DOWNLOAD PDF SWEDEN CASTEN VON OTTER

Chapter 1 : Anne Sofie von Otter - Wikipedia

View Casten von Otter's profile on LinkedIn, the world's largest professional community. Casten has 4 jobs listed on their profile. See the complete profile on LinkedIn and discover Casten's.

This article has been cited by other articles in PMC. Abstract Health care systems in Sweden, Finland, and Denmark are in the midst of substantial organizational reconfiguration. Although retaining their tax-based single source financing arrangements, they have begun experiments that introduce a limited measure of competitive behavior in the delivery of health services. The emphasis has been on restructuring public operated hospitals and health centers into various forms of public firms, rather than on the privatization of ownership of institutions. If successful, the reforms will enable these Nordic countries to combine their existing macroeconomic controls with enhanced microeconomic efficiency, effectiveness, and responsiveness to patients. Introduction This article reviews current reform experiments and proposals that reflect the search for a new, specifically Nordic planned market approach to the delivery of health services. It examines both the intentions and the potential complications that accompany the present reform process. Finally, it considers a series of future factors that can be expected to affect the long-term implementation of Nordic planned market models. Searching for a new paradigm Health care systems in Sweden, Finland, and Denmark 1 are well reputed for their commitment to values of equity and social justice Anderson, Access to comprehensive health services has been a fundamental pillar of the welfare state approach articulated in the post-World War II period throughout the region by Social-Democrat-led governments Einhorn and Logue, In Sweden and Denmark, a regionally elected council, and in Finland a municipally elected council hired both an administrative staff to plan the necessary services and professional providers to deliver them. The result was a tax-based, publicly operated health system organized on a regional or municipal, democratically accountable, command-and-control basis. Based on their performance, health care systems in these three Nordic countries have been among the most successful in the industrialized world. On measures of health status like infant mortality, all three countries are among the lowest in the world, while life expectancy in Sweden and Denmark is among the highest NOMESKO, Although life expectancy in Finland is significantly shorter, particularly for males, the rate of improvement in the last decade has been significant, in part because of public policy toward health promotion World Health Organization, On financial measures, similarly, the Nordic countries have had stable or, in Sweden, declining aggregate measures of health expenditure as a percent of gross domestic product Schieber and Poullier, During the s, however, a series of new circumstances brought the long-term viability of the traditional Nordic planning approach into question. Among other factors, one can point to changes in demography for example, 18 percent of the Swedish population is 65 years of age or over compared with 11 percent in the United States , technology rapid advances in both invasive and non-invasive procedures, with a concommitant need for additional resources , and economy constraints on public sector spending reflecting economic convergence either inside [Denmark] or in parallel with [Sweden and Finland] the European Community as well as strong competitive pressures from the growing globalization of the world economy. The prior social ethic based on self-effacement was increasingly challenged by new forms of individualist behavior that included demands for more responsiveness to direct patient influence and treatment preferences within health care systems. What made this perception different from those that stimulated prior reform efforts, for example, decentralizing operating responsibility to county Sweden and Denmark or provincial Finland levelsâ€”was the shift in emphasis from continued commitment to command-and-control planning and its concomitant central administrative control to a widespread desire to establish a locally autonomous, incentive-driven, decisionmaking environment. The fact that this shift took hold in Sweden and Finland, with their then Social-Democrat-led governments Denmark, which has been something of a laggard in this process, has had a Conservative-led coalition administration since , and at roughly the same time as did the initiation of a similar reform process by a Conservative government in the United Kingdom, suggests the extent to which the fundamental pressures triggering this reform process in publicly operated health systems involved predominantly pragmatic rather than ideologically-driven criteria Saltman, The new wave of reform

in these three Nordic countries can be traced to a decision by Stockholm County to allow pregnant women to select whichever of eight maternity clinics they preferred, and to link those decisions directly to clinic budgets. In January , Stockholm County created a single fixed-price market in which maternity clinics were paid the estimated operating cost of an uncomplicated delivery. Although this experiment was not comprehensive the payments did not, for example, include personnel salaries or capital costs , it successfully introduced the twin notions of patient choice and money following the patient Saltman and von Otter, , both of which represented a radical departure from the prior command-and-control framework. A parallel inception in Finland was the introduction of capitation for general practitioners in the Personal Doctor Program Vohlonen et al. In a series of experiments around the country, citizens could choose to be on the list of a particular health center physician who would then be paid a three-part compensation predominantly determined by the size of his or her list 60 percent and the degree of population coverage. Although this experiment was subsequently transformed into the considerably less patient-responsive Small Area Population-Based Responsibility Group Program Saltman and von Otter, , the same seminal issuesâ€"patient choice inside the public system and money following the patientâ€"had been raised. Starting in , what began as a trickle widened into a flood of major reform experiments and proposals. Sweden and Finland are now making fundamental changes on the production side of their health systems. In Sweden, the new Conservative-led coalition government is also raising questions about how health care is financed. Although Denmark has been slower to take up the challenge, perhaps because of its weak coalition government, there are signs of movement there as well Organization for Economic Cooperation and Development, to be published. What began as an exercise in reformist reform, in an effort to mitigate problems of efficiency and responsiveness within Nordic health systems, has emerged as a full-fledged search for a new strategic model Gorz, Viewed functionally, the present approach combines longstanding social objectives equity of access to clinical services, population-based responsibility for preventive care, and better continuity of care among different service subsectors with more recent financial objectives increased efficiency of organizational performance, better management of existing institutional resources and an increased concern for enhanced patient influence over services received. Viewed conceptually, Nordic health policymakers have begun to select specific mechanisms from a neo-classical market model of health deliveryâ€"consumer choice, negotiated contracts, performance-linked payâ€"and inject them into existing command-and-control planning structures in an effort to develop a new hybrid health system model that can best be termed a planned market Saltman and von Otter, Although planned market frameworks can be configured in a number of different ways, their central characteristic is that they are intentionally designed markets, constructed by public sector officials in a manner that maintains public accountability over institutional behavior and that will achieve explicitly public sector objectives. This new hybrid paradigm extends beyond the Nordic Region to include current reforms in the United Kingdom in a more completely mixed market, contract-based format as well as proposed reforms to the production side of health care systems in Southern and Eastern Europe. Current reforms The present profusion of health reform projects and proposals in the Nordic countries can be grouped into two basic categoriesâ€"changes taking place predominantly inside the existing publicly operated systems, and changes concerning predominantly the private finance or delivery of health services. Although activities in these two subsectors are largely independent of each other, in both instances they reflect the current level of organizational ferment in the health sector overall. Moreover, as will be noted in a later section, certain initiatives involve the development of cross-boundary relationships between the health and social welfare sectors which had not occurred previously. Finland began its reform process rather more cautiously Vohlonen et al. Denmark, consistent with its long-term political as well as geographical posture of locating itself between the other Nordic countries and continental Europe, has only recently begun to move down a parallel health care reform road. These dual patternsâ€"public as much as private subsector changes, and Swedish leadership in the reform processâ€"organize the discussion of reform initiatives that follows. Predominantly public sector initiatives will be presented first, followed by private sector and joint activities, and Swedish examples will be followed by Finnish and Danish experiences as appropriate. Contracts Perhaps the most striking change in these three Nordic health systems is the growing emphasis on contracts inside the public

sector. Personnel salaries, including those of physicians, typically were included in these institutional budgets. Although this financing approach created macroeconomic discipline Schieber and Poullier, , it has not been very successful in encouraging microeconomic efficiencies inside or between individual institutions. Triggered by the announcement of the Dalamodel in June , the 23 county councils and 3 municipalities that operate the Swedish public system on a largely independent basis Saltman, are now almost without exception developing various types of contract-based payment systems for their hospitals and specialist physicians Bergman, a. These new contract systems all involve some form of separation of financing from provision inside the existing county council structure. In the Stockholm and Dalarna approach, local boards are expected to utilize their control over hospital funds to closely monitor primary care referrals to hospital, and to encourage primary health physicians and centers to provide an increased proportion of necessary services themselves Saltman, In all these reform models, individual hospitals and primary health centers will be transformed from dependent administrative units to something approaching public firms. They will no longer be funded through an automatically allocated budget, but will be expected to support themselves partially or entirely on the revenues each provider institution can generate within this new public market Saltman and von Otter, As of March , none of the existing or emerging contracts restricted patient choice of provider inside the publicly operated system Bergman, b. At present, the evolving structure of contracts in Swedish counties is not based on a detailed statement regarding price, quality, or volume Bergman, b. Rather, it is an agreement to enter into an open-ended arrangement to provide care for a specific period. In effect, Swedish contracts establish a care relationship rather than specify the precise content of that relationship. They thus resemble the contracts that previously existed within the Dutch health care system between the sick funds and the hospitals Saltman and de Roo, That is, the financing board behaves more like a financial intermediary, rather than acting as a prudent purchaser, as is the case in the selective cost-based contracting undertaken by preferred provider organizations PPOs in the United States. This raises interesting questions about what the new Swedish contracts actually accomplish. Instead, they define a general but short-term rather than permanent relationship between purchaser and provider. The implication of the Swedish contracts is that potentially, sometime in the future, the purchasing board could decide to change the contract conditions to specify cost and volume or to place the contract with a private provider instead. In turn, although the new contract structure has not changed revenue flows, it has influenced the balance of power within the Swedish health care system. This shift involves two components. First, where local boards control both primary health centers and the purchasing of hospital services, hospital physicians must pay more attention to the desires and concerns of the primary care doctors. Second, worried about future changes in the contract structure, all physicians feel they must pay more attention to the politicians and managers who run these boards. As a consequence, the introduction of contracts has generated a shift in the prior distribution of power within the health sector: Hospital specialists have lost some of their leverage over hospital decisions, whereas general practitioners GPs in Sweden, as elsewhere, less respected in physician circles and managers have gained. Hospital specialists are still far from powerless, of course. However, the use of contracts may help Nordic hospital administrators and politicians achieve their long-term goal of making hospital specialists more managerially accountable Saltman, The present approach to contracting in the Swedish system is thus not explicitly at least not yet about reducing costs. In practice, it is about changing the balance of power and, in the process, encouraging hospital specialists to become more productive and more organizationally compliant. Increased efficiency and overall value for money are a byproduct of the contract process rather than specified within the contracts themselves. In Finland, the development of the contracting process and of a new planned market model for the publicly operated health system are currently in the design stage. The tightly controlled national planning process, instituted in conjunction with the Primary Care Act, has been weakened considerably, however, its legacy remains in that decisions about the structure of the new contract-based framework are being determined by national government agencies. Although the cabinet and Parliament have decided in principle to replace most of the national plan with a block-grant system known as the Hiltunen Plan named for the Finance Ministry official who devised it , the date of implementation was delayed from January to January as the complexity of this transformation became apparent. Under the Hiltunen scheme, the Finnish municipalities

which formally own and operate the public health centers and hospitals but in practice have had little to say about their management would gain practical control over the flow of public health care revenues Saltman and von Otter, Each of the central hospital districts is already free to contract with any of the five university hospitals for tertiary or subspecialty services. At present, however, the municipalities have no experience in writing such contracts and little or no basis on which to monitor or evaluate hospital performance. Although central hospital districts have some experience sending patients on a contract basis to the small but growing private hospital sector in Finland, municipalities have little background in contracts between the public and private sectors. In preparation for the coming changes, the national Finnish League of Cities, the League of Municipalities, and the Hospital Association have agreed to merge into a more politically powerful representative of municipal governments in the health sector Vohlonen, Another alternative is that, as in Sweden and, at least for the first 2 years, in the United Kingdom, the contracts themselves will be structured as soft statements of service relationships rather than hard agreements about price, volume, and quality Saltman and von Otter, The pressures for reform have become sufficiently great, however, that it seems likely that Finland will in some fashion follow the United Kingdom and Sweden in their learning-by-doing approach. In Denmark, there has been considerable interest at the county level in the contract-based restructuring under way in Sweden and Finland. The governing Conservative-led coalition in the national Parliament has put forward for the second time the necessary enabling legislation. However, as of June its passage appeared unlikely Vang-Nielsen, Cross-boundary initiatives As fully articulated welfare states, Nordic societies provide their citizenry with a wide range of social as well as health-related benefits. However, many of these entitlements were developed independently of each other, and there often is little or no effective cooperation among different programs. Under recent pressures to reduce total public sector spending, a variety of proposals have been made to combine or coordinate certain benefits so as to reduce overall social sector costs. As they have with contracting, the Swedes have taken the most visible initial steps in cross-boundary integration. Two major initiatives are under way, one in the care of elderly, the other in disability payments and rehabilitation. Although both initiatives were begun by the then-governing Social Democrats, they have been continued by the new Conservative-led coalition in a demonstration of the pragmatic agreement that undergirds much of the current health care reform process. In so doing, one public entity now budgets and administers the full range of nursing home, sheltered housing, old age home, and home care services that elderly patients require. This consolidation is expected to improve coordination and continuity of care while at the same time reducing unnecessary medical and custodial expenditures. To finance this change, over the next 5 years the counties will transfer a portion of their own revenues to the municipalities, utilizing a complex series of population-weighted formulas Petersson, Drawing on research which indicates that a higher percent of injured individuals can be successfully rehabilitated if they receive intensive treatment immediately after being injuredâ€”and thus will not enter into a destructive personal development cycle nor require long-term income support Federation of County Councils, â€”this initiative is expected to substantially reduce overall social expenditures. In a demonstration project in North Jutland, municipalities were required to accept such patients within 5 days, beyond which the municipalities had to pay the county-run hospital for each extra day of care. This application of incentives to what was as much a cross-budget as a cross-boundary dilemma was deemed sufficiently successful Organization for Economic Cooperation and Development, to be published that it has been introduced elsewhere in Denmark as well as in Sweden. In Finland, both social services and primary care are administered directly by the municipality. Patient choice A third set of reform initiatives in publicly operated Nordic health systems concerns the introduction of patient choice of physician and treatment site. Moreover, where the clinic approach was adopted, patients often had little or no influence over which doctor treated them.

Chapter 2 : Casten Gransbo () | WikiTree FREE Family Tree

Asplund, Christer and Casten von Otter (): Introduction to Research in Working Life Science in Sweden Casten von Otter Swedish Center for Working Life.

DOWNLOAD PDF SWEDEN CASTEN VON OTTER

Chapter 3 : Recent health policy initiatives in Nordic countries

Genealogy profile for Carsten Fredrik von Otter Carsten Fredrik von Otter (-) - Genealogy Genealogy for Carsten Fredrik von Otter (-) family tree on Geni, with over million profiles of ancestors and living relatives.

Chapter 4 : Casten von Otter - Wikidata

View the profiles of professionals named Von Otter on LinkedIn. There are 20+ professionals named Von Otter, who use LinkedIn to exchange information, ideas, and opportunities.

Chapter 5 : Birgitta von Otter - Wikidata

Genealogy profile for Friherre Casten Fredrik von Otter Friherre Casten Fredrik von Otter (-) - Genealogy Genealogy for Friherre Casten Fredrik von Otter (-) family tree on Geni, with over million profiles of ancestors and living relatives.

Chapter 6 : Category:Birgitta von Otter - Wikimedia Commons

Carl von Otter, - Carl von Otter Carl von Otter was born on month day , at birth place, to Salomon von Otter and Barbara von Otter (born Schaeij). Salomon was born on October 10 , in Ã–rebro.

Chapter 7 : Casten Otter â€“ Wikipedia

This page was last edited on 1 September , at All structured data from the main, property and lexeme namespaces is available under the Creative Commons CC0 License; text in the other namespaces is available under the Creative Commons Attribution-ShareAlike License; additional terms may apply.

Chapter 8 : The Sweden-New Zealand Association: Group booking - Anne Sofie von Otter - Fri 18 Nov

Anna von Otter was born on month day , at birth place, to Axel Filip von Otter and Helga Mathilda von Otter (born Vult von Steijern). Axel was born on June 27 , in GrÃ¤nna LandsfÃ¶rsamling, JÃ¶nkÃ¶pings lÃ¤n, Sverige.

Chapter 9 : Category:Anne Sofie von Otter - Wikimedia Commons

The distinguishing features of the once-celebrated "Swedish model" were national bargaining, full employment, and "solidaristic" wage policy. In conceptualizing and framing the discourse of this.