Abstract
From June 5 to 8, 2017, the International Hospital Federation (IHF) and Health investment & Financing hosted a Hospital Executive Study Tour in Montreal, Province of Quebec and Ottawa, Province Ontario, Canada. The objective of the Hospital Executive Study Tour was to allow participants to learn how the Canadian hospital sector addresses some of the key challenges and solutions to transform the way hospital care is delivered in the 21st Century. The Montreal Study Tour was part of a series of premier events offered by the IHF. This Study Tour was a collaborative effort among Canadian partner organizations in both Montreal and Ottawa who hosted various events to allow an exchange of ideas, knowledge, experiences and best practices in the delivery of healthcare services, and in the leadership and management of their organizations.

Introduction
Health care in Canada is delivered through a publicly funded health care system, administrated on a provincial or territorial basis, informally called Medicare, which is free at the point of use for services provided under the Canada Health Act of 1984. As stated within the Canadian legal frameworks, the design and delivery of health care to most Canadians is the responsibility of the provincial and territorial governments. However, the federal government makes a significant annual financial contribution to the provinces and territories to help offset the costs associated with that responsibility1.

Since the latter part of the 1980s, the Canadian health system has continued to evolve. To release the financial pressure on government funds while supporting the universality of the system public-private partnerships models emerged early on. The Canadian Health Care System was providing for physician visits and hospital care while other aspects were either finance privately or under a mix model. Therefore, starting with what was already a mixed public-private partnership, recent reforms have not significantly altered this approach to both funding and delivery of healthcare. The public character of tax funding and public/non-governmental/private character of the service delivery system has prevailed, despite periodic constitutional challenges.2,3 Private health insurance is present in the market, playing a somehow limited role (as a market share), covering services that are not covered under the public mandate such as vision, home care, rehabilitation, outpatient drug expanses, private rooms in public hospitals.

In 2002, the Royal Commission on the Future of Health Care in Canada, also known as the Romanow Report led by Roy Romanow, made comprehensive recommendations on ways to preserve the long-term sustainability of Canada’s health care system.4 The proposed changes were outlined in the Commission's Final Report, “Building on Values:

1 Canadian Parliament “The Canada Health Transfer (CHT) and Other Federal Health Transfer” at https://lop.parl.ca/Content/LOP/ResearchPublications/tips/tip99-e.htm
The Future of Health Care in Canada” which was tabled in the House of Commons on 28 November 2002.\(^5\)

The Report led to an important agreement in September 2004 whereby the Government of Canada agreed to strengthen ongoing federal support provided to provinces, through the Canada Health Transfer Act (CHT). While it was up to the provinces how they allocated the funds, the CHT required that the aims should also target the maintenance and or increase of the population access and system universality. A separate financial commitment was made during the 2003 Health Accord that specifically targeted waiting times for certain procedures\(^6\).

It did not alter the underlying fundamental principles of the Canadian healthcare system set forth in the Canada Health Act 1984, led by Health Minister Monique Bégin, which replaced the earlier Hospital Insurance and Diagnostic Services Act and the Medical Care Act.

The Royal Commission continued to discourage co-payments and user fees for physician and hospital services. It required the federal government to deduct (dollar-for-dollar) the value of all extra billing and user fees from a given provincial government’s share of Established Programs Financing The Established Programs Financing (EPF) were set in 1977 and are considered the first modern transfer mechanism between the federal government and provinces in Canada\(^7\). Private profit-making hospitals were excluded from public funding arrangement, thus restricting the growth of such hospitals in Canada, although the municipal and non-profit-making hospitals were allowed such funding leading to a proliferation in this segment of the hospital sector. It also meant that other than mental health hospitals, the hospital sector in Canada has remained small.

In addition to the CHT in 2003 the federal government also created the Health Reform Fund (HRF), which was designed to assist provinces in implementing primary health care reform, short-term acute home care and catastrophic prescription drug coverage.

Overall, for the past 40 years, the Canadian health care system has remained remarkably resistant to erosion in the basic principles established under the Canada Health Act of 1985.\(^8\) As of 2017, the Federal Government continues to co-finance provincial and territorial programs, providing that the provinces and territories adhere to the original five principles of the Canada Health Act: 1) publicly administered; 2) comprehensive in coverage; 3) universal; 4) portable across provinces; and 5) accessible (i.e., without user fees).\(^9\)

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\(^6\) Canadian Parliament “The Canada Health Transfer (CHT) and Other Federal Health Transfer” at [https://lop.parl.ca/Content/LOP/ResearchPublications/tips/tip99-e.htm](https://lop.parl.ca/Content/LOP/ResearchPublications/tips/tip99-e.htm)

\(^7\) Canadian Parliament “The Canada Health Transfer (CHT) and Other Federal Health Transfer” at [https://lop.parl.ca/Content/LOP/ResearchPublications/tips/tip99-e.htm](https://lop.parl.ca/Content/LOP/ResearchPublications/tips/tip99-e.htm)


After a period of fiscal restraint under the Conservative Prime Minister Stephen Harper, Justin Trudeau leading the Liberal Party, assumed office on November 4, 2015. This has once again ushered in a new era of a more favorable Federal fiscal support for health care in the Canadian provinces.

Today, in terms of financial resources mobilized, cost, and public affordability, after the initial period of stable spending following introduction of universal access, healthcare spending in Canada like in all other OECD countries, has increased over time at a rate slightly higher than the OECD average but much lower than in the USA. Age adjusted total expenditure on health in 2012 was 10.6 percent of GDP. Health Expenditure per GDP in Canada has remained in the range of 10-11 percent of GDP over the past decade varying slightly from year to year.\(^\text{10}\)

As a result health care expenditure in Canada is among the highest among OECD countries that have a universal health care system. It is the 3rd highest in age adjusted expenditure per GDP and 5th highest in expenditure per capita.\(^\text{11}\)

At the aggregate level, health status does not have a strong correlation with the financing of health care such as health insurance or health care interventions. It has a stronger correlation with socio economic and other non-medical factors. So, no direct attribution to universal health care should be implied in the following section.

Nevertheless, among the OECD countries, Canada ranks 10\(^\text{th}\) for life expectancy, 9th for healthy-age life expectancy, 25\(^\text{th}\) for infant mortality, 18\(^\text{th}\) for perinatal mortality and 8th for mortality amenable to health care. In these terms, health outcomes in Canada across a large range of variables remain among of the top third in the OECD for some but bottom third on infant mortality and perinatal mortality.\(^\text{12}\)

**Facilities Visited and Executives Participating in the Study Tour**

The Study Tour included visits to leading Canadian policy makers, hospital managers and decision makers, researchers, entrepreneurs, community leaders, and health financing experts. In Montreal, the Executive Study Tour, included visits to the following groups:

- Department of Management, Evaluation and Health Policy, School of Public Health, University of Montreal
- Leadership program in Health Care Management, Desautels Faculty of Management, McGill University
- Integrated University Center for Health and Social Services
- McGill University Hospital Center
- Montreal University Institute of Geriatrics; and
- Arbec Health Group


\(^\text{11}\) Barua et all, 2016, p. 9.

\(^\text{12}\) Barua et all, 2016, p. 35.

www.ihf-fih.org
In Ottawa, the Executive Study Tour, included meetings with Health Canada; HealthCareCAN, Canadian Medical Association; Canadian Nurses Association; Accreditation Canada; Canadian Institute of Health Information (CIHI) and Elizabeth Bruyère Hospital leadership.

The participants in the Study Tour included executives and leaders from Albania, Australia, Brazil, Canada, France, India, Spain, Switzerland and the USA. (see Annex 1 for a more detailed agenda of the Study Tour).

**Highlights and Lessons Learned from the Different Visits**

The following provides a summary of some of the key highlights and of lessons learned from the different visits during the study tour. For a complete a more detailed description of the study tour, you may download a copy of the complete report from the study tour at the following website: (https://www.ihf-fih.org/activities?type=training&section=study-tour).
Monday, June 5th, 2017

SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MONTREAL

Policy Framework, Recent Reforms, Leadership and Managing Change

09:30 – 10:00 Overview of Study Tour - Eric De Roodenbeke & Alexander S. Preker

10:00 – 10:15 Welcome Remarks - Réjean Hébert

10:15 – 10:30 History of Universal HealthCare in Canada – Alexander S. Preker

10:30 – 11:30 Recent Reforms in Canadian and Quebec in Health Care - Jean-Louis Denis

11:30 – 12:30 Systems Integration and Care Management - André-Pierre Contandriopoulos

Working Lunch

13:00 – 14:30 Models of Long-term Care - Réjean Hébert

15:00 – 16:00 Managing the Myths of Health Care – Henry Mintzberg

17:00 – 17:45 Evaluating the Performance of Health Care Systems – François Champagne
Professor Jean-Louis Denis summarized some of the recent reforms in the Canadian, Quebec and Ontario Healthcare Systems.

**Reforms in the Canadian Healthcare System**

*Canada* is a Federal state with 10 Provinces and 3 Territories, each of which has its own health system. Key recent landmarks highlighted in the evolution of the Canadian Health Care System include the following:

- **1984 Canada Health Care Act.** It reaffirmed the original five principles of the Canada Health Act: 1) publicly administered; 2) comprehensive in coverage; 3) universal; 4) portable across provinces; and 5) accessible (i.e., without user fees).

- **2002 Royal Commission on the Future of Health Care in Canada** (known as Romanow commission), focused on the access to services by different population groups and long-term sustainability of the health care delivery in Canada. The Commission’s recommendations led to an agreement in September 2004 whereby the Government of Canada agreed to transfer an additional CAN$41 billion over the next 10 years in support of Provincial health plans.

Because of the Provincial jurisdiction over health care delivery, there is a considerable variation in implementation across Canada despite the single set of principles established by the Canada Health Act of 1984. With the shift from matching Federal funding for health care to non earmarked block grants the historical 50:50 split has eroded to an 80:20 split in funding by the Provinces and Federal Government. Furthermore, since the 1984 Canada Health Act covers mainly payment of medical doctors and hospital services, other services are left out of formal coverage and to the discretion of the provinces. Services not included include things like ophthalmology, dentistry, physiotherapy, geriatric services and outpatient drugs. Some provinces cover some of these services. In other provinces, individuals and households have to carry the cost though supplemental insurance or out of pocket payments. Although everyone has access to care, General Practitioners (GPs) are used as gatekeepers for access to specialist care and waiting times for elective procedures and non-urgent care, mental health and elderly care are sometimes still long despite efforts to reduce them.
Reforms in Quebec and Ontario Healthcare Systems

*Quebec* is a predominantly French-speaking Province in Eastern Canada, with a population of 8 million compared with the total Canadian population of 35 million (2016). Key recent landmarks in the evolution of the Quebec Health Care System include the following:

- **Phase I: From 2003-2014**: Services were divided into 95 territories; there was the creation of the local integrated services; autonomy of operating units increased. At the same time, the reforms created fragmentation and redundancies.

- **Phase II: From 2015-today**: Services were once again merged into 26 territories rather than 95, with some regionalization. There is a sense of bureaucratization, with loss of autonomy gained in the previous phase.

*Ontario* is a predominantly English-speaking Province in Eastern Canada, with a population of 14 million compared with the total Canadian population of 35 million (2016). Key recent landmarks in the evolution of the Ontario Health Care System include the following:

- **Phase I: From 1990-2002**: There was an attempt to reduce fragmentation and to shift care from in-patient hospital care to primary care.

- **Phase II: From 2003-2010**: Accountability and efficiency was emphasized through performance contracting (with home care and some private providers).

- **Phase III: From 2010-today**: There was a shift in emphasis focus more on outcomes, quality and safety. Recently, the has been a shift to more patient-centered care, mirroring trends in the USA and elsewhere.
Professor Andre –Pierre Constandriopoulos emphasized the importance of Systems Integration and Care Management in the Quebec health system.

**Systems Integration and Care Management in the Quebec health system**

Integration can be thought of on several levels: a) normative (capacity to create a common societal and cultural values); b) functional (governance, management and financing); c) clinical level (among practitioners); and (d) patient level (integration between patients and practitioners around patient care).

The purpose of integration is to: a) welcome, listen, explain, reassure the individuals that they can be taken care of; and b) increase the efficiency and effectiveness to diagnose and treat medical conditions; c) provide orientation and support to patients during the entire time they are ill or have health-related disorders.

The main challenge for integration is to create a long-term and durable framework to promote the cooperation among different stakeholders, and shared values.

Historically, several factors have contributed to fragmentation starting in 1980s when there was a health paradigm shift towards: a) a medicalization of ways to look at many things in society; b) more reliance on technology; b) and c) changes in the role of governments (diminished) with a greater reliance on markets, private sector and patient preferences (increased). All of these mitigated against integration.

- Among the factors that promoted integration were the following: the completion of the demographic transition, there is an ageing of the population, both in terms of the number and percentage of people in the higher age groups, a need for more service integration for this segment of the population.
- The continuous deterioration in the environment (around 6 million deaths attributable to the environmental causes), with a need for inter-sectorial approaches to health problems.
Professor Francois Champagne provided a framework for evaluating the performance of a health care system.

Measuring the performance of a health system remains a major challenge. There is a lot of data available on health systems. But there are no standard accepted guidelines for measuring outcomes and impact that might be influenced by changes in the health systems, inputs, process and outputs.

To address this problem, the researchers at the University of Montreal have developed and are testing a complex systems performance evaluation tool which looks at several key variables: adaptability, attaining of goals (i.e. effectiveness; efficiency; equity; etc), maintaining values, factor of production (i.e., all things that go into producing services) and other improvements.

Popular dissatisfaction with poor services responsiveness have increased partially because of: a) waiting lists and consumer quality of services nevertheless put a pressure on policy makers; and, (b) partially because increase in population expectation, not necessarily related to deterioration of the health care system.

Policy makers have been slow to respond, partially because of competition for attention from repeated global financial crisis and partially because of various conservative political trends concerned with the impact of social spending on fiscal space. Reforms that did occur every five to seven years, were often more of an expression of political cycles (elections), than a response to the need to reform the health system. In Quebec, three major reforms are noteworthy:

- **1970**: Introduction of the universal health care reform with the model of integration using the US Kaiser Permanente model
- **1990**: The creation of the integrated health and social services.
- **2014**: Continued emphasis on increasing integration of the service delivery system, both horizontally and vertically

Despite past progress, successful experiences in Quebec have tended to be small experimental programs that still need to be scaled up and generalized.
Dean Rejean Herbert provided an overview of the Montreal School of Public Health

Innovative work on supporting patient autonomy in the ambulatory setting

The Montreal School of public health which opened in 1911 has 700 students enrolled in Master and PhD degree programs today.

The school is extensively involved in innovative public health and health policy research. One particular program is the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) in Canada supported by the Canadian Policy Research Networks (CPRN), Ottawa.

Canada spends 1.2 percent of GDP to home care, surpassed only by the Nordic countries. Most of these funds are used to pay for medical services rather than other social care needs, the main challenges faced by the elderly living in a domestic setting.

The goal of the (PRISMA) was to develop systems and mechanisms that will lead to more coordinated, efficient and effective services to frail seniors living in the community. Specifically the pilot project intended to create an inter/intra organizational structure with a single point of entry to assess, coordinate, monitor and evaluate multidisciplinary services being delivered by practitioners, public service providers and volunteer organizations serving the elderly.

According to the program, service integration means:

- Culture changes that will bring together the stakeholders needed by the elderly
- Single entry point (on stop show operating 24/7)
- Case-managers covering different levels of care rather than specific institutions
- Individualized service plans for specific patients
- A new assessment tools to evaluate disability and handicap
- A specific computerized EMR for elderly patients

The pilot project using this approach has been conducted in three sites, one urban and two rural areas affecting 1500 people. Preliminary results so far have been encouraging, including improved functionality, reduced hospitalization, identification of shortcomings in care management coordination. The program highlighted the importance of identifying local champions for better coordination, and lack of funds for GP involvement. The challenge is now to scale up and generalize this experience for the benefits of the elderly in Quebec.
The study tour team visited the Leadership program in Health Care Management, Desautels Faculty of Management at McGill University.

**Site Visit at Desautels Faculty of Management at McGill University:**

Professor Henry Mintzberg discussed the challenge of managing the myths of health care.

A first myth relates to who is better at managing health care facilities, a hot topic for debate in health care. There are two schools of thought:

*Professionals.* The old approach which was popular in Canada in the past (and still is popular in some countries, especially developing countries today) was to have successful health care professional promoted to management and leadership positions. The argument for this approach is that doctors know health care and have the respect of other staff. The counter argument is that the clinical model which is based on protocols and following standards often leads doctors to be bad managers of health care facilities, because good management requires many other skills than just clinical. Nurses have broader team management and people skills but often do not command the authority of highly trained medical staff.

*Masters of Business Administration (MBAs).* The newer approach is to have MBAs parachuted in to lead health care facilities. The argument for this approach is that MBAs are trained in management and business skills that goes well beyond that of a clinically trained doctor. The counter argument is that MBAs often do not fully understand the social model of health care or how to deal effectively with highly trained technical and independent technical staff that don’t being told what to do in the clinical management of their patients.

- So who is better at leading health institutions? The answer is that Health care is a calling and not a business. There are no silver bullets in choosing leaders or managers based on training. Some people simply have a better personality and people skills to lead complex organizations. Identifying such people can be a hit and miss process.

A second myth is that healthcare systems are failing. On the contrary, healthcare systems suffer from their own success not failure. Because of knowledge on prevention and clinical care, people are living much longer today than before. Taking care of older people at the end of their lives requires more of a social services response than curative care interventions. Most countries are just beginning to learn how to deal with this problem and patients often need “Health navigators” to help get the right information about all the needed services and options available at different stages of their lives.

Several other healthcare myths were discussed.
Tuesday, June 6th 2017

**MCGILL UNIVERSITY HOSPITAL CENTER IN MONTREAL**

*Site Visit to Emergency, Ambulatory and In-patient Care Facilities*

10:00 – 10:05 *Introduction* – Eric De Roodenbeke

10:05 – 12:00 *CIUSSS du Centre-Sud* – Richard Massé

Open Lunch

15:00 – 15:05 *Introductions* – Eric de Roodenbeke

15:05 – 17:30 *McGill University Hospital Group* – Pierre Major & Normand Rinfret

18:30 – 21:00 *Private Reception* - Medtronic at Hall Residence
Normand Rinfret, Pierre E. Major and other staff from the McGill University Health Centre (MUHC) provided vivid highlights from one of the world’s foremost academic health centers.

**MUHC Highlights**

The MUHC was founded in 1997, through the merger of five Montreal hospitals: the Montreal General Hospital, the Royal Victoria Hospital, the Montreal Children's Hospital, the Montreal Neurological Hospital and Institute, and the Montreal Chest Institute. The goal of this historic merger was to create a modern academic health center where the resources and activities of the five founding hospitals would be consolidated for the benefit of all the Quebeckers they serve. Later, in 2008, the Lachine Hospital and Camille-Lefebvre Pavilion joined the MUHC family, adding a community-focused hospital to the MUHC family.

In 2015, the MUHC underwent an historic transformation and the biggest hospital move in Canadian history, when three of its founding hospitals (Royal Victoria Hospital, the Montreal Children’s Hospital, and the Montreal Chest Institute) transferred to a new healthcare complex located on the site of the former Glen rail yards in Notre Dame de Grace. Notably, 154 inpatients were safely transferred from the Royal Victoria Hospital to the Glen site in 5 hours 20 minutes; 66 children were safely moved from Montreal Children’s Hospital in 3 hours and 57 minutes; and 17 patients were safely transferred from the Montreal Chest Institute in 2 hours.

From its beginning 150 years ago when Dr. William Robertson performed the first operation at the newly built Montreal General Hospital (MGH now MUHC) in 1822 and establish the Canada’s first medical school in 1825. MGH has a long list of distinguished accomplishments like the creation of the first respirator called the "Iron Lung" in 1932. Over the next century, MGH received the well-deserved distinction one of the few Canadian “Ivory League” – standard health care centers.

Today, the MUHC provides exceptional multidisciplinary patient-centric care. Affiliated with the Faculty of Medicine of McGill University, the MUHC continues to shape the course of adult and pediatric medicine by attracting clinical and research expertise from around the world, assessing the latest in medical technology, and training the next generation of medical professionals. It has one of the first fully automated labs in the world and other cutting edge technology advances.
Wednesday, July, 29th 2016

THE ARBEC HEALTH GROUP IN THE LANAUDIÈRE AND LAURENTIDES REGIONS NORTH OF MONTREAL

Extended Care and Innovative Delivery Models

09:30 – 09:35 Introduction - Alexander S. Preker

09:35 – 12:00 General Overview of Long-term Care in Quebec - Paul Arbec

Networking Lunch

15:00 – 15:05 Introduction – Alexander S. Preker

15:00 – 17:00 Montreal Institute of Geriatrics – Isabelle Matte & Jouhayna Zahreddine
Mr. Paul Arbec presented the services provided by the Arbec Health Group in the Lanaudière and Laurentides Regions north of Montreal

The Canada Health Act of 1984 did not have detailed provisions for healthcare for the elderly or long-term care for the disabled. This was left to the provinces, both in terms of funding and provision of services. Most provinces have a complex mix of public and private engagement in this area.

The Arbec Health Group is an expanding third-generation private family business, specialized in the development and management of modern facilities for seniors experiencing a loss of autonomy.

Its network comprises ten locations in the Lanaudière and Laurentides Regions, north of Montreal, with 900 employees, 234 intermediate resources rooms, 418 rooms in residential and long-term care (CHSLD) and 34 rooms in seniors' residences. It is considered a high quality extended care network servicing both private for-pay and government subsidized residents.

The group prides itself for providing seniors that have a loss in autonomy with a warm, safe, and personalized environment while ensuring their daily well-being. It strives to create a client centered environment that is respectful to its residents even when they have a loss in autonomy.

The following are some background statistics for long-term care in Quebec, presented during the visit:

- The Province has 33,350 long-term care beds among which: (a) 6,800 private beds receiving some public subsidy (regulated and fixed payment); (b) 3,530 are private beds paid on an out-of-pocket basis or through private long-term care insurance.
- The female to male ratio is 60:40
- Many of the residents suffer from dementia, lack physical mobility and loss of family connections: 30 percent have no close family connections; and 30 percent receive only one family visit per week.
- On the subsidized public side, referrals are through the local geographic catchment area
- At the provincial level, there are 3,000 persons on the waiting list for long-term care.
- There are plans to build another 1,500 new long-term care beds to deal with this backlog.

In this context, private operators like the Arbec Health Group, provides a valuable service for the province in the area of long-term residential care.
Ms. Isabelle Matte and Ms. Jouhayna Zahreddine presented the services provided through one of the Integrated University Social and Health Service networks

Since April 1, 2015, the Integrated University Social and Health Service Network of Center South region of the Island of Montreal provides an integration mechanism for 10 health and social services organizations in that geographic area. The aim is to provide better care for patients that need both social and health care services in an integrated manner.

The Montreal Institute of Geriatrics the Province of Quebec’s leader in clinical practice, specialized care, health promotion and development of knowledge related to aging and seniors’ health. It provides various short-term and long-term programs, including intensive functional rehabilitation, short-term geriatric assessment, long-term care, living accommodations and an ambulatory center.

It is considered one of the only geriatric pain management clinics in the world as well as a Cognitive health center working to promote, maintain and improve seniors’ cognitive health.

The Institute also includes teaching and research facilities on health and aging, on a national and international scale. Supported by a strong research fund and affiliated with the University of Montreal, the Institute is considered as one of the best references in its field, for the broadcast of its expertise, its technology assessment capabilities as well as its intervention initiatives.

The complementarity between private players like the Arbec Health Group, the Montreal Institute of Geriatrics and the provincial Integrated University Social and Health Service networks, makes Montreal one of the best locations in integrated geriatric care in the world.
Thursday, June 8th, 2017

FEDERAL ROLE IN HEALTH CARE IN CANADA IN OTTAWA

Role of National Organizations in Ottawa

10:00 – 10:05 Introduction - Eric de Roodenbeke

10:05 – 11:30 HealthCareCan – Bill Tholl

Networking Lunch

14:00 – 16:00 Canadian Institute for Health Information – Brent Diverty

Wrap up and Closing Remarks

Introductory Remarks

Although the Federal Government plays a minimal role in Canada in terms of direct provision of health services to patients, together with a range of Federal Agencies, professional bodies and non-governmental organizations, it has an important function in terms of the funding and intelligence function in the Canadian health system.
Mr. Bill Tholl, the outgoing President of HealthcareCan presented a summary of recent reforms in Canada

HealthCareCAN is a membership-based organization that was formed through a merger of the Canadian Healthcare Association and the Association of Canadian Academic Healthcare Organizations in January 2014. It’s mission is to advance an integrated, innovative, sustainable and accountable approach to healthcare: (a) being the collective voice of Canada’s healthcare organizations; (b) enhancing pathways to innovation; (c) supporting service excellence across the continuum of care; and (d) developing the health leaders of today and tomorrow.

In just a few years, HealthCareCAN has become the national voice of healthcare organizations and hospitals across Canada. It fosters an informed and continuous dialogue among the main actors that are involved in providing healthcare to Canadians, focused on building capability for high quality care and in ensuring value for money in publicly financed, healthcare programs.

Notable highlights from the visit to HealthCareCAN was an overview of major recent changes in healthcare delivery in the different provinces:

1. The shift in funding to block grants for health care from the Federal Government to the Provinces and Territories.
2. Continued rise in private sending (out-of-pocket and supplementary private health insurance to cover non-mandated services (comprising 30 percent of total funding today).
3. Maintenance of portability between the provinces, ensuring that Canadians have full access to care across the country.
4. With the exception of Quebec, hospital in all other Provinces are no longer legal entities.
5. A continued swing back and forth at the provincial level between devolution to regions and re-concentration. Most provinces today are merging smaller regions into larger catchment areas.
6. Continuation of a philosophy of public administration with:
   a. Strong regulatory oversight in the areas of new pharmaceuticals, new medical technologies and health IT. This has led Canada to becoming a global leader in new technology assessment and price controls in the pharmaceutical sector.
7. Doctors, on the other hand, have resisted reforms and are still mostly independent contractors paid on a fee-for-service basis, not on salary, with ongoing re-negotiation of the fee structure at the provincial level.
Brent Diverty and colleagues from the Canadian Institute for Health Information (CIHI).

The Canadian Institute for Health Information (CIHI) is an independent, not-for-profit organization that was established in 1994 as one of the key recommendations of the The Royal Commission on the Future of Health Care in Canada (Romanow Report). It contributes to the improvement of the health of Canadians and the healthcare system through the collection, analysis and dissemination of health information. Its vision is to be a leading source of unbiased, credible and comparable information so that Canadian healthcare organizations and leaders will be able to make better-informed decisions. It has offices in Ottawa, Montreal and Victoria, British Columbia.

CIHI tracks data in the different provinces with the help of information that is provided by hospitals, regional health authorities, medical practitioners and governments bodies. This information is then analyzed and disseminated through various paper and web-based reports. The aims of the analysis is to:

1. Provide insights into the effectiveness and efficiency of the health care system in Canada with respects to the populations needs
2. Link the performance of the health care system to the actual outcomes; and
3. Help decision and policy makers assess the changes in policies, practices and processes and their impacts within the health care system.

Currently CIHI is working on an enterprise warehouse approach: making all data compatible and of good quality. Focusing on priorities for next 5 years:

- Patience experience
- Quality and safety
- Outcomes and
- Value for money
Social Activities

Mr. Bill Tholl, the outgoing President of HealthcareCan, hosted warp-up lunch with the Canadian Deputy Minister, some of his senior staff and senior executives from Accreditation Canada, Canadian Institute for Health Innovation (CIHI) at the Rideau Club, one of the prestigious social Clubs in Canada.

In addition to the academic program, the Montreal 2016 Executive Study Tour also allowed the participants to enjoy a wide range of social activities, excellent food, and the culture of both Metropolitan Montreal and the historic sites in Ottawa, the nation’s capital. Following the academic part of the visit, a few participants stayed joined the jet set from around the world for the F1 Grand Prix and the celebrations of 375th anniversary of Montreal and 150th Anniversary of Canada.
Summary

Canada is successful in providing a comprehensive range of medical and social services through public finance, free of fees at the point of care for its citizens. The country has made a strong commitment to continue to provide high quality care under a system that will remain mainly public. The federal government allows a high degree of autonomy to provinces concerning the funds they receive with the condition to respect the core principles such as provide comprehensive services to its citizens free of charge at the point of delivery, universal in nature, portable across provinces, and accessible. In provinces such as Quebec successful models of integrating medical with social services exists. Care for the elderly, delivered in both public and private facilities is very important and thus provinces and the government embarked in strong partnerships together with the private sector to find optimum solutions for the aging population. The care for the elderly is seen as a society responsibility, not a burden for families or individuals like in other countries. The aim of these partnerships are to increase the mobility, autonomy and emotional support for these patients. The lessons learned in Canadian education centers such as McGill University and University of Montreal contribute to knowledge about health care organizational, management, research and clinical interventions around the globe.

But like most countries, improving health care in Canada continues to be an ongoing challenge and endeavor with a close interplay between politics, policy, governance, socio-economic trends, and expectation/demand by the population.

The International Hospital Federation is committed to helping its members continue to learn from others. Another Hospital Executive Study Tour is planned for Israel in mid-2018. For more information about this follow up opportunity please see www.executivestudyvisit.com.
Bios of Speakers

Paul Arbec, President and General Director, Arbec Health Group, Quebec

Paul Arbec is the President and General Director of the Arbec Health Group, a post he has held since 1999. Mr. Arbec's role within the organization, as well as the organization as a whole, has evolved considerably over the last twenty-five years. He invested his first five years in auxiliary services, heavy work and renovations, then moved to administration (purchases, payroll, accounts payable, accounts receivable), through the Human Resources Department and the Administrative Services Department. He is a Founding member of the Association of Long-term Private Institutions of Québec (AELDPQ); a Member of the Board of Directors of the Association of Self-Funded Private Care Centers (ACAPA); a Member of the board of directors of the Association of Private Colleges for; a Member of the Board of Directors of the Laurentides / Lanaudière Health and Social Services Supply Corporation for over 15 years; as well as several other influential groups dealing with the care for the elderly in Quebec. Mr. Arbec studied administration at Concordia University in Montreal and completed, in June 2008, training in residential management and private CHSLDs offered by the Université de Sherbrooke and the Association des Résidences and private CHSLDs in Quebec (ARCPQ).

François Champagne, Professor, Department of Management, Policy & Evaluation, School of Public Health, University of Montreal, Montreal

François Champagne is a Professor in the Department of Management, Policy and Evaluation in the School of Public Health at the University of Montreal. He is a researcher at the Institute of Public Health Research (IRSPUM) and a contributor to the International Health Unit at The School of Public Health of the University of Montreal. From 2003 to 2013, he was the Scientific Assistant to the Canadian Health Services Research Foundation, now the Canadian Foundation for Health Services Improvement, and was Chair of the Canadian Institutes of Health Research Institute's Advisory Board. Services and policies from 2004 to 2007. He was one of the founders and co-chairs of HealNet / Relais, a Canadian network of centers of excellence, dedicated to research on optimizing the use of Evidence in health decisions. In 2002, he received the Recognition Award from the Société québécoise d'évaluation de program. He has published books in French, English, Spanish and Portuguese on the use of epidemiology in management, research methods, assessment, quality of care and performance of health care organizations. Since 1976, he has often acted as a consultant for health care organizations, international organizations and governments in Canada, France, Africa, Brazil, Haiti, Turkey, the United States and in China. His training includes a Ph.D. Community Health (University of Montréal) and M.H.A. [Master of Health Administration] (University of Ottawa)
André-Pierre Contandriopoulos, Professor Emeritus, Department of Management, Policy & Evaluation, School of Public Health, University of Montreal, Montreal

André-Pierre Contandriopoulos is a Professor Emeritus in the Department of Management, Policy and Evaluation in the School of Public Health at the University of Montreal. He is member of the Royal Society of Canada and of the Canadian Academy of Health Sciences. Professor Contandriopoulos’ research and public interventions have had a significant impact on the evolution of Quebec’s public health system. In particular, his work on the financing of care and the importance of preserving a public and universal health insurance system have often been at the heart of many public debates on this theme. He has trained dozens of masters and doctoral students and his ideas have had a significant influence in the field throughout the world. Several of his former students and colleagues have eventually ended up in senior positions in international organizations like the World Health Organization and the World Bank where his ideas and thought leadership have benefitted countless populations in developing countries.

Jean-Louis Denis, Professor, Department of Management, Policy & Evaluation, School of Public Health, University of Montreal and Chair on Governance & Transformation in Health Care and Systems Health Innovation Forum, Montreal

Jean-Louis Denis is a Professor in the Department of Management, Policy and Evaluation in the School of Public Health at the University of Montreal. He is a researcher at the Institut de recherche en santé publique de l’Université de Montréal and visiting professor at Euromed Management (Marseille). He has worked for over 20 years in the training of health system managers and as a researcher in the transformation of healthcare organizations and systems. Author of numerous papers on governance and the process of change in healthcare organizations and systems, his current research looks at the integration of care and services, healthcare reforms, medical leadership and leadership in professional organizations, and the role of scientific evidence in the adoption and implementation of clinical and managerial innovation. He is a member of the Royal Society of Canada, Fellow of the Canadian Academy of Health Sciences and chair of the advisory board of CIHR’s Institute of Health Services and Policy Research.

Brent Diverty, Vice President of Programs at Canadian Institute of Health Informatics (CIHI), Ottawa

Brent Diverty is the Vice President of Programs at CIHI. He has executive responsibility for CIHI’s range of health services, expenditure and workforce data holdings and many of the standard information products that flow from them. Prior to re-joining CIHI in February 2013 Mr. Diverty spent two years at the Australian Institute of Health and Welfare in Canberra where he provided strategic leadership to the organization as a member of the executive team and programmatic leadership to a diverse portfolio of health and welfare information programs. Previously Mr. Diverty worked as a director at CIHI in management consulting roles and at Statistics Canada. Over his 20-year career he has worked on both the supply and demand sides of data and information in most cases with a focus on health
services and population health. He holds an MA in economics from McMaster University with a specialization in health.

Asmita Gillani, Partner on Global Policy, Health Standards Organization (HSO) and Accreditation Canada, Ottawa

Asmita Gillani is a Partner on Global Policy for the Health Standards Organization (HSO) and its affiliate, Accreditation Canada. HSO is a premier international organization for developing and assessing healthcare standards to improve quality of care worldwide. Prior to joining HSO, Ms. Gillani was the Chief Executive Officer at the Aga Khan University Hospital (AKUH) in Nairobi, Kenya, which is part of the Aga Khan Development Network, headquartered in France. AKUH is a major University Teaching and Referral Hospital with over 45 satellite medical centers in multiple countries. More recently, she was the Regional Director for Africa where she led the establishment of high quality healthcare facilities in East, Central and West Africa. Before her tour of duty in Africa, she was the Chief Operating Officer and interim Chief Executive Officer of Mackenzie Health Centre (formerly known as York Central Hospital) in the Greater Toronto Area in Ontario, Canada. Ms. Gillani has over twenty years of international executive experience in leading complex national multi-site health care organizations. Her international health care experience includes working in the UK, Canada, Saudi Arabia and East Africa in both public and private sectors. Examples of her recent accomplishments include: Leading the design of an Integrated Health System consisting of four hospitals, 66 satellite medical centers and 5 primary care centers in four countries; Establishing the first comprehensive Heart and Cancer Centre in sub-Saharan Africa; Transforming a community hospital into a major Academic Medical Centre and establishing post graduate residency programs in nine medical disciplines and two clinical fellowships; Redefining the role of Primary Medical Centers in rural Africa to include birthing services with dramatic improvements in MDG (SDG) goals in select populations. Through her extensive travels to some of the poorest healthcare settings, she has developed a deep appreciation of the resilience of the human spirit and of the innovations that come from necessity.

Réjean Hebert, Dean, School of Public Health, University of Montreal, Montreal

Réjean Hebert is Dean of the School of Public Health at the University of Montreal. He holds a diploma in geriatric medicine from the University of Sherbrooke and a master's degree in epidemiology from the University of Cambridge. He was the first Scientific Director of the Institute of Aging of the Canadian Institutes of Health Research, after he created the Center for Research on Aging at the Sherbrooke University Institute of Geriatrics, in 2001. He was Dean of the Faculty of Medicine and Health Sciences at the University of Sherbrooke from January 2004 to September 2010. Elected MP in September 2012 and subsequently appointed Minister of Health and Social Services and Elders in the same year. In addition, he was appointed Minister responsible for the Estrie Region. He has carried out work that has had a significant impact on the health service of the elderly. It is engaged in the definition of public policies for the elderly and caregivers. Réjean Hébert is a full professor in the Department of Health Administration at the University of Montreal.
University’s School of Public Health since 2014. Hébert is a member of the Canadian Academy of Health Sciences (2005). His training includes a MSc Epidemiology (University of Cambridge) and a Ph.D. in Geriatric Medicine (University of Sherbrooke).

**Pierre E. Major, Associate Director of Planning, Project Management and PPP Contracts, McGill University Health Center (MUHC), Montreal**

Pierre E. Major has over twenty-five years of management experience at the MUHC, many years of which closely tied to the organization’s redevelopment project and its relationships with external stakeholders such as the City of Montréal, Government of Québec, transport bodies and community groups as well as with internal stakeholders. Currently, as the Associate Director of Planning, Project Management and PPP Contracts—a $2.355 billion modernization project—Mr. Major provides strategic oversight and helps coordinate a broad range of activities related to project planning, project management and PPP contract management at the Glen site. He also participates in the finalization of the transportation plan for the Glen Site (new entrance to the site via the Vendôme multimodal station) and the reuse of existing properties, several of which are of heritage value. Mr. Major holds a Bachelor of Science degree and a Master of Health Administration from the University of Ottawa.

**Geneviève Martin, Director of Canadian Accreditation, Accreditation Canada, Ottawa**

Geneviève Martin is the Director of Canadian Accreditation at Accreditation Canada, an affiliate of HSO (Health Standards Organization). In this role, Ms. Martin works with a team of highly skilled professionals who support client organizations in their quality improvement journey. Ms. Martin’s experience includes working as a special project lead and clinical specialist at the Canadian Institute for Health Information. She also worked as a research and policy analyst for the Commission on the Future of Health Care in Canada (Romanow Commission). Prior to completing her Masters degree in public administration, Ms. Martin worked as a physiotherapist in rehabilitation and acute care settings in several Canadian provinces. She also worked on international rehabilitation projects in Armenia, Ukraine, Albania, Kosovo and Guatemala.
Richard Massé, Director of Public Health at CIUSSS du Centre-Sud, Montreal, Former Assistant Deputy Minister of Health and Chief Medical Officer for Health (CMOH, Québec)

Richard Massé has been Director of public health at CIUSSS du Centre-Sud_de-l’Île-de-Montréal since April 2012. He is a community health specialist. From 1998 to 2003, Dr. Massé served as Assistant Deputy Minister of Health and Chief Medical Officer for Health (CMOH) for the province of Québec, and then as President and CEO of Institut national de santé publique du Québec. He has also had a prolific academic career as assistant professor in the Department of Epidemiology and Biostatistics, McGill University, as well as Director of Université de Montréal's School of Public Health. Since 2008, he has been an associate professor in the Department of Social and Preventive Medicine at Université de Montréal. Throughout his career, he has sat on several committees, participated in numerous research projects and has over 30 publications to his name. Under his leadership, INSPQ produced nearly 80 public policy notices as well as scientific and technical documents on a variety of topics such as communicable diseases, suicide prevention in youth, use of cellphones while driving, and health and aging, to name a few. As Director of public health, Dr. Massé has taken on two public health priorities: reducing social inequalities in health and chronic disease prevention and management. His strategies target three main risk factors associated with chronic diseases—smoking, poor diet and sedentary lifestyles—and implementation of healthy public policies. He is committed to using scientific evidence, enhancing evaluations of population health initiatives as well as the health impacts of public policies.

Isabelle Matte, Associate Director of Long-Term Care, Support Program for the Autonomy of Seniors, Integrated Health and Social Services University Network (CIUSSS), South-Central Montreal

Isabelle Matte has been the Associate Director of Long-Term Care within the Support Program for the Autonomy of Seniors of the Integrated Health and Social Services University Network (CIUSSS) for South-Central Montreal since May 2015. This long-term care services branch, with over 2,800 long-term care beds in 17 long-term care facilities and nearly 4,000 employees is one of the largest in Quebec. Ms. Matte holds a post graduate degree in Social Administration and is specialized in social work. In 2013, she was Director of the Long-Term Care in the CSSS du Sud-Ouest-Verdun which had 7 facilities and 1187 long-term care beds. Prior to this, she was a counselor for the environment in long-term care, then site coordinator at the Champlain Long-Term Care Centre and before that, worked for 12 years at the Pointe St-Charles Community Clinic (a private institution with a Local Community Service Centre mission), three of which were in the Senior Management.
Henry Mintzberg, Cleghorn Professorship of Management Studies, (Strategy and Organization), Montreal

Henry Mintzberg is the Cleghorn Professor of Management Studies Strategy and Organization International Masters for Health Leadership. Mintzberg is an internationally renowned academic and author on business and management. Perhaps the most distinctive feature of Mintzberg’s research findings and writing on business strategy, is that they have often emphasized the importance of emergent strategy, which arises informally at any level in an organization, as an alternative or a complement to deliberate strategy, which is determined consciously either by top management or with the acquiescence of top management. He has been strongly critical of the stream of strategy literature which focuses predominantly on deliberate strategy. Mintzberg joined McGill's Faculty of Management in 1968 and was awarded the Bronfman Chair in 1982. In addition to teaching at McGill, he has been a Visiting Professor at the Université d'Aix Marseille (France), Carnegie-Mellon University, École des Hautes Études Commerciales (Montreal), the London Business School (England) and INSEAD (France). He holds a joint appointment at INSEAD in France. Henry Mintzberg is also a former President of the Strategic Management Society. Henry Mintzberg’s current research interests are general management and organization, including the process of strategy formation, the design of organizations and the impact of design on organizations. He runs two programs at the Desautels Faculty of Management which have been designed to teach his alternative approach to management and strategic planning: the International Masters in Practicing Management in association with the McGill Executive Institute and the International Masters for Health Leadership. With Phil LeNir, he owns Coaching Ourselves International a private company using his alternative approach for management development directly in the workplace.

Alexander S. Preker, CEO Health Investment & Financing, and Commissioner, Global Commission on Pollution, Health and Development, New York, NY

Alexander S. Preker is President and CEO of the Health Investment & Financing Corporation and a Founding Member of the New York Chapter of the Keiretsu Forum and LLP with Keiretsu Capital. He is a Commissioner with the Global Commission on Pollution, Health and Development and Chairs the External Advisory Committee for the WHHSJ of the International Hospital Federation. He is a Member of the Board of the USA HealthCare Alliance and several health care companies. Mr. Preker was a former Head of the Health Industry Group and Health Investment Policy Analysis for the Investment Climate Advisory Services of the World Bank Group. He leads a team of advisors and analysts that work with policy makers, investors and health businesses in improving the market environment for private sector participation in the health sector in developing countries. Mr. Preker has had a distinguished career, working at different times for World Bank, International Finance Corporation (IFC) and World Health Organization (WHO). Previously, as Chief Economist for the health sector, he coordinated the technical team that prepared the World Bank’s Health, Nutrition and Population Sector Strategy in 1997. Mr. Preker is an Adjunct Professor of Health Policy and Management in the Mailman School at Columbia University in New York and an Adjunct Professor of Public Administration and Health at the Wagner Graduate School of Public Service at New York University. He is a member of the teaching faculty for the Berkeley/Cambridge Health Leadership
Normand Rinfret, Former Director General and CEO of the McGill University Health Centre (MUHC), Montreal

Normand Rinfret is the former Director General and CEO of the McGill University Health Centre (MUHC). He is a seasoned executive with over thirty years of management experience in the health sector. In 2012, Mr. Rinfret was named unanimously by the Board of Directors of the MUHC to the position of Director General and CEO. Subsequently, as a result of the Quebec government’s decision to modify the organization and governance of the health and social services network, Mr. Rinfret re-applied for his position and was appointed in March 2015 by the Ministry of Health and Social Services to the newly-named role of President and Executive Director. In September 2016, Mr. Rinfret stepped down from his role at the helm of the MUHC. Mr. Rinfret leveraged his vast knowledge and experience in administration, governance, labour relations and government negotiations to influence and shape positive changes at the MUHC and, more generally, in the health sector. Between 2005 and 2015, he worked tirelessly to assure that the MUHC prepared meticulously for the opening of the $1.3-billion state-of-the-art Glen site, including the harmonization and optimization of practices, the highly-orchestrated moves of departments and clinical/research units as well as the safe transfer of pediatric and adult patients from legacy sites. In parallel, he supported the foundations’ collaborative efforts to complete the $300-million Best Care for Life campaign, returned the organization to fiscal equilibrium in record time and continued to drive the organization’s plans for the future forward. During his tenure, Mr. Rinfret established rigorous governance mechanisms and a performance culture based on continuous improvements.

Eric de Roodenbeke, CEO of the International Hospital Federation, Geneva

Eric de Roodenbeke assumed the position of Director General of the International Hospital Federation in June 2008. Between July 2007 and May 2008 he was Senior Health Specialist at the World Health Organization (WHO) for the Global Health Workforce Alliance (GHWA) during which time he was involved in support country action programs to develop a response to the HRH crisis; development of strategies for regional networks in support of HRH development and was the focal point for follow up actions in Francophone countries. He was Senior Health Specialist at the World Bank (AFT2 & WBI) from 2004 to 2006 in which time he was Team leader (TL) for various health intervention, educational, management and capacity building programs mostly in Africa. He was Director of a hospital of the University Hospital (CHU) of Tours, and Senior Officer responsible for hospital and health financing interventions at the French Ministry of Foreign Affairs from 2001 to 2003 and 1999 to 2001, respectively. Between 1996 and 1998, he was Senior Officer on hospital policy expertise at the French Ministry of Cooperation. From 1994 to 1996, he was Deputy Director of the 870-bed University Hospital of NANTES. 1989 to 1994, Dr. de Roodenbeke was the Expert, task team leader for a project involving construction,
equipment, management of a 500-bed hospital in, Burkina Faso. He was Deputy Director of Epinal-Vosges (France) General Hospital from 1984 to 1989. Dr de Roodenbeke has published widely on hospital organization, health systems reforms human resources and health facility management, health policy, insurance and financing in developed and developing countries. Dr. de Roodenbeke holds a Ph.D. in health economics - University of Paris 1, Sorbonne (France); a Hospital Administration Diploma from ENSP Rennes (France); and a Diploma in Public Health from the University of Nancy (France).

Bill Tholl, Founding President and CEO of HealthCareCAN, Ottawa

Bill Tholl serves as the Founding President and CEO of HealthCareCAN (formerly the merged Association of Canadian Academic Healthcare Organizations and the Canadian Healthcare Association). The mandate of the new organization is to speak with one unified voice on behalf of Canada’s healthcare community to advance organizational and health system performance. Mr. Tholl is a respected senior executive, with extensive experience in health policy, planning and financing in Canada and abroad. Prior to joining HealthCareCAN, he was the Founding Executive Director of the Canadian Health Leadership Network (2009-2014). This network was formed to increase leadership capacity throughout Canada’s health and healthcare systems. Mr. Tholl also served as CEO and Secretary General, Canadian Medical Association (2001-2008) and CEO of the Heart and Stroke Foundation of Canada (1995-2001). The Globe and Mail has described Bill as “Medicare’s Mr. Fix-it”. He is a much sought-after speaker, being billed as a “leader of leaders” for his pioneering work with CHLNet. He is the lead author of “Twenty Tips for Surviving and Prospering in the Association World” (Canadian Society of Association Executives, 2010) and has written on many topics, most recently as the co-author of “Bringing Leadership to Life in Health” (Springer, January 2014). He was the recipient of numerous national awards and is a Certified Corporate Director (ICD.D). Prior to these appointments, he served as a senior public servant with the Government of Canada. Mr. Tholl has served as an associate faculty member at Royal Roads University and as a lecturer in health leadership, policy and economics at the University of Ottawa. He holds a Master’s Degree in health economics (from University of Manitoba).

Jouhayna Zahreddine, Site Coordinator, Montreal Institute of Geriatrics, Montreal

Jouhayna Zahreddine has been the Site Coordinator for the Montreal Institute of Geriatrics since November 2016. The Institute has 446 long-term care beds and an active program for short-term geriatric care. For the past 12 years, she has held various positions at the Montreal Institute of Geriatrics, notably as head of administration for the geriatric evaluation and post-acute care programs and as head of the housing unit. A nurse by training, she holds a Master’s degree in aging, health and society and a Diploma in cultural diversity.
Participants in Ottawa Networking Lunch

Owen Adams, Chief Policy Advisory, Canadian Medical Association
Gavin Brown, Director, Health Care Systems, Health Canada
Paul-Émile Cloutier, Incoming President & CEO, HealthCareCAN
Brent Diverty, Vice President, Canadian Institute of Health Information (CIHI)
Asmita Gillani, Partner, Global Programs, Health Standards Organization, Accreditation Canada
Simon Kennedy, Deputy Minister, Health Canada
Daviel Levac, President and CEO, Elizabeth Bruyère Hospital
Genevieve Martin, Director, Accreditation Canada
Louise Ogilvie, Vice President, Canadian Institute of Health Information (CIHI)
Carolyn Pullen, Director, Policy, Advocacy and Strategy, Canadian Nurses Association
Bill Tholl, Outgoing President & CEO, HealthCareCAN
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Alexander S. Preker

Mr. Alexander S. Preker is President and CEO of the Health Investment & Financing Corporation and a member of the board of several of the companies in which the group has invested. He is a Founding Member of the New York Chapter of the Keiretsu Forum and an LLP with Keiretsu Capital. Mr. Preker is one of the Commissioners for the Global Commission on Pollution, Health and Development, a Member of the Board of the USA HealthCare Alliance, and the Chair of the External Advisory Committee for the World Hospitals and Health Services Journal of the International Hospital Federation. He is the Editor-in-Chief for the World Scientific Series on Health Investment and Financing. He is an Executive Scholar and Adjunct Professor at Columbia University, New York University and Ichan School of Medicine at Mt. Sinai.

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Hortenzia Beciu

Hortenzia Beciu is director for the Middle East and Africa at Johns Hopkins Medicine International. She provides direction and oversight in project management, research and analysis, and she participates in Johns Hopkins Medicine International strategic planning. Dr. Beciu has extensive experience in the health sector, working with governments, development partners and various health industry groups (hospital sector, pharmaceuticals, medical technology and information technology). Before joining the Johns Hopkins team, she worked at the World Bank and International Finance. Prior to her work at the World Bank, she worked with the Pan American Health Organization and the Institute for Health Services Management in Romania. She holds a medical degree from the Carol Davila University of Medicine and Pharmacy in Romania and a master’s degree in global health from the George Washington.
Executive Study Tour in Montreal 2017

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Eric de Roodenbeke
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