the system are trying to achieve. You can't dictate to them; you have to engage them.

**HQ: Does healthcare have the right DNA for the changes inherent in today's workplace: shifts away from say "seniority" and "credentials" to "contribution," "innovation" or "personal accountability?"**

MH: If the leaders of my generation (who are retiring) would abandon their hubris and recognize that the next generation will be just as good or better than us, yeah, we do.

**HQ: System design and governance, organizational integration and complex program delivery models, among strategies, have required rapid change within a relatively change resistant industry. The need for innovations that deliver first-time success has never been greater given the political consequences of failure. Has this made a difference in how we approach challenges and implement solutions?**

MH: I used to advise people: do the right thing, the politicians will deal with the politics and don't second guess that. More recently, I started to tell our clients – and these are big organizations and senior people – that before you start down the road to change, before you even begin the conversation, make sure the Premier's office in your province is involved. Because in the end, it's not the local MPP or Minister of Health, it's the political machinery behind the Premier's office that will be worried about losing one or two seats that will determine whether or not you're going to be able to implement significant change. And that's been repeated over and over. Boards have gone out on a limb to do things right, straining social, political and even family relationships, to introduce or sponsor change only to be undermined by the Premier's office that tells them they cannot do it. It's just incredible.

**HQ: Discussions around healthcare's triple aim – better access, better quality and lower costs – have identified the need for a fourth requisite: provider satisfaction. The Hay Group was arguably a leader in workplace and employment dynamics. Given that providers are also voters, how do you see public policy reacting to this concept?**

MH: The largest provider group is nurses and I would suggest governments have recognized that front-line nurses are incredibly important. We cannot deliver healthcare without nurses. Nurse practitioners, along with physician assistants, are the future of primary care. However, in the end, governments have to look beyond the interests of nursing to deal with the critical issues related to healthcare reform.

**HQ: Physicians are not bashful when it comes to giving their take on public policy and healthcare. How do you see their satisfaction nuancing public policy debate?**

MH: The issue with physicians, not because they have a lot of votes, is that they can influence their communities and the public for whatever issue. Physicians are incredibly important in influencing public policy, possibly beyond their importance to the system. Lately, some outspoken groups of physicians have been more worried about their own interests versus the public's interest. Politicians and policy makers need to listen to the expertise of physicians, to understand what is feasible, what is possible and what is in the interest of good healthcare. They do have to look beyond the narrow personal interests of physicians, especially pecuniary interests, to develop policies that really meet the needs of Canadians.

**HQ: Thinking back over your career and projects, what was the most important lesson you learned?**

MH: The most important lesson, other than to worry about the Premier's office, is to listen. Listen carefully to what people – especially front-line workers and physicians – say. Listening is a key learning and, as those who have worked with me understand, that's really hard for me to do.

**HQ: In comparison to other jurisdictions, say the US or abroad, how do you think we're doing as a country when it comes to the evolution of our healthcare system and its ideals?**

MH: I think we're doing great. In the end, people who really need care get really good care. We have really good clinicians in really good systems providing really good care. However, we're a bit

behind in technology. Yes, we have issues with access, but it's not access for critical things; it's access for less important things. The biggest problem is the worried well who don't get the kind of access that would address their concerns. That creates political pressure to make changes that perhaps are not [always] necessary.

**We have to** focus on strengthening, expanding and enhancing primary care, which will solve a lot of the apparent issues in Canada's health system.

**HQ: Earlier you said you were a data guy: is there any particular piece of data, evidence or trend that underpins that opinion?**

MH: Yes: infant mortality, access to care, utilization rates, length of stay. The concern is – and this goes back to my primary care issue – people wait in emergency rooms and for access to specialists.

My hypothesis: patients wait a long time in emergency rooms when they probably should be seeing their primary care providers. And, they have long waits for specialists because primary care providers don't have the time to deal with complex issues and therefore refer rather than deal with the case themselves. If we expanded the capacity of primary care by introducing more nurse practitioners and physician assistants, general practitioners would have more time to deal with only the complex cases and would refer less. Greater capacity in primary care would divert cases from emergency rooms. And if we would pay primary care providers for phone consultations, for example, there would be a hell of a lot fewer people going to GPs' offices or clogging up access to emergency rooms for real emergency care. We have to focus on strengthening, expanding and enhancing primary care, which will solve a lot of the apparent issues in Canada's health system.

**HQ: I have to ask: Trump-care or Obama-care?**

MH: Definitely not Trump-care but something that fixes Obama-care, perhaps a single-payer system that would enrol

all the people with pre-existing conditions into Medicare. Then everybody else who needs coverage could buy cheap insurance. Many issues, other than the delivery problems, would go away.

**HQ: What advice would you want to give emerging leaders?**

MH: The advice I would give: find a situation where you are valued as a person and, then as you become a leader, also value and respect the people who work with you.

**HQ: If you had it do all over again: any changes?**

MH: Yeah, I'd go into real estate, make a lot of money.

**HQ: Any other comments you'd like the readers of HQ to know about Mark Hundert now that he has hung his shingle at the golf course, not an office?**

MH: Two critical arguments I lost were really important. One was about the importance of integrated primary care; the other, home care.

In the mid-90s, we were trying to figure out where home care should reside and I argued strenuously that there are two kinds of home care. First, there's post-acute home care, part of an acute episode that should be managed and perhaps partially funded by the hospital. The other is community home care (chronic home care), a community service managed in the community, perhaps by primary care providers or social services.

Acute home care, after a hip or knee replacement, is part of the acute care hospitalization. Since the length of the acute hospitalization will be based upon how good the home care is, it needs to be part of the episode of care owned by the hospital. There are several examples in Ontario linking acute episodes to acute home care, enabling chronic home care to do its job better, including saving money.

**HQ: Thank you.** HQ

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