

Insight

In Conversation
with

Janet M. Davidson

Ken Tremblay

You know when Janet Davidson is in the room. A nationally renowned health executive with more than 30 years of experience in government, voluntary, hospital and community sectors in Alberta, Ontario, Saskatchewan, Manitoba and British Columbia, she recently did two remarkable things: left the C-suite to become a global consultant in healthcare, and returned to Alberta when that province called earlier this year. With a long list of credentials and experiences, and the gratitude of a country as officer of the Order of Canada in 2006, Davidson and her resume are, quite possibly, peerless.

When she assumed her role as official administrator of Alberta Health Services (AHS), Davidson was the Canadian Executive of KPMG's Global Healthcare Centre of Excellence. Prior to that, she was president and chief executive of Trillium Health Centre in Mississauga where, with a merger with the Credit Valley Hospital, she helped create the largest community academic hospital in Canada. She is presently a member of board of directors for the Canadian Institute for Health Information (CIHI) and serves as the chair of the CIHI Board's Governance Committee. Until recently, Davidson was a member of the board of the Ontario Institute for Cancer Research, and she is the immediate past chair of the Ontario Hospital Association.

Ken Tremblay interviewed her early this fall. Days later, Davidson was appointed as deputy minister of Health for Alberta.



HQ: You are no stranger to challenges. Tell us about your mandate as official administrator for AHS, which is, in fact, a governance role.

JD: Yes [it is], and it was created by a ministerial order in June. The Board of Alberta Health Services was removed by the government, and there is a requirement under the legislation – the Regional Health Authorities Act – to have the equivalent of a board. I’m that person right now.

HQ: A daunting role for one individual?

JD: It is, but I spent the longest portion of my healthcare career in Alberta – both in government and the Ministry of Health, pre-regionalization. I was also quite familiar with the province’s model post-regionalization.

HQ: What was the first thing you did when you arrived?

JD: The minister, Fred Horne, Chris Eagle, chief executive officer (CEO) of Alberta Health Services and I hosted a media scrum in Edmonton. It was an opportunity for the media to meet the leaders and pose questions to the minister about the terms of [my] appointment. They asked what his expectations were. It was an opportunity to chat with me to get a sense of who I was, and to consider my beliefs about healthcare, leadership and the like.

I’ve been quite transparent with things like my salary and expenses, which are posted publicly. I meet with the executive team quite regularly and health advisory councils. I have participated in many meetings: if people ask a question, here’s the answer. I don’t believe in keeping much of this information under wraps, quite honestly.

HQ: Alberta seems to have gone full circle with its health system governance model. What are its strengths for what lies ahead, and what might be its limitations?

JD: The big strength [of the model] is the degree to which you can get alignment: everybody’s singing from the same song sheet. Once a strategy is developed, how do you make sure that everybody’s going in the same direction? In this province, you have one minister, one Ministry of Health and, essentially, one service delivery organization. Yes, there are partners in the delivery of services – clinicians, physicians, other organizations, long-term care agencies etc. – but getting alignment is easier.

I have always been a fan of integrated systems, that healthcare [be delivered] over a continuum [of providers] over an individual’s lifespan. Healthcare is rarely a one-off event. Notwithstanding acute surgery, generally speaking healthcare is the progression of chronic diseases and the aging of the population. We deal with health problems not only over a lifetime,

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but often across different organizations. The opportunities to address the interfaces between those elements are more present in an integrated system.

HQ: Any limitations that come to mind?

JD: It’s a big organization with 93,000 employees and budget of over \$12 billion (then I look at the NHS in the United Kingdom with its budget of \$93 billion). As complex as healthcare is, it does require you to be on top of the major issues to ensure that you’re moving on them. That’s not particularly unique to Alberta. Critical for success is making sure that you know where you’re going, having appropriate indicators to measure progress and monitoring them religiously so that you understand what might be impeding progress or the speed you require.

HQ: With significant leadership experience in several provinces, what are your thoughts about how the Canadian dream for healthcare will be realized?

JD: I’m not so sure ... We have a new federal health minister; her speech to the Canadian Medical Association demonstrated her commitment to a strong federal presence in the healthcare arena. Many people have commented that a federal voice may not have been as strong as it could be, particularly when it comes to funding arrangements. Previously, it was, “Here we are; now go away and do it.” Now, there are some signals that there is [growing] interest in a national strategy.

I worry that provinces are increasingly going their own way, for example, portability vis-à-vis different types of programs and services, financing arrangements. In the case of funding, some are using a flat percentage increase plus a factor for growth; others have no growth or even negative growth. What does that do to the Canadian philosophy of portability and its impact on equity and equality? It will be interesting to see what happens in the future.

Healthcare has always been a challenge for me, and I view that in a positive way. It means you’ll never be bored in healthcare because there is always something new. The extent to which we, as a country, develop new models [of delivery] and move ahead is going to be critical for us.

HQ: Some have stated that Canada’s early leadership in healthcare has been eclipsed by other countries. How should Canada catch up? Is there any country out there “getting it right”?

JD: Before I joined Alberta Health Services, I heard someone comment that Canada is not really a place that other countries

look to for good examples of healthcare. Yes, the single payer [model] holds some interest to some, but when it comes to systems that deliver real quality, the literature reports on providers like Geisinger, Kaiser and Birmingham or countries like Australia, Singapore and South Korea.

It will be interesting to see if whether we can move ahead because it does distress me. When you look at Commonwealth Fund data, we are succeeding in spending more money. While we were not at the level of the United States, spending would not be as big an issue if our performance were better; unfortunately, in many cases our [relative] performance has dropped.

Every country is looking around at other systems. One of the challenges we have is when we pick a country [for a particular outcome], we tend to discount the measure without understanding its full context. For example, we often discount the American system on the basis of the amount of money it spends (one measure). However, if you look at its leading organizations, like Kaiser, DVA [the Department of Veterans Affairs], Intermountain Health and some of the Harvard sites, there are lessons to be learned. Similarly, I'm quite intrigued about some of the changes occurring in New Zealand and Australia. Those should be of interest to Canadians because they are Commonwealth countries, particularly Australia, with big space and not a lot of people.

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HQ: Alberta is arguably a fully integrated healthcare delivery system. What are the lessons learned for other Canadian jurisdictions?

JD: Actually, we are not fully integrated because there are elements related to primary care excluded [from the model]. Alberta is doing some unique things with primary care, so there will be some opportunities for learning there. But these challenges refresh my thoughts about the big advantages of integrated systems.

HQ: You are a nurse, healthcare executive and governor of Canada's largest health system. What message would you have for professionals at the bedside? For other leaders?

JD: I have said it for years: healthcare is all about people. I'm hearing it more and more often; whether it is people-powered care, people-focused care, people strategy or patient first strategy, there is an increasing awareness that if healthcare is going to drive quality and value for money – whatever those terms are – then you really have to look at the front-line people

who are providing the care. And, if there weren't any people who required care, [providers] wouldn't exist. Progressive organizations are really focusing on their people, much more than they have in the past.

It's going to be a challenge. I recall someone commenting that healthcare is now a whitewater world. It's no longer a little rough spot and then return to smooth sailing. There is constant change, and that's good. Leaders need to apply their skills and commitment to their vision and commitment to the people who are following them. If change and challenge are viewed as, "Oh my heavens, I'm not going to be able to do this and isn't life horrible," a leader can send a very distressing message to those in the system, either those providing services or those receiving them.

The other message I would have for leaders is their absolute imperative to support and nurture others to lead the system in the future because without leadership development, we're going to be in dire straights.

HQ: Given the scale of your organization, how do you get close enough to the action to make a difference? For example, how are you engaging some of healthcare's stakeholders: policy makers, the public, professions, unions or the various populations across Alberta's diverse geography?

JD: I've only been in the job two and a half months! Alberta has done a good job of creating health advisory councils composed of individuals from local areas who provide input to AHS. In those meetings, I have heard about the issues and concerns that they have. I have attended a number of meetings with members of the legislative assembly (MLAs) about their issues and concerns. I meet with the staff in the organization, the executive team in particular, as well as ministry staff. I am in a governance role, so it is not my mandate to get into the detailed operations of the organization. But I certainly try to attend meetings, read documents and participate when needed. As things start to ratchet up in the fall, there will be more issues for me to get involved in.

HQ: Fee-for-service [physicians] and accountability – in your view, how should these two elements reconcile within a publicly funded healthcare system?

JD: As discussions go, that issue is global. The fee-for-service debate is sometimes a red herring. It's not so much [about] the method of funding; rather, it's what you're asking to get from that, that is, accountability. For example, in Ontario, hospital funding is very much tied to very specific outcomes that are measurable. [Metrics and accountability] are going to be increasingly important in any physician payment system we have.

HQ: Arguably, there no silver bullets for what ails the healthcare system. The treadmills of chronic diseases and aging, system integration and the promise of the information age will only go so far. What happens when these strategies reach their shelf life?

JD: One of the advantages of Canada's healthcare system is its federal-provincial framework. As these issues surface within the system, by working together as a country, we can learn from each other as we ask, "What is the next big thing we need to work on?" As you point out, aging, chronic disease management etc. are going to continue to challenge us given the finite resources we have. The challenge is going to be this: of the millions of things we could look at, what are the things we need focus on and devote our time and attention to, that is, make improvements and move on? Sometimes we spin our wheels on doing a lot of disparate activities that don't deliver the bang for the buck.

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HQ: How will Alberta's healthcare system be better as a result of your efforts?

JD: I hope Alberta will be better off because of my efforts! I'm trying to focus on what I can do to improve results. An organization needs to look at itself on a regular basis and ask, "Are there ways in which we can improve what we're doing?"

My hope would be that by working with the minister, the government and AHS, there are things we can do together that will improve the way we are organized, deliver services or measure and improve performance. The last thing I would want anyone to say is, "She's come and gone and nothing was achieved." My mandate is to look at the organization and structure of AHS, to give some recommendations on a framework for performance measurement and to weigh in on the issue of executive compensation.

HQ: What's ahead for Janet Davidson?

JD: I don't know and have no idea. What is so great about healthcare is that there will always be all kinds of opportunities. If one can rise [to the occasion], the world is your oyster. To me, making a contribution is what it's all about, and who knows where that might take me?

HQ: Thank you. **HQ**

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