Politics, health systems and population health: An interview with David Levine

J. Ross Graham, MSc, CHE

Mr. David Levine

David Levine has been a senior health leader for over forty years. This includes serving in CEO roles with the first community health centres in Montréal, multiple community and academic hospitals, and later with the Montréal regional health authority for over a decade. David was also briefly the Junior Minister of Health in Québec, and the Delegate General of Québec in New York City. These experiences are described in his new book, *Health Care and Politics: An Insider's View on Managing and Sustaining Health Care in Canada* (Véhicule Press, 2015). Now semi-retired, David is an Adjunct Professor in the Faculty of Medicine at McGill University, and an Associate Professor in the Faculty of Public Health at the Université de Montréal.

Interview

J. Ross Graham (JRG): *How dire is the relationship between politics and the health system?*

David Levine (DL): We're going through a phase. Because of economic constraints, provincial governments have forced greater system regionalization and centralization in an attempt to increase political control. Health service providers and health systems are far less democratic than they used to be. Alberta Health Services, for example, has been through tremendous change in an effort to increase its performance and efficiency. It turns out they haven't saved any money and there is little evidence anything has improved. Plus, seven CEOs have been fired in the process, which has negatively impacted organizational culture. In Québec, hospital boards have been emasculated in order to increase political control. Boards have decreased in size, and all board members are now appointed. Hospital CEOs are ministry employees who do not report to boards. This significantly decreases community leadership in the health system, and CEOs speak much less often to the media, for self-preservation purposes.

The effects of increased political involvement have been negative for public health. Public health funding has decreased, and health systems remain hospital-centric. Politicians see an immediate return on investment in health care. Conversely, most see public health as an expense with no immediate political benefits. Economic constraints intensify public health funding issues. For example, an early decision by the current Québec government was to cut public health funding by 30%. This was a truly unfortunate decision. The pendulum of political involvement has swung too far. Let's hope it swings back.

JRG: *What do public health leaders need to know about politics to be effective?*

DL: There will always be political involvement in the health system. Leaders need to understand political motivations and concerns. Once elected, a politician's primary concern is how to get re-elected. The exceptions are true visionary politicians: those who have a clear vision of what they want for their province. These individuals are rare, and there is less opportunity for them to succeed given the influence of global economics on politics. Health leaders need to develop their own "political base". This means building relationships and trust with colleagues and community members. Leaders need support from local physicians, staff, union leaders, staff, board members, patient groups and community groups. This support is essential if you want to gain political support for your ideas of how the system can be improved. Leaders also need to have a clear vision of how the system can be improved. Hopefully this vision extends beyond increasing funding for their organization.

Author Affiliations

Vancouver Island Health Authority, Victoria, BC; Centre for Health Services and Policy Research, University of British Columbia, Vancouver, BC

Correspondence: J. Ross Graham, Royal Jubilee Hospital, Memorial Pavilion KW 335, Victoria, BC V8R 1J8, Tel: 250-370-8462, E-mail: ross.graham@viha.ca

Editor's Note: This is part of a series of interviews conducted with Canadian public health leaders. The aim of the series is to capture the leaders' personal perspectives, allowing readers to benefit from the former's wisdom and insights gained through a career in public health.

doi: 10.17269/CJPH.107.5736

JRG: *In your book, you suggest prevention should be integrated into all aspects of health service delivery – how would this work in practice?*

DL: Every program should have a prevention component. While this would require significant time and energy, it is essential to have everyone in society involved in learning about health and participating in the improvement of health. In primary care, we need public health practitioners more involved with family physician offices and with interdisciplinary primary care teams. All primary care activities should have a public health component. In hospitals, front-line teams need greater understanding of how prevention can be integrated into their work and how it will benefit patients. We need public health practitioners involved in health care, instead of having public health as an overlay, on top of primary care and acute care.

The *Health-Promoting Hospitals* and *Planetree* models are examples of how we have tried to advance health promotion in acute care in Montréal, in tandem with *Healthy Cities* work led by Montréal public health practitioners. Looking at workplace health promotion alone, there are 90,000 health care employees in Montréal. Wouldn't it be great to create 90,000 health promotion ambassadors in the city? While this work has significant potential, its effect and future remain unclear, particularly when governments demand immediate results.

JRG: *What can public health practitioners do to better integrate prevention into health service delivery?*

DL: Once you can demonstrate the value of public health interventions, you need to also communicate it effectively. I've always believed the adage, "give people the data and they'll see the light," but this is perhaps becoming less true. For example, I chair the board of the Québec Network for Personalized Health Care, which has an interest in advancing genomics. The potential benefits of genomics for individuals and population-level prevention warrant further exploration because we can choose the right medicine for the right patient according to their genetic makeup, and provide clinical prevention options to patients at a higher risk of contracting a disease. We have lots of data and have spent countless hours trying to convince government to invest in more research, and to pay for genetic testing. However, this has proven challenging as governments are afraid this will increase cost in the short term. Public health should continue to play a leadership role championing new technologies that can improve population health, such as genomics.

JRG: *The majority of your career has been in Québec – What can the rest of Canada learn from Québec's experience?*

DL: Québec's greatest success has been putting social services and health services together. We now have organizations that support both social and health needs in an integrated way. These organizations also better understand the needs of their communities, given the relationship between social issues and health status. I'm surprised health services and social services remain separate in many provinces.

Québec has also made positive strides to strengthen primary care over the years. However, all provinces and territories need to do more. We need interdisciplinary primary care teams that serve patients and populations with services ranging from prevention to home care. Information technology can play a facilitating role, creating a true system with primary care at the centre. There are US examples of this, such as Kaiser Permanente or the Cleveland Clinic, where hospitals play much less of a central role. People only visit hospitals when absolutely necessary, and since hospitals are so expensive, funds can be reallocated. Canadian hospitals provide excellent care, but this is not where we should be spending our money. For example, \$3 billion was recently spent on the McGill University Health Centre. Who benefits most from this? I'd argue hospital staff will benefit most, not patients who stay for a few days, and certainly not the population. Strengthening primary care will yield significant population health benefits.

JRG: *What advice would you give someone considering a health leadership role?*

DL: I would encourage them. This is an exciting and complex field. It is different than leadership in other sectors. Health systems require management of professional bureaucracies: organizations staffed with professionals who have strong opinions and valuable expertise necessary to improve care and population health. Leaders must find ways to reduce bureaucracy in the system in order to support these professionals' work and collaborate effectively.

If you're an entrepreneurial individual, work hard to keep it up. The health system is often unsupportive of an entrepreneurial spirit in leaders, even though this is required. Plow ahead. Introduce new ideas and new programs. Test new ways to improve care and improve health. The leader with genuine concern for patient care and population health will be most successful. You can't fake it in the health system. Leaders who are deeply committed to improving health will be better able to create change.