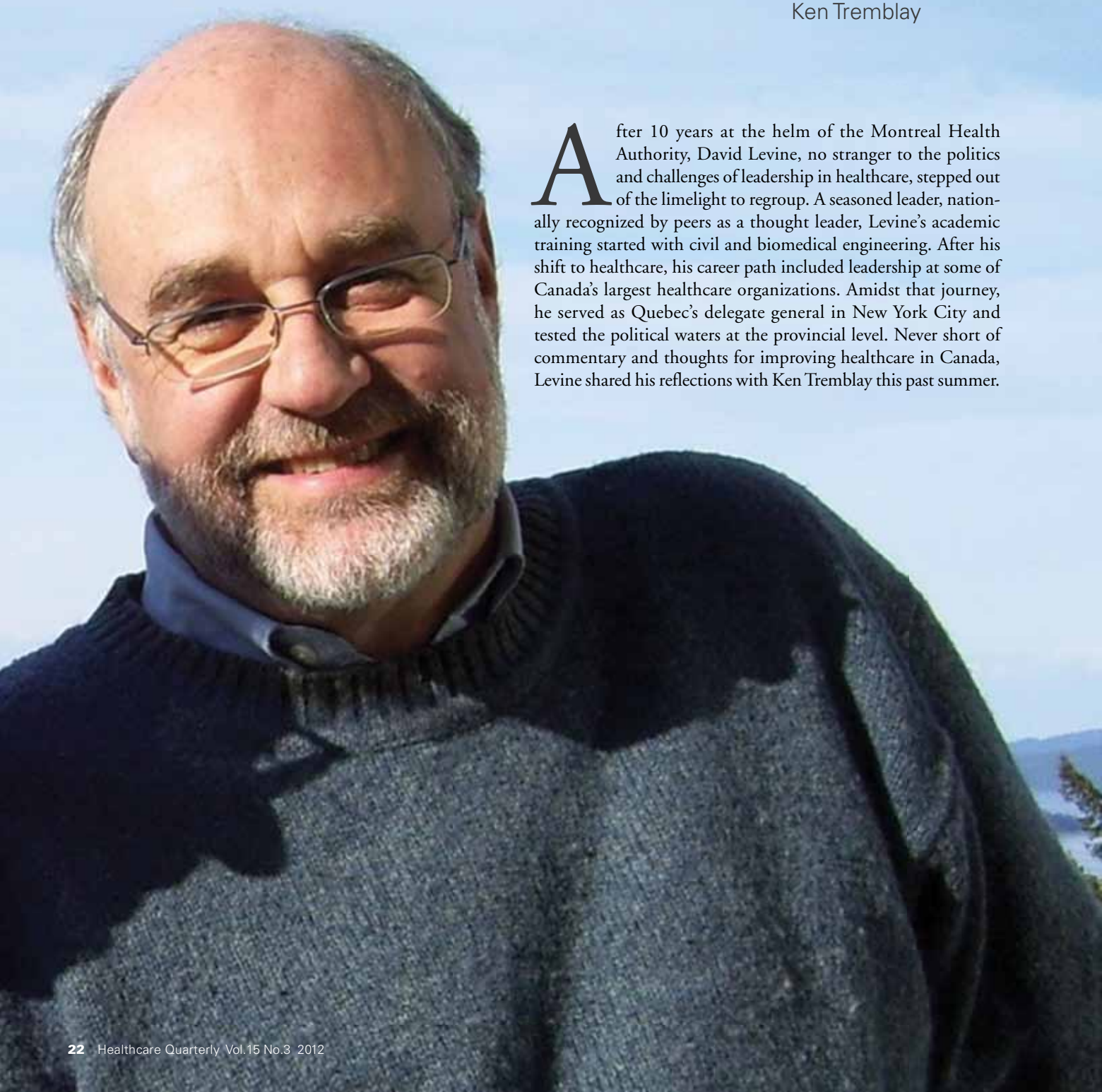


In Conversation with David Levine

Ken Tremblay

A close-up portrait of David Levine, a middle-aged man with a grey beard and glasses, wearing a dark blue sweater over a collared shirt. He is smiling slightly and looking towards the camera. The background is a bright, clear blue sky.

After 10 years at the helm of the Montreal Health Authority, David Levine, no stranger to the politics and challenges of leadership in healthcare, stepped out of the limelight to regroup. A seasoned leader, nationally recognized by peers as a thought leader, Levine's academic training started with civil and biomedical engineering. After his shift to healthcare, his career path included leadership at some of Canada's largest healthcare organizations. Amidst that journey, he served as Quebec's delegate general in New York City and tested the political waters at the provincial level. Never short of commentary and thoughts for improving healthcare in Canada, Levine shared his reflections with Ken Tremblay this past summer.

HQ: What did you enjoy the most and least about your experiences with the Montreal Health Authority?

DL: What touched me the most was that I was managing a system as opposed to an organization. I had managed smaller institutions and very large hospitals and completed mergers. Now I had the opportunity to manage the whole system, but not from a traditional regional authority perspective. In the Montreal model, each institution retained its own chief executive officer (CEO) and board, so the regional authority was sandwiched between the ministry and the institutions. The challenge was to navigate [change] within that environment.

In 2005, we integrated many of our institutions, from over 70 institutions, each with their boards and CEOs, to 12. Each of the 12 became part of an integrated network on the island of Montreal, with services ranging from community and primary care to hospital to home care and long-term care services. [System] integration through reform was one of the most important experiences.

The difficulty? Things move slowly in healthcare. Changing the system is a real challenge; there are a lot of embedded, cultural biases. That's what we have to work at.

HQ: Did you find hospital boards an asset in your model?

DL: I found them an asset. It was very important to have CEOs with their boards, volunteers looking at quality, keeping the focus on the patient and challenging their CEOs. Because CEOs reported to their boards, versus my directors, that was a help. The hindrance was that it was much harder to introduce consistent change; CEOs became more concerned for their organization than the health system.

HQ: Many of the presentations you made offered a compelling vision for Montreal's healthcare system. Looking back after 10 years, what did you get right and what might you reconsider?

DL: The vision for healthcare in Montreal was to integrate services, to remove silos of care within the system and to better integrate primary care, hospitals, home care, long-term care and mental health and social services into one organization. Creating the 12 population-based healthcare centres on the island was a very important structural change toward a better healthcare system. After that, we made clinical changes: getting professionals to work together in multidisciplinary teams across the continuum of care. That change was far more difficult than the structural changes – those efforts continue to today.

The other challenge was to transfer activities and services from hospitals to the primary care/community care sector. Changing how hospitals and the hospital system have been performing for over 40 years is much more difficult, given

their embedded cultural biases. For example, psychiatrists and mental health professionals are very reluctant to transfer their complex patients to community health teams; they want to keep them under their wing. However, if you don't make the transfer,

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the system remains the same – top heavy. [It's the same] with chronic conditions: we don't allow for life-to-death care through the primary care system. That kind of change is really important, more difficult, and you have to be very persistent.

HQ: Any integration effort that didn't work out for you?

DL: We had difficulty with mental health (which I mentioned), and some work has yet to be completed, that is, the resource transfers between hospitals and community agencies. The integration of care between primary care providers and hospitals is not yet done. Primary care physicians still don't have easy access to technology or easy access to specialists needed to make diagnoses, and they still spend a lot of time hunting down results. That connection has not yet happened. Similarly, primary care services and community services – social services and home care – are not yet well integrated. The result: we still have primary care teams disconnected from and lacking easy access to our healthcare networks and the hospitals.

Hospitals are resistant [to change] as well when they say, "We want to take care of our in-patients first." Patients coming from the primary care sector tend to wait for diagnostics and access to specialists.

HQ: Notwithstanding those gaps, Quebec's approaches to health system integration have led the country. What parts do you think would be transferable to other jurisdictions?

DL: The regional integration of health *and* social services is really essential. Then you have to ask, how do you manage care? We need patient rostering of primary care and then a really strong multidisciplinary team that can share the care and help manage the physician [workload]. If we can do that, we will begin to have a managed healthcare system that will reduce costs, reduce use and demand, allow for the autonomy of individuals and facilitate self-management. Those are some of the things we've been working on. Quebec has made some very strong moves in the reform area; it's important that we learn from each other.

HQ: Many of us recall the healthcare system in Ontario in the wake of the Restructuring Commission and the directions it made for Ottawa. How did your

experiences in Ottawa shape your approach to change management for the health system in Montreal?

DL: My experience in Ottawa made it very clear to me that if you want to succeed, you must focus on the patient. For example, by [repurposing] the Riverside site rather than closing it, we were able to gain the support of physicians, management,

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staff, the community and even the media. Because we focused on the patient and found a winner, people supported our moves with other issues [associated with] the merger: How were we going to divide up services? What services would be offered, and in what location? How were we going to regroup physicians? That's what I got from the Ottawa experience.

HQ: Your career made a turn when you became the province of Quebec's delegate general in New York City. What factors motivated you to go in that direction and then shape your return to healthcare?

DL: The then minister of health wanted to merge Notre Dame with two other academic centres, Saint-Luc Hospital and Hotel-Dieu Hospital, with the idea that I would become the CEO of the new organization; however, it became clear that selecting one of the existing CEOs was not the best idea. The government asked if I would like to do something new for a while – the delegate general position – and I accepted it as both a challenge and something new and different. I stayed there for about a year and a half and, although I found it fascinating and very interesting, my real interest remained healthcare. When a head hunter contacted me about the opportunity to [consummate the merger] in Ottawa, I thought that challenge would be very exciting and, in the end, accepted it.

HQ: As you note, engaging physicians during change is often a challenge. What has been your experience with physician engagement during system integration strategies, and what has worked best for you?

DL: The first challenge is to get the primary care physicians involved in primary care teams. Over the past decade, we established about 55 teams on the island. Because Montreal is divided into 12 territories, we set up 12 physician councils that, in turn, sent one leadership representative to an executive committee for the region. The councils were very helpful in getting the physicians in their territory to work together, and they became an official body to work with the specialist groups (because we have another council of specialists of the island, that is, the departments from our various institutions). Those

two groups work together to develop a better bridge between the primary care sector and specialized services.

[For this to work], you have to be very present and provide incentives. It is not the “big bang” theory – this can't happen overnight. It is a journey that moves physicians along a road at a pace they can absorb. I became quite close with the Federation of General Practitioners. When we developed our primary care centre, physicians participated in its creation and selected the ratio of professionals to physicians [for the model]. We had a lot of work to do: how would we move to a shared care model? We knew if we didn't go down that route, we wouldn't increase the [clinical] capacity of general practitioners. As our population becomes older, we need to find ways of increasing general practitioners' capacity. Shared care is part of the answer.

HQ: Academic health sciences centres are under fire these days – institutions we love to hate. What would you say to policy makers as we shift the cost curve away from hospitals and academic centres to these community-based models?

DL: They truly need to embrace this concept and accept [the notion] that the academic health sciences centre must not become a volume-driven environment; that payment of physicians by volume generates a desire to place outpatient clinics in hospitals, causing a multitude of primary care/specialists contacts; and that primary care should be in the community. Teaching hospitals still want large emergency rooms; they should have very small emergency rooms. They should work more like American teaching hospitals: use satellite facilities and take on only the more complex cases. Keep enough activity to support training you need at the primary and secondary levels, but make this a small part. Try training in the community hospitals. There's a great opportunity here, but there needs to be a change in mindset.

HQ: What advice would you give to someone just starting a leadership career in healthcare?

DL: Be patient focused in everything you do, and ask yourself, how is what I'm doing going to ultimately affect the patients? That's number one, and it will always keep you guided on the right track. Second, understand the zones of power and influence in your environment, both internal and external, be they physicians, nurses, unions, board members, foundations, media or government. Understand these groups, their leadership and their interests, and adapt. Focus on patients and engage these groups.

It's very important to really understand the physician group. They are and will remain strong, strong leaders in the system. The nursing side of our system has not been given the leadership opportunities that they should have. A lot of change in the healthcare system could come from nurses: they have regular

contact with patients every single day and understand [patient] care. So, focusing on these two groups would be very important.

HQ: You did something few healthcare administrators have done – you openly declared your political stripes. How did your experiences shape your views on the politics and policies shaping healthcare in Canada?

DL: [When] managing in healthcare, you are managing at the organization and service levels. At a system level, such as a regional health authority, you try to manage at a system [level]. Because Canada's [system embraces] public administration – not only of health insurance but also of the delivery of services – governments are very much involved in healthcare. Thus, we have a lot of politics in almost everything we do.

Some [healthcare] decisions are made for political reasons. As managers, we have to be aware that this is the context of Canadian healthcare, whether at the municipal level or riding or right up to the ministry. I went into politics – for a very short period of time, I was a minister – and realized that it is a very difficult position; you have many masters and have to respond to a lot of different pressures.

I enjoyed the hands-on roles more than the system [roles]. At Notre Dame, my office was right in front of radiology. I could see all the patients waiting to go in and was able to talk with them, making me feel much closer to the delivery of care. I enjoyed that the most. As you move up, certainly at the political level, you become more distant and influenced by other factors.

HQ: Some people might argue that the healthcare system is so political that it makes management virtually impossible. What would you say to people who are trying to balance the politics of healthcare with the right management decisions?

DL: You have to learn to live with that reality and best adapt to it. Politics can block certain decisions and can move money into areas that you, as a manager, don't feel are the best for the system or are for political reasons. One has to learn how to adapt to that and get the most for the patients whom you are trying to serve. The barriers within public administration are there, and you have to live with them.

Why is healthcare being managed by the political system? The Canada Health Act requires public insurance, a single payer, and the management of that single payer through public administration. Governments have said, "If we're going to receive and spend 50% of the money, we had better be the ones managing it." Once they decided that, politics became very much involved.

It's the number one issue for Canadians, in elections, in the media. The media often use healthcare as a lens for political parties, governments or an individual minister. That's why

managers have to be very aware [of the issues] and have an excellent communication team. [You have to] be close to the players, create relationships, etc. so that you can present your points of view clearly. Have strong board and community support for your position. Let politicians see that there is strong and broad community support. Those are the things you need to do.

HQ: What do you hope your leadership legacy will be as you reflect on your career?

DL: In 1986, our Hospital in the Home project put physicians and hospital beds into the home to alleviate pressures on emergency rooms. From that activity, extensive home care services grew, such that we can do a lot more in the home today than we did in the past. Generally speaking, the move to

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primary care is the key to a successful healthcare system. That's what I hope to work on: building a better bridge between the hospital and the primary care sectors.

When I was president of the association of CEOs in Quebec in the 1980s, I stated that we had too many acute care beds and that we should reduce the number of acute care beds because our lengths of stay were too long. CEO colleagues almost strung me up for those comments. Five years later, we closed seven hospitals on the island of Montreal and reduced a large number of beds. We were able to get lengths of stay down and become more efficient. I believe in [gaining greater] efficiency of the system and think there's still a lot more we can do.

I hope people see me as a healthcare manager, someone committed to the healthcare system and continually working to improve it. When I meet [former] students and they say, "Oh, I remember your class," that sparks my desire to go back to do some teaching.

HQ: What is next for David Levine?

DL: I'm looking at the healthcare system differently. I don't know whether I want to go back to running another large organization. I had my first CEO position when I was 26 years old, so I've been doing this for 37 years. I love it. I think I can get my message across through teaching, meetings, working with various groups across the country – that might well be the next step. I still feel raring to go for the next couple of years.

HQ: Thank you. HQ