

Integrated Services in Rehabilitation - on Coordination of Organisation and Financing

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The present paper discusses a number of aspects of the Financial Coordination of Rehabilitation Measures Act, introduced in Sweden in 2004. It begins with a description of the allocation of competencies in the field of rehabilitation in Sweden. There follows an account of the reasons for and organisation of financial coordination. Finally, experiences and results in this area is reviewed, with special emphasis on lessons, observations and outcomes from efforts in connection with financial coordination in Hisingen in Göteborg/Gothenburg (DELTA). The description of DELTA is written in collaboration with Ola Andersson, senior administrative officer at DELTA.

In the 2007 budget bill, presented on 16 October 2006, the Swedish Government states that co-operation between the various principals involved must improve, and that financial coordination must become more flexible and more adaptable to local conditions. However, as no specific changes have been proposed, the organisation of financial coordination as set out in this paper apply until further notice.

1. Divided responsibility for rehabilitation

Rehabilitation provision is the concern of a number of actors, each with different tasks and responsibilities. The principal actors are employers, the Social Insurance Agency, the health and medical care services, the social services and the Public Employment Service offices. In addition, decisions relating to the actors' aims and objectives are made by different political assemblies. A number of issues are dealt with at national level, while others are decided at regional or local level.

Employers

An employer of an insured person is required to ensure – in consultation with the latter – that her/his rehabilitation needs are clearly defined and that appropriate measures are taken to secure effective rehabilitation. An employer's responsibility is limited to occupational rehabilitation interventions that can be implemented as part of, or in connection with, the organisation's own activities.

The Swedish Social Insurance Agency

The Government is the principal responsible for the Swedish social insurance system, whose design and construction is mainly a matter for the Riksdag¹. The system is administered by the Swedish Social Insurance Agency, a central government authority.

¹ Swedish parliament.

Under the current provisions governing social insurance, the aim of rehabilitation must be to restore to a person who has suffered an illness her/his ability to work and maintain her-/himself financially. The Social Insurance Agency is responsible for the coordination and supervision of measures necessary to the implementation of rehabilitation interventions. The agency is required to ensure – in consultation with the insured person – that her/his rehabilitation needs are clearly defined and that appropriate measures are taken to secure effective rehabilitation. The agency is further required to cooperate with the insured person's employer, the health and medical care services, the social services and the Swedish Labour Market Administration and other relevant agencies. The agency must seek to ensure that the above actors – each within its own field of operation – adopt and implement measures needed to secure effective rehabilitation.

The health and medical care services

Overall responsibility for health and medical care services in Sweden rests with 18 county councils, two regions (Skåne and Västra Götaland) and one municipality (Gotland). Every county has a decision-making assembly, the county council. The assembly appoints a central executive committee and such additional committees as may be needed to discharge the county council's tasks and activities. As principals county councils are required by law to offer good health and medical care services to all residents in its health and medical care catchment area.

The health and medical care services are responsible for medical rehabilitation. This responsibility includes provision of medical care, treatment, habilitation and rehabilitation. The purpose of medical rehabilitation is to ensure that the individual concerned develops or recovers optimum functional capacity and achieves physical and mental wellbeing. Rehabilitation can also be used to ameliorate a disability and develop compensatory functions. In addition, the health and medical care services are required to provide the Social Insurance Agency and other actors with support data for assessing rehabilitation needs and designing suitable interventions.

The social services

Overall responsibility for social services lies with Sweden's 290 municipal councils. The political decision-making body of a municipality, the municipal assembly, is required to appoint a central executive committee and such additional committees as may be needed to discharge the municipal council's tasks and activities. The councils' responsibilities in the social services field are discharged by the committee or committees appointed by it.

Municipal councils are ultimately responsible for ensuring that all residents in the municipality receive the support and assistance they need. Municipal responsibility for services inter alia for the elderly, disabled people, children and young people, and people with substance abuse problems is defined in the Social Services Act. The overall aim of the act is to promote economic and social security, equality in living standards and active participation in community life. Under the act, municipal councils are responsible for the individual's social rehabilitation. This includes advice, support, services, employment and treatment.

The National Labour Market Administration

Overall responsibility for labour market policy rests with the Government; decisions in this area are a matter for the Government and the Riksdag. The general goal of labour market policy, which is decided by the Government, is to contribute to the maintenance of an efficient labour market. The Government has laid down a set of criteria for evaluating the effectiveness of labour market policy and plans to conduct a review of existing labour market policy goals.

Labour market policy is administered by the National Labour Market Administration. The agency is responsible for job placement activities, occupational rehabilitation and training aimed at helping people find jobs. The agency comprises the National Labour Market Board and 20 county labour boards. The latter incorporate the local Public Employment Service offices. The Labour Market Board is both the central administrative agency responsible for general labour market issues and the county labour boards' governing authority. The county labour boards are the authorities responsible at county level for labour market issues and the operations of the local Employment Service offices. The Government plans to introduce a uniform agency organisation, which will entail the closure of the county labour boards.

Collaboration and financial coordination in rehabilitation

Since the mid-1990s, various forms of collaboration and coordination have been tried involving one or more actors in the rehabilitation field. These have been aimed at dealing with demarcation problems and improving cooperation among the actors concerned. A number of pilot projects involving various forms of financial coordination have been undertaken. Since 1998, collaboration of rehabilitation measures has been subject to common guidelines. The Financial Coordination of Rehabilitation Measures Act, which came into force on 1 January 2004, is based on lessons and observation from this period.

2. Reasons for financial coordination

Rehabilitation is a collective term for interventions of a medical, social, psychological and/or occupational character aimed at restoring an individual's ability to function, work and lead a normal life. However, responsibility for rehabilitation is divided among various sectors and actors. While rehabilitation measures are implemented in accordance with each actor's specific terms of reference and responsibilities, they are dependent on one another for efficient and effective rehabilitation interventions.

Sectorisation problems in rehabilitation

The fact that responsibility is divided among a number of actors can hamper effective rehabilitation. Pursuit by each actor of its own goals and tasks can lead to conflicting priorities with implications for the individual and for the undertaking as a whole. There is a risk that rehabilitation measures may not reach their intended target or have the desired effect. The same applies where one actor takes over ongoing rehabilitation from another. Important information can be lost if rehabilitation planning involving more than one actor is poor or inadequate.

It can be particularly difficult to rehabilitate people who suffer from a combination of medical, physical, social and work-related problems. Such people could end up in an indeterminate 'grey zone' as the necessary interventions do not fall solely within one actor's area of responsibility. This can lead to a vicious circle involving the Social Insurance Agency, health and medical care services, the social services and the local employment service office, with short-sighted, ineffective interventions as a result. If these people are to be helped, actors must coordinate their activities. Collaboration and coordination are therefore essential in ensuring that people do not go without rehabilitation.

Gains for the individual and society

In view of the above, financial coordination of rehabilitation involving the Social Insurance Agency, the health and medical care services, the social services and the National Labour Market Administration can be justified on two grounds. Improved coordination is necessary to meet the rehabilitation needs of individuals more efficiently and effectively, and thereby help restore their ability to engage in gainful employment. At the same time, cost-effective use of available resources is desirable from an economic position. Combining the resources of the four areas mentioned above will facilitate coordinated assessments and interventions.

3. Financial coordination – structure and scope

The Financial Coordination of Rehabilitation Measures Act came into force on 1 January 2004. Under the act, financial coordination involving the Social Insurance Agency, county councils, county labour boards and one or more municipal councils may be undertaken with a view to achieving efficient resource utilisation. Although coordination is voluntary, all four parties must participate if it is to take place. In geographical terms, coordination will include one or more municipalities in the same county, depending on what the parties have agreed. It may also be limited to part of a municipality.

Target group and measures

The target group for financial coordination is made up of people in need of coordinated rehabilitation interventions from several collaborating parties, which will help them develop or enhance the capacity to engage in gainful employment. The group is estimated to comprise some 280 000 people, or 5 per cent of the working-age population (normally 20–64 years old). Individuals in need of coordinated interventions may suffer from different physical or mental conditions and/or have labour market or social problems, or, as is often the case, a combination of these. These people, for whom the labour market is not a very viable prospect, are often dependent on the public sector for income maintenance. The aim is to get the individual out into the labour market and away from long-term dependency on public maintenance systems for her/his support. This will also serve to reduce dependence on public support systems, which may be said to be a sub-goal of financial coordination.

The interventions financed as a result of financial coordination must fall within the collaborating parties' joint sphere of responsibility, i.e. within any one of the parties' area of responsibility or in the borderland between them. Achieving the objective of financial coordination, i.e. to restore or enhance the individual's ability to function and work, is contingent on the creation of a structure

for rehabilitation activities that meets the target group's needs. This calls for assessment and development efforts aimed at addressing current problems and bottlenecks. These efforts can result in measures such as additional resource allocation and the creation of special projects based on the target group's needs and the parties' shared responsibilities. Coordination can also include preventive measures.

Resources and management

Financial coordination involves those resources which, in accordance with the specific agreement reached by the parties, are to be used to finance coordinated rehabilitation interventions aimed at the relevant target group. This means that the parties must set aside resources for financial coordination. Insofar as the parties contribute resources they share responsibility for costs incurred. The parties are required to contribute in equal amounts. It may be pointed out that each party's contribution is not limited to covering interventions that could be regarded as falling within its own sphere of responsibility. Contributions are not earmarked for interventions coming under any one party's sphere of responsibility. On the contrary, the coordinated resources are used for interventions considered necessary to achieve the objective of coordination.

Financial coordination is carried out under the direction of a coordinating body – known as a coordination association – in which the collaborating parties are represented. The association is a legal person in public law with legal powers. Its task is to lay down goals and guidelines, and to finance measures in accordance with the aims and objectives laid down for financial coordination. The association also supports cooperation between the collaborating parties, e.g. by providing financial assistance to assessment groups for which the principals are responsible. However, it does not make decisions relating to benefits or rights in individual cases. Nor does it adopt measures involving the exercise of official authority.

Members or alternates members of a municipal or county council, members of a social insurance commission or of a social insurance tribunal, or executive committee members or employees of a county labour board may be selected as representatives or alternate members of the executive committee of a coordination association. The Government has announced its intention to abolish social insurance commissions, social insurance tribunals and county labour boards. This will have repercussions in terms of representation of the Social Insurance Agency and the National Labour Market Administration on the executive committee of a coordination association.

4. Experiences and results so far

A total of 41 coordination associations representing some 80 municipalities had been established by September 2006. Just over 10 of these include representatives from more than one municipal council. In two cases, all the municipal councils in the county are represented. All the city's district councils are represented in four Göteborg/Gothenburg associations. A further 10 associations are expected to begin operations over the coming six months. Four counties have no plans at present to establish associations.

Financial coordination in line with intentions

The Swedish Agency for Public Management has been tasked with following up and evaluating financial coordination. Its final report is to be delivered on 15 May 2008. The agency notes in its most recent follow-up report that the coordination associations' target groups and activities are in accordance with the intentions of the legislation and that the associations have effective working practices. However, association budgets, and thus the scope of their activities, vary widely. Some aspire to provide care for everyone in need of rehabilitation interventions while others only help certain groups. Most associations give priority to young people. The agency considers that interventions should be aimed at enabling participants to develop or recover their capacity to engage in gainful employment, which is fully in line with the aims laid down for financial coordination.

The Swedish Agency for Public Management points out that continued financing of a given activity is a crucial issue as it can be difficult to get a party to take over successful, time-limited projects. Difficulties in making projects a part of a party's mainstream activities are often put down to lack of resources. In the agency's view, one reason may be that financial coordination measures are – and must be – such that they are usually marginal to normal operations and do not clearly form part of any party's everyday tasks. This can lead to a lack of interest among parties to re-prioritise financial coordination measures so that they continue to be implemented as part of their normal operations.

5. Financial coordination in Hisingen (DELTA)

DELTA on the island of Hisingen in the municipality of Göteborg/Gothenburg was launched in 1997 as a financial coordination pilot project. On 1 January 2005, project activities were subsumed under the new Financial Coordination of Rehabilitation Measures Act. The principal difference was the addition of a new party within the coordination association: the local county labour board. This strengthened the association's ability to rehabilitate people and get them back into the labour market.

To understand DELTA today, however, some background on its formation and initial organisation is needed. Accordingly, a brief history of DELTA since 1997, when financial coordination began in Hisingen, follows below.

The purpose of DELTA

When DELTA was established in 1997 in Hisingen, the latter was one of six areas hosting pilot projects on financial coordination involving the social insurance authorities, the health and medical care services and the social services. The purpose of the projects was to determine whether resource coordination would help reduce suffering among individuals and cut costs arising in connection with absence from work due to illness, unemployment and social security benefits. The county labour board was brought in under a separate agreement as this was not provided for under existing legislation.

A joint political structure in the form of a client-side association was set up to direct the operation. This was basically project- and network-based involving some 30 separate activities.

Approximately 120 000 people reside in Hisingen and the target group is comprised of people aged 16–64 (approx. 78 000 residents) whom the collaborating parties, acting on their own, had been unable to rehabilitate effectively. In other words, DELTA has targeted those groups in Hisingen that tended to fall between the chairs. At present, some 4 000 Hisingen residents come in contact with different DELTA activities each year.

When DELTA was launched, a number of collaborative undertakings then in progress were incorporated into the programme, and further projects were added in succeeding years. Personnel in the collaborating authorities were encouraged to contribute ideas for projects involving the development of job creation measures as well as new rehabilitation methods and approaches. The following goal headings were drawn up:

- The over-riding objective and purpose of the programme is to reduce costs arising in connection with absence from work due to illness, unemployment and social security benefits, and to reduce unnecessary suffering in the population.
- Assessment and treatment processes must be made shorter and more effective through better collaboration between personnel categories and between authorities.
- Bottlenecks are to be eliminated where these involve passive drawing of sickness or other benefits.
- Efforts must be made to combat long-term unemployment and vulnerable groups must be given the opportunity to enter the labour market or find meaningful employment.
- Efforts must be made to broaden the knowledge and skills of relevant personnel groups.

Organisation

DELTA was largely organised on the basis of confidence- and legitimacy-building structures rather than as a formal organisation with traditional management elements. Building a 'collaborative administration' when the objective is to get existing structures in the welfare sector to collaborate was a novel experience. Moreover, it was hoped that the model chosen would enable DELTA to turn the lessons gained from previous experience and observations to account.

DELTA's overall – and over-riding – strategy was to ensure that collaboration was "owned locally and supported centrally". Although the strategy continues to apply it does not have the same force as it had during the pilot project period. By "locally" the project planners meant meetings taking place between Hisingen residents and an executive officer. This is where the options for continued rehabilitation were discussed and established, both in terms of time and content. It was these meetings, and the valuable lessons they provided, which from the start served as the basis and point of departure for DELTA collaboration. "Centrally" refers to any level within the collaborating authority. The principal and crucial function of these levels is to confer the necessary legitimacy to cooperation at officer level.

Information and project establishment

One strategy was to allow sufficient time for the information process and project establishment. This was reflected inter alia in the fact that DELTA's first year, 1997, was devoted entirely to disseminating information and getting the project securely anchored. These undertakings were partly horizontal in character, i.e. between authorities and professions, and partly vertical, i.e. within the authorities concerned. The purpose of the latter was to instil a sense of security on home ground. Without this security it would have been difficult to establish closer collaboration.

'Knowledge DELTA'

Another strategy was to ensure that every measure in the DELTA project was preceded by a 'Knowledge DELTA', i.e. a comprehensive survey involving all the authorities concerned. The strategy had a twofold aim: to create a set of shared values, a common approach based on Hisingen residents' needs and prospects, and to ensure that every measure, activity or project was based as far as possible on shared knowledge and experience.

DELTA groups

Establishment of the project at local level was the task of the DELTA groups, which were particularly active in the initial stages. The groups, set up in each district, were made up of officers from the collaborating authorities. Their task was to identify residents' needs in each district that had not been met effectively by the authorities acting alone.

The drafting committee

Central support was basically provided in two ways: via a drafting committee and through networks. It was clear from the start that local managers in Hisingen would have a central part to play in the project, partly because the management group was made up of line managers of most of the employees who would be involved in DELTA activities. Together, the members of the Hisingen management group set up a drafting committee, whose task was to prepare items of business for DELTA's governing board, and deal with other issues of principle.

Networks and reference groups

Networks were formed at an early stage around strategic collaboration issues and areas such as evaluation, financing, information, personnel matters and trade union issues.

Secretariat

A secretariat was formed to serve DELTA's board. From the start, the secretariat was composed of a senior administrative officer, who served as rapporteur on the board, and two junior officers. Keeping the administrative apparatus to a minimum has ensured that decision-makers within DELTA are never far from those involved in activities on the ground. Short decision pathways have made it relatively easy to move from proposal to decision to action.

Resource personnel/process facilitators

In 1998, the collaborating authorities recognised the need for expert resources to support the collaboration process on the basis of each authority's means and tasks. Support was provided in the form of four half-time resource personnel representing the Social Insurance Agency, the social services, primary health care and the labour market board.

Some functions, including financial follow-up, information/communication and implementation, were strengthened in the autumn of 2000, and the term 'resource person/personnel' was replaced by the designation 'process facilitator(s)'. This new title may be seen as an indication of the change in this type of support activity from a vertical, authority-based perspective to a horizontal, process-related approach marked by collaboration and the assumption of joint responsibility. At present (2006), resource personnel comprise one process facilitator and one person employed on a half-time basis for follow-up purposes.

Evaluation

DELTA has been systematically evaluated. The process has included self-evaluation of each activity and an external appraisal by external researchers at Göteborg and Karlstad Universities. The evaluation work was monitored and supported by the evaluation network, comprising representatives of the collaborating authorities, researchers and process facilitators.

Finances

DELTA's budget for 2006 is approximately SEK 44 million (appr. € 4.7 million). It covers the following expenditure items:

- Activities SEK 34.3 million (€ 3.7 million)
- Funds for new projects SEK 5.0 million (€ 0,534 million)
- Knowledge DELTA SEK 3.0 million (€ 0,320 million)
- Association, secretariat SEK 1.7 million (€ 0,182 million).

These costs may be compared with the collaborating authorities' aggregate expenditure on transfers (sickness benefit, sickness compensation, maintenance support and unemployment benefit), which totalled approximately SEK 2.3 billion (appr. € 245 million) in Hisingen in 2004.

Activities in DELTA

Each DELTA-based activity/project is assigned a project coordinator, a number of project assistants and a steering committee. Where possible, members of the latter have been local line managers from authorities with personnel involved in the project in question. The object here has been to facilitate continuous feedback to each authority and ensure that problems arising in connection with the project were dealt with promptly. The steering group is mandated to deal with issues within frameworks laid down by the board when DELTA funds are allocated to the project. Issues involving questions of principle have been dealt with by the drafting committee. The same organisation and procedures apply today, with the difference that the term 'project' has been replaced by 'activity' in order to emphasise the non-temporary character of the undertaking.

Where possible, project coordinators and project assistants have been recruited internally from the collaborating authorities on the basis of an expression of interest. Recruits have been granted leave of absence from their normal duties by the authority concerned during their period of service in the DELTA project. Personnel have therefore retained their employment within the authority, which has also paid their salaries, etc. The authority has subsequently debited DELTA's board for costs incurred in connection with the project. Thus the staffing of activities in the DELTA project has been characterised by voluntary participation, interest and security.

Just over 25 activities have been undertaken within DELTA since its inception in 1997. A number of these were terminated due to formal or other obstacles, while others have been completed. Some 10 activities are currently in progress. Ongoing activities can be grouped into one of three categories: preventive and promotional, socio-medical and occupational.

Preventive and promotional activities

These activities are concerned with interventions aimed at preventing absence due to illness, combating social exclusion and helping people become more securely established in Swedish society. Working methods include interviews and discussions, theme-based sessions, group activities, dissemination of information and education.

Socio-medical activities

The objectives of the Early and Coordinated Rehabilitation programme² are to:

- reduce waiting times and shorten patient treatment,
- speed up the return to work/rehabilitation and thereby reduce the costs of public income support systems, and
- enhance professional knowledge, and thereby increase the accuracy and effectiveness of interventions, through inter-professional and cross-sectoral assessments.

Activities are conducted by inter-professional teams at six of Hisingen's eight primary health care centres. Access to team-based resources in the other two centres is limited. Working practices and the range of treatments on offer are adapted to the current needs of Hisingen residents. An efficient, effective team structure, which includes clearly defined collaboration approaches, has been established with the Social Insurance Agency and, in some cases, the social services.

Occupational activities

These activities are based on the need for coordinated interventions aimed at helping people to maintain themselves either through employment or self-financed studies. The aim is to get people back into work more quickly, or into the right rehabilitation programme with less delay, and thereby shorten times on maintenance support, sickness benefit or unemployment benefit. Interventions must also serve to reduce passivity and increase the self-confidence and self-awareness of participants.

An example of this type of activity is the Labour Market Plaza (Arbetsmarknadstorget). The creation of this scheme was prompted by the limited extent of collaboration between relevant authorities. Hisingen residents were shunted from one authority to another, were not given a coordinated reception and thus did not receive the right intervention. Interventions were implemented without co-planning, resulting in discontinuities and problems obtaining assistance from the various income maintenance systems. Inadequate collaboration also made it difficult for officials to contact their counterparts in other authorities, which meant they were poorly informed about the latter's regulatory frameworks and activities. Thus officials at any one authority lacked access to all the tools needed by Hisingen residents to rejoin the workforce and begin supporting themselves.

² Tidig och Samordnad Rehabilitering.
4-5 December 2006

In the interest of better collaboration and more accurate and effective interventions, DELTA's board resolved to co-locate activities and work in inter-authority teams, conducting joint surveys, guidance activities and follow-ups. This approach has been applied throughout DELTA's entire period of operation.

The Labour Market Plaza (Arbetsmarknadstorget) has adopted the following targets:

- speedier employment of unemployed Hisingen residents,
- a minimum rate of return to self-maintenance among those terminating participation in the scheme of 60 per cent,
- development of joint action plans, and close joint monitoring by collaborating authority officials of unemployed people until they have secured work, and
- a maximum period of collaboration in the scheme of 12 months, with extensions in exceptional cases only.

The target group comprises people who are unemployed but not immediately employable. This includes people who are out of work, are receiving some form of income maintenance and stand in need of coordinated interventions from the social services and the local Public Employment Service office in order to become employable.

Working methods and practices

Financial coordination is in effect a structure for dealing with collaboration and coordination issues, not a model for organising the activity itself. A frequent success factor is co-localisation, which provides an 'open door' to all. While some programmes have their own premises, others are integrated into the authorities' regular operations.

Activities undertaken at the primary health care centres under the Early and Coordinated Rehabilitation programme are conducted by inter-professional teams using clearly defined formats for inter-authority collaboration. Their composition and working methods vary according to local conditions. All activities offer early intervention, which acts preventively by cutting down the rate of absence from work due to illness and promoting shorter, more active periods of sick leave. Treatment alternatives are designed on the basis of patient needs in the city districts covered by the programme. External forms of collaboration vary according to district needs and resources.

The Labour Market Plaza (Arbetsmarknadstorget) is run by the social services and the local Public Employment Service office, which share the same premises and a joint reception area. This also applies to the 'Lundbykajen' activity, which supports people who are further removed from the labour market, by means of interventions aimed at determining their ability to work while seeking to strengthen their motivation.

There are various ways in which a person can become eligible for participation in a DELTA activity. Collaborating primary health care centres are open to anyone in need of inter-professional interventions, while those taking part in occupational activities are referred by the relevant authority.

The development of joint action plans entails joint planning by authorities and coordinated interventions. The methods themselves are not unique. What is unique is the common approach and the fact that joint planning makes for more efficient resource utilisation. In the Early and Coordi-

nated Rehabilitation programme fixed times (a number of hours per week) are set aside to discuss and agree on issues relating to individual cases.

Implementation of activities as part of normal operations

DELTA disposes of resources for activities as long as these are undertaken within its project framework. In addition, DELTA can influence decisions concerning organisation and working methods. However, it has limited impact on management structures and practices in the collaborating authorities. In recent years, therefore, efforts to implement activities (in the permanent sense) have intensified.

One of DELTA's aims has been to implement new and better working practices and improve the way in which activities are organised. Activities were previously implemented in two stages. In the first stage, project coordinators were phased out and responsibility for everyday operations was brought under the appropriate line management. There is still a need here for the development of new, common organisational approaches and the continued exercise of joint responsibility for common aims and objectives. The second stage was financial implementation, which concerned taking over the financing needed to continue translating recently acquired experience into action.

The chances of successful implementation vary according to the extent to which activities are run as free-standing projects as opposed to forming an integral part of an authority's regular operations. The Labour Market Plaza (Arbetsmarknadstorget) is an example of a free-standing project, while the Early and Coordinated Rehabilitation programme based in the primary health care centres forms part of the normal operations of the health and medical care services.

Qualitative implementation has been associated with major problems. As implementation involves prioritising activities, further commitment is required at management level in the authorities/principals concerned if it is to succeed. Continued joint organisation of working practices and management functions is needed to ensure successful implementation. This process has already begun in the form of discussions in the drafting committee. 2005 saw the launching of a project on leadership in collaboration. Its aim was to develop the role of manager and leader in collaboration organisations. Work has continued in 2006.

Follow-up and evaluation of DELTA

In 2001 a report was presented on the findings of the national evaluation of the financial coordination pilot project in which DELTA took part between 1997 and 2004 (National Social Insurance Board and National Board of Health and Welfare, 2001). A parallel special evaluation of DELTA was also carried out (Göteborg University and DELTA, 2001). A comprehensive follow-up of its activities was subsequently conducted after DELTA had commenced implementation of financial coordination under the new act (DELTA, 2005). The main results of these studies are set out below.

The 2001 evaluation

Unless otherwise stated, the findings in the following section are from the special evaluation of DELTA carried out by Göteborg University and DELTA.

DELTA's effect on personnel

The evaluation found that the new organisational and collaborative structures and procedures had helped to enhance the knowledge and skills of those involved in the project. The project was characterised by an approach where people defined problems jointly and in continuous collaboration, identified desired results and attempted to select appropriate solutions. Different perspectives on reality were challenged and impacted on.

New professional capacities or roles were developed deploying both individual expertise and skills associated with staff members' own special professions and a shared organisational competence. This combination of competencies made a new way of working possible in which decisions based on a common approach emerged via new communication pathways, thereby helping to improve the effectiveness and quality of interventions and treatment.

The DELTA projects, have through common activities and regular contact with DELTA's secretariat and resource personnel, had a sound understanding of the underlying visions and goals. These meetings, combined with daily contact with people coming from other authorities, provided information and knowledge about the latter's operations, regulatory frameworks, etc. DELTA's various networks acted as personal and knowledge support mechanisms for activities while serving to establish project ideas and implementation.

Project workers brought their professional knowledge to bear on the activities, as well as extensive experience of identical or similar projects. Out of this professional experience came new thinking and ideas about ways to meet users and implement rehabilitation or treatment interventions. It was described by many as "having a clear picture of what one wanted to do". DELTA provided the opportunity to put these ideas into practice in collaboration with others who had been thinking along similar lines.

DELTA's effect on users

The bulk of testimony and case descriptions from both personnel and participants indicated that the latter had experienced the activities as positive. Their feeling was that:

- they had been respectfully received,
- they had been "seen", listened to and taken seriously, and
- personnel believed that a change was possible.

In short, the findings indicated a greater sense of wellbeing and reassurance among participants when dealing with personnel, the project and the authority. Although this may be regarded as an interim objective it can also be seen as a component of the final goal: a better quality of life.

DELTA's effect on users was the subject of a research paper (Eva-Lisa Hultberg, Göteborg University, 2005). Its findings indicate that personnel at the primary health care centres in Hisingen felt that DELTA facilitated and improved the collaboration process within and between the various authorities involved. On the other hand, it found no evidence that the model resulted in better health or a reduction in sick leave among patients with musculo-skeletal problems. Despite the new approach in terms of working methods and procedures, patients at DELTA primary care centres received the same kind of treatment and rehabilitation as patients at control health care

centres. The difference was that patients at DELTA centres were treated more often, particularly with regard to physiotherapy.

The results showed no difference in change of health status between the groups. The average number of sick leave days in one year was 94 for DELTA patients against 84 for the control group. After a 12-month follow-up, the number of DELTA patients on sick leave was that same as that recorded for control centres. The author of the research paper pointed out that the findings should be interpreted with a measure of caution owing to the small patient sample. These findings are difficult to extrapolate to other patient groups. Nor can general conclusions be drawn either regarding DELTA or financial coordination as a whole.

DELTA’s effect on cost trends in public income maintenance systems

Although it is difficult to make definite pronouncements on DELTA’s impact on costs trends in public income maintenance systems, there is a tendency towards lower costs in Hisingen, which combined with information from other evaluation results would indicate that DELTA has had a favourable impact, i.e. led to lower income maintenance costs for Hisingen compared to the rest of Göteborg. The national evaluation of the financial coordination pilot project in which DELTA took part between 1997 and 2004 showed that coordinated interventions had been strengthened, with favourable results in Hisingen and other places in terms of sickness benefit costs, social security benefit costs and long-term sick leave trends (National Social Insurance Board and National Board of Health and Welfare, 2001).

The 2005 follow-up

As the findings presented below are the result of follow-up studies, they cannot be used to evaluate project effectiveness. This will require a wider study and more detailed analysis. On the other hand, the follow-up gives an indication of the ‘flow’ as well as the impact on Hisingen residents covered by the DELTA project.

Hisingen residents covered by the project

Of Hisingen’s 120 000 residents, almost 4 000 took part in occupational and socio-medical rehabilitation activities in 2005, as shown in Diagram 1 below.

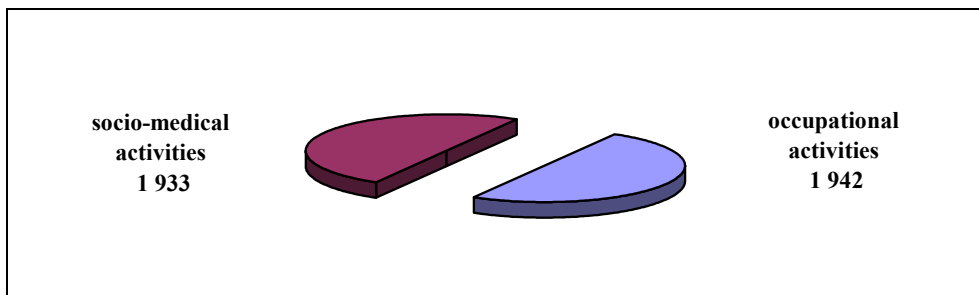


Diagram 1. Number of residents in Hisingen covered by DELTA

Twice as many women as men took part in the socio-medical activities, while more men than women took part in the occupational activities. This distribution tallies closely with social insurance figures and unemployment statistics.

Hisingen residents no longer covered by DELTA

Of the Hisingen residents who took part in DELTA in 2005, almost 2 400 (60 per cent) left the activities, as shown in Diagram 2 below.

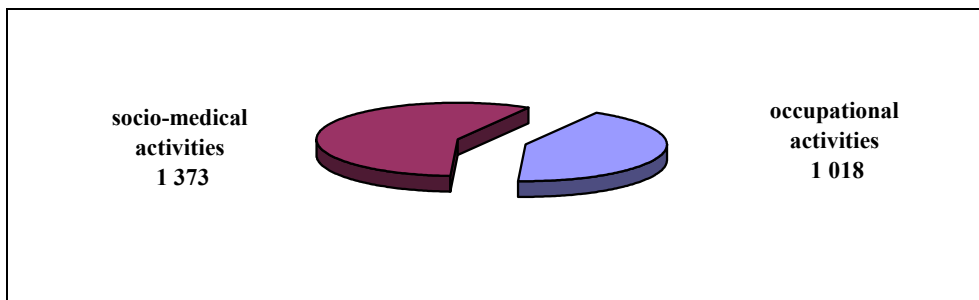


Diagram 2. Number of residents in Hisingen who terminated participation in DELTA

Reasons for termination

Just over 50 per cent of those participating in socio-medical activities returned to work, while the remainder no longer needed the teams’ interventions but required other specific interventions (see Diagram 3 below).

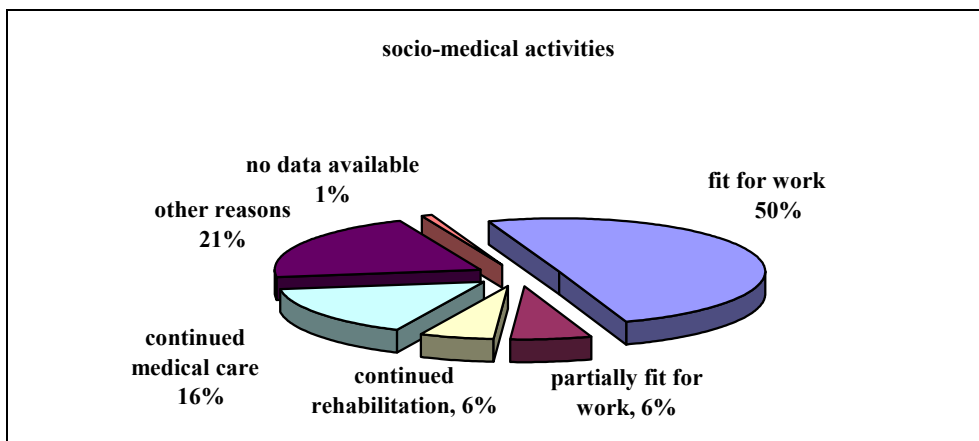


Diagram 3. Reasons for terminating participation in socio-medical activities (1 373 participants)

Just over 50 per cent of those who terminated participation in occupational activities were able to maintain themselves through gainful employment or self-financed studies, as shown in Diagram 4 below. Just under 25 per cent of the participants have either moved away or no longer receive public maintenance benefits (“other reasons”). However, no data on their self-maintenance is available. Just under 15 per cent are receiving assistance from the social services as they are not yet ready to enter the labour market (“not yet rehabilitated for work”).

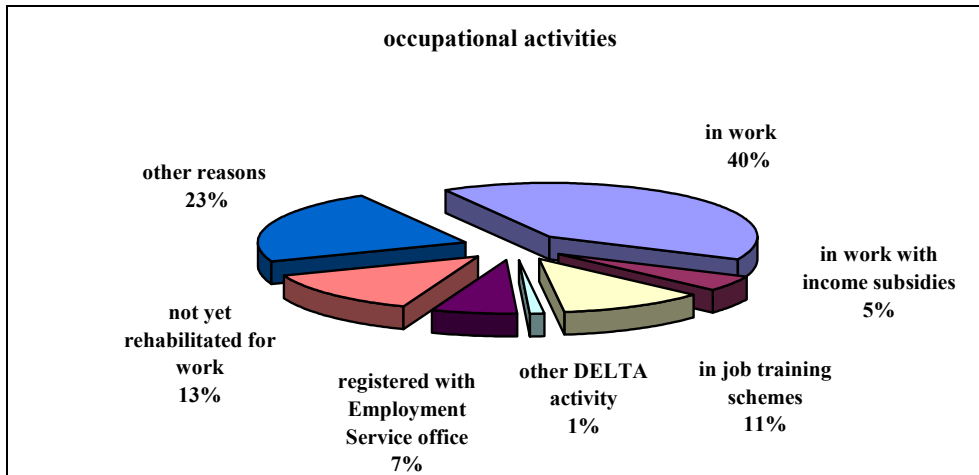


Diagram 4. Reasons for termination by 1 018 participants in occupational activities

Time spent in activities

Three out of four Hisingen residents who took part in socio-medical activities remained in contact with their team for less than 6 months, as shown in Diagram 5 below. This group also includes patients (an estimated 10 per cent, with some variation between teams) who were referred to interventions other than those carried out by the team after the first assessment interview.

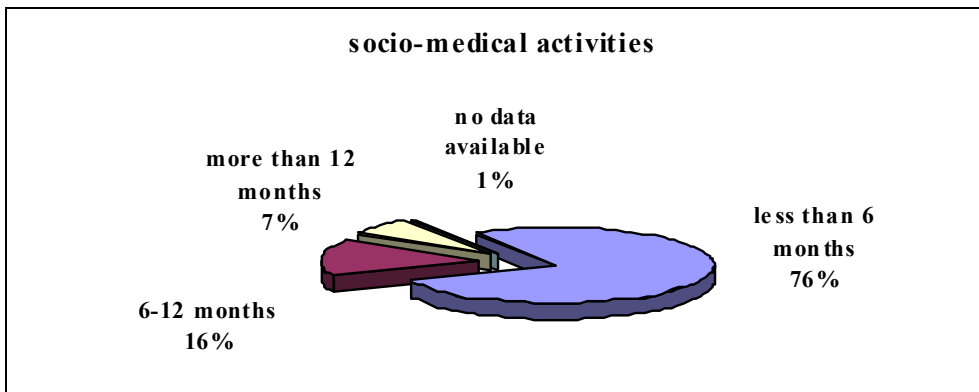


Diagram 5. Time spent in activity – socio-medical activities

Half of those taking part in occupational activities participated for less than 6 months, while every fourth person continued for longer than 12 months (see Diagram 6 below). Activities here are differentiated on the following basis: while 60 per cent of job applicants remained in contact for less than 6 months, while half of those taking part in another activity continued for longer than 18 months. The aim of this activity is to develop a team that carries the rehabilitation process forward from sobriety to stability in working life.

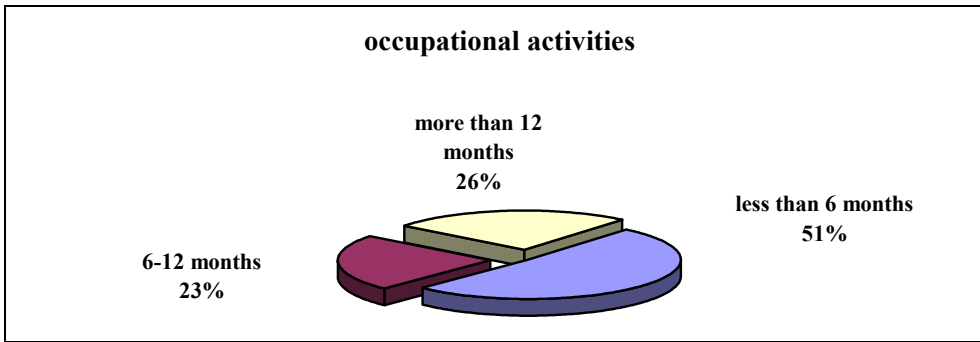


Diagram 6. Time spent in activity – occupational activities