



Sweden 2006

Integrated Services in Rehabilitation – on Coordination of Organisation and Financing

Minutes



On behalf of
European Commission
DG Employment, Social Affairs and Equal Opportunities



Integrated Services in Rehabilitation on Coordination of Organisation and Financing

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Day 1

Welcome address

Elis Envall from the Swedish National Board for Health and Welfare opened the meeting and welcomed the participants. He introduced the state secretary from the Ministry of Health and Social Affairs Bettina Kashefi.

Ms Kashefi said that the Swedish government welcomed the opportunity to present its programme for financial coordination in rehabilitation services to the peer countries. Introducing herself, she explained that she had previously worked in the Ministry of Finance as a Budget Officer, and had been responsible for areas covered by the Ministry of Health and Social Affairs and Ministry of Labour.

To be successful in getting people with multiple problems back into work, financial coordination between agencies is essential.

In Sweden, 23% of the population is dependent on benefits (full year equivalents). There is no great variation in the total number of beneficiaries, but the type of benefit alters: e.g. when unemployment is high, sick leave usually tends to be low. Recently, there has been a slight rise in disability pensions, payable to younger and younger people.

The newly elected Swedish government regards it as a high priority that people who have the capacity to work should do so, and measures in the budget tackle both the supply and demand side. Taxes are lower for low and middle-income earners, and 'new start' jobs entail a reduction in the cost of hiring people who have previously been unemployed. A flexible financial coordination system is a very important tool in getting people into work.

The Swedish Agency for Public Management (SAPM) is carrying out an assessment of financial coordination, but there are also a need to hear other countries' experiences of what works and what does not. Therefore it is useful for Sweden to know more about other Member States' actions plans.

Hugues Feltesse, from the European Commission DG Employment, Social Affairs and Equal Opportunities, (unit for inclusion, social policy aspects of migration, streamlining of social policies), expressed his deep appreciation to the Swedish authorities for their contribution to the social inclusion peer review programme.

He recalled that this was the second time the peer review programme had come to Sweden to examine the very important issue of mobilising local actors. In Stockholm, in April 2004, the focus was on local agreements as a tool to stop segregation in vulnerable metropolitan areas, and the key lessons were very fruitful for both the participants and the many policy-makers in Europe who made use of the report disseminated after the seminar.

This review, addressing inter-agency working for the rehabilitation of people on long-term leave or unemployment and suffering from a variety of medical, physical, mental, social and work-related problems, where a multifaceted approach is needed, will be very useful to Member States trying to improve their policies for the active inclusion of people furthest from the labour market.

The last Spring European Council 2006 endorsed new objectives and working methods for social protection and social inclusion, aimed at making a decisive impact on the eradication of poverty and social exclusion through the active social inclusion of all. They stressed that social inclusion policies must be well coordinated and involve all levels of government and relevant actors, including people experiencing poverty or social exclusion. They must be mainstreamed into all activities, including economic, budgetary, education and training policies and structural fund (notably European Social Fund) programmes. Therefore the issues this peer review meeting addresses are of prime importance for the European Commission.

Mr Feltesse highlighted the three main objectives of the peer review exercise:

1. The goal is mutual learning. Representatives of the peer countries want to learn with their Swedish partners about how successful the strategy has been. They expect a frank and objective account not only of what works well, but also of what does not work as intended, or not at all. At the same time, the host country can benefit from the critical remarks of peers. However, although reaching a better understanding is an important objective, it is not sufficient.
2. The second aim is to improve the effectiveness of policies and strategies in this area in all Member States. This is a vital challenge, if economic growth and well-being is to be combined with social cohesion and inclusion.
3. This leads on to the third and most ambitious objective: to facilitate the transfer of key policies, arrangements and approaches that have proved effective in combating social exclusion and poverty. This places a special responsibility on all participants in the current seminar, and in particular those closer to policy-making at national level, since they are the key actors in enabling effective transfer of policy as a result of their privileged access to information. Transfer can also be facilitated through the wide dissemination of conclusions, for example through the short report presented in the newsletter, the minutes of the meeting and discussion papers placed online on the dedicated website, and a wealth of information material from which key lessons can be drawn.

The objective of the peer review programme is not competition, emphasised Mr Feltesse. "We don't want to rank policies, but to know why certain policies are successful in certain circumstances and whether they can be replicated." Even if 'success' is a word to be used sparingly, the peer review programme should be looking for success stories, or at least inspiring stories.

Mr Feltesse said he, his colleagues in the Commission and the consulting consortium would follow the seminar attentively, not only in order to find out more about the Swedish experience but also with a view to improving the peer review process and mutual learning. To this end, he welcomed feedback and urged participants to complete the evaluation forms they had received. An evaluation survey is to be carried out in a few months, which will reveal the practical results of the process both in individual countries and at EU level.

Presentation of the policy under review (see Annex 1)

National expert **Peter Wollberg** from the Swedish Ministry of Health and Social Affairs explained that social inclusion and rehabilitation in Sweden involves a number of actors with different responsibilities (see Annex 2):

- At national level, the government is responsible for labour market policy, through the National Labour Market Board and 20 country labour boards, and for the social insurance system;
- At regional level, the 18 county councils (+ two regions and one municipality) are responsible for health care;
- At local level, the 290 municipal councils are responsible for social rehabilitation.

Therefore, responsibility is divided in two ways: between different sectors and between different political assemblies. These divisions must then be dealt with at local level where the services are delivered.

This means that on the ground, four administrations are involved and dependent on one another for achieving effective rehabilitation. Since the 1990s, Sweden has tried out various ways of coordinating these services.

Earlier evaluations in 2001 form the basis of the current approach. They showed that without financial collaboration, authorities were less able to organise successful treatment of people needing integrated rehabilitation interventions. With financial coordination, on the other hand, the shared responsibility offers an incentive to work together, and brings favourable results in terms of sickness benefit and social allowance costs, and long-term sick leave trends.

On 1 January 2004 the Financial Coordination of Rehabilitation Measures Act came into force, to provide the necessary framework to meet people's needs more effectively, and for the cost-effective use of resources. It allows for financial coordination involving

- the Social Insurance Agency
- county councils
- county labour boards
- municipal councils.

The conditions for effective collaboration comprise common management and responsibility, common resources, and a flexible approach adapted to local conditions.

The scheme is aimed at the 5% of the working population usually dependent on the public benefit system and suffering from a combination of health and social problems requiring an integrated response. The long-term aim is to get them into the labour market. Mr Wollberg said the employer could be seen as the 'missing stakeholder' and recognised that this is an important issue. Financial coordination offers a permanent model for voluntary collaboration between authorities. All four parties must participate financially, and allocate an equal amount of funding to a pooled budget.

Management is the responsibility of an independent Coordination Association (CA), which lays down goals and guidelines, provides support for professionals and sets financial targets, but does not make decisions on individual cases. The measures it funds must fall within the organisations' spheres of responsibility.

Results so far

Authorities in Sweden have two options for rehabilitation services: either financial coordination or a looser form of non-financial cooperation, which can achieve a lot, but lacks the structure and coherence found in the model under review.

A total of 41 CAs have been set up involving 80 municipalities and 12 counties. The fact that there are not more is probably because:

- it is a voluntary system, on which all four parties must agree;
- it takes time to negotiate guidelines and organisation – but a further 10 associations are due to be formed in the coming months.

The Swedish Agency for Public Management is evaluating the policy. So far it has found that activities are in line with the aims of the legislation, and associations have effective working practices, but budgets and therefore scope of interventions vary widely. It is too early for overall conclusions about the success of the model, and the agency will make a final report in May 2008.

Financial coordination makes it possible to prioritise groups and activities to which single authorities could not give special attention by themselves, and this is a very important aspect of the initiative.

Priority groups include sick-listed and unemployed people, young people with mental health problems, young women and single mothers, and immigrants and refugees who are far from the labour market.

Activities include social work teams at primary health care centres, coaching and job-matching by employment services, vocational rehabilitation for young adults and cooperation with immigration offices.

Delta is one practical example of financial coordination. It was launched on the island of Hisingen in the municipality of Göteborg in 1997 as a pilot project, to serve a working population of 80,000. On 1 January 2005 it was subsumed under the new Act. Its work is now known as 'activities' rather than 'projects' to emphasise its permanent nature. Ten activities are currently underway in three categories: prevention, socio-medical, and occupational.

Evaluation and follow-up are very important. Since 2003 a government commission (Working Group on New Forms of Cooperation) has been established to develop a cross-sectoral system for follow-up of the results of cooperation and financial coordination and to design a nationwide framework for local follow-up. Feedback from activities is important in judging whether they are effective and good value for money.

Questions from peer country representatives

Q: Does the scheme bring any extra money? Since the different partners cover different geographical areas, can they move funding from one area of their responsibility to another covered by the CA?

Mr Wollberg: There is no extra money, and funding for financial coordination comes from within the normal budgets of the organisations involved. The aim is to make their activities more effective. The

partners decide how much money they wish to contribute. A large council like Göteborg might participate in a number of CAs.

Q: Why is the scheme voluntary? Is central guidance provided?

Mr Wollberg: Financial coordination is an alternative to routine collaboration between authorities. There are some problems with such unstructured cooperation, although there are also a number of good examples. Therefore it is up to the parties at local level to decide whether they need a more formal arrangement. Swedish municipalities already enjoy a considerable degree of autonomy in the way they work.

Nevertheless, support at national level is important, and comes from the government commission for the Social Insurance Agency, the National Labour Market Board, the National Board for Health and Welfare and, for example, through organising conferences and setting guidelines.

Q: Could one partner ' earmark ' its money to go to special groups, such as single parents?

Mr Wollberg: This is a matter for the CA, which decides how the funds should be used. However the four partners can agree, when they set up the financial coordination, what they want it to do and what are the main problems locally.

Q: In Norway, recent national structural reforms reflected the need for more cross-sector activities. Is there no national strategy for the reform of administration in Sweden?

Mr Wollberg: There is a lot of discussion about how to organise Swedish society, and whether to alter the responsibilities of authorities concerned with alleviating poverty and getting people back to work.

Q: The final evaluation takes place in 2008, but in the meantime more CAs are being created. Is there a rolling evaluation before 2008 so that bodies coming into the scheme could get a feel for how things are going?

Mr Wollberg: The SAPM prepares a follow-up report every year, and CAs also carry out follow-up and evaluation. Some results already exist, but there is a need for networking to exchange ideas. There is no national overall assessment, but some comparisons have been made between areas.

Q: What kind of cooperation existed prior to financial coordination? Between 1997 and 2000 there was discussion in Poland about coordination between social welfare and health authorities at local level.

Mr Wollberg: There was one pilot scheme involving health care and social insurance services, and another taking in social insurance, health care and social services. The new model adds a fourth partner: the employment authorities.

Comments by peer country representatives

Mr Envall specified that the cross-sector follow-up initiative is not designed primarily for evaluation, although it could be used for that purpose. Financial coordination does not set out simply to target a specific group such as disabled people, but takes a broader approach, with emphasis on vocational training, for example.

Ireland

Independent expert **Shira Mehlman** believed there is a value in financial coordination. In Ireland there have been pockets of good collaboration at local level, and the country is beginning to think about it at national level. However there are also many local cases of duplication of services or gaps in provision.

She wanted to know how to ensure that developments at local level are in tune with the national framework, how to identify specific needs in the context of this framework, and how to involve the social partners (employers' and workers' representatives).

Netherlands

Lennart Janssens from the Ministry of Social Affairs said the Netherlands focuses less on coordination. The emphasis is on giving incentives to the different players, including social services, employers, and unemployed people and job-seekers themselves. Recently, there have been major changes in the social security system.

The results are positive, but the bottom line is that the system is different to the one in Sweden. The downside is a lack of coordination or joint working on a voluntary basis, with clients being handed from one organisation to another. He believed the best answer would be to find a balance between voluntary coordination and financial incentives.

An example of one incentive is the benefit funding from national government to municipal councils. If they are successful in moving people off benefits and into work, they can keep the money saved and use it within their own budgets. They will not be 'punished' by a lower budget in the following year. The Dutch government allocates funds for social assistance to almost 500 towns and cities.

Another example is that of employers. When they fire someone, they have to pay to dissolve his or her contract. And if an employee is ill or has a disability, the employer must continue to pay wages for up to two years. This amounts to a very strong incentive for the employer to prevent people falling ill or to reduce the number of lay offs, and seems to be effective, although it does not always create a cooperative atmosphere. In some cases it takes away from the much needed dynamics of the labourmarket.

The lack of coordination between services is a problem for individual job-seekers who do not always know which organisation to turn to. The transfer of personal files takes a long time and information can be lost, sometimes due to problems with IT structure and implementation. This is a weak point.

Norway

Independent expert **Gro Kvåle** said the Swedish model is particularly interesting. Recent organisational reforms in Norway's welfare administration are aiming for the same goal: integrated services for social inclusion. In Norway at present there is virtually no unemployment, but a growing number of people on sickness benefit.

One response has been the setting up in summer 2006 of the New Employment and Welfare Administration (NEW), merging employment, municipal social assistance and national insurance services, with the aim of creating a holistic approach at all levels of the administration. A merger of ministries took place in 2005, followed by the local level in 2006. The government wants to offer "one door to the house" for people in need.

At the same time, the government and social partners have just concluded a new Tripartite Agreement on an inclusive working life, designed to reduce sickness absence and promote the recruitment of people with reduced capacities and older workers.

The new welfare administration is a necessary reform because there is a need for more coordination, but it is not enough, as further issues need attention:

1. Organisational structure is not everything; there need to be new ways of working with clients, and closer follow-up of individuals with complex life situations.
2. Employers, especially public employers, have to improve their practices because there is a risk that the financial incentives in the Tripartite Agreement could be used to increase budgets rather than make workplaces more inclusive.
3. Changing the workplace sub-culture, to boost acceptance of workers with reduced capacity and disabilities.
4. Medical doctors decide who is fit for work, but both specialists and GPs sometimes carry out 'sloppy work' when asked to assess individuals' work capacity.
5. The national insurance administration and employment services have had joint programmes for a long time, but municipal authorities are now the new partners.

Gunnar Tveiten from the Norwegian Ministry of Labour and Social Affairs said the Swedish model is interesting for several reasons. "Experiments have been going on for 15 to 20 years, but our conclusion is that it is difficult to sustain in the long run and to develop an overall approach for the coordination of different actors." This was the rationale behind the administrative reform, which should hopefully lead to better coordination at local level. Between 2006 and 2009, one integrated office for services will be established in each municipality.

The national Tripartite Agreement was concluded for the first time in 2001. In November 2006 it was negotiated for a further three years. It means that employers play a key role and have a major responsibility for improving the working environment of their workforce. If someone drops out of work, the employer must draw up an individual plan after six weeks to get him or her back into work. By 12 weeks, the employer must arrange a meeting with the GP to assess the individual's health and work situation. The aim is to agree on the person's capacity for work. Employers will be fined if they fail to respect the terms of the agreement.

The recent structural reforms are not enough to achieve full social inclusion. The government has recently drawn up a White Paper on labour market inclusion, proposing a new type of welfare contract spelling out the mutual expectations of the authorities and the user.

Also proposed on a trial basis is an improved system of permanent subsidies for employers, and a temporary national insurance benefit, linked to more active measures and follow-up, to replace the old rehabilitation benefit and time-limited invalidity pensions.

Ms Kashefi remarked that attempts in Sweden to organise a system involving employers have been unsuccessful.

Thematic expert **Rienk Prins** pointed out that in the Netherlands, in the 13th week of employee sickness the employer has to give a report on whether rehabilitation is working. It is compulsory for companies to employ occupational therapists (OTs).

Poland

Prof. Adam Kurzynowski said coordination is also under discussion in Poland, which is trying to build a new social policy model. The Swedish approach is very interesting for three reasons:

1. evaluation shows that results are better if local bodies work together;
2. it activates the partners to think about local development;

3. it promotes sustainable development, allowing for a combination of economic, environmental and social policy measures.

Two research projects on social exclusion and how to accelerate professional reactivation have been carried out recently in Poland, one by the Institute of Labour and Social Affairs and the other by the United Nations Development Program (UNDP). The idea of closer cooperation between social welfare, health and employment centres is not new, but results so far have not been very successful.

Work is underway, therefore, to create better conditions and better cooperation between labour and social welfare services. The 2003-2013 Social Policy Strategy provided for local social integration centres, but how can coordination be improved?

Getting long-term unemployed and disabled people into the labour market is difficult, requiring training and the creation of new jobs. However, by 2013 the current 15% unemployment rate is expected to fall to 8.5%, and the long-term unemployed will benefit as a result.

Studies show that whereas 10% of social welfare beneficiaries take on work, half of them return to welfare within the first year, meaning that only 5% achieve real economic independence. Disabled people make up 14.3% of the population, but the proportion of them who are economically active is only 19.2%, so there is a lot of scope for professional reintegration. Two options exist: the social economy and the open labour market. In 2004-5, 167,000 disabled people were working in protected employment and 750,000 in open enterprises. This suggests a large potential for the employment of more disabled people in the open labour market, and studies show that this is the best way to achieve social integration.

Good relations between different partners at local level are crucial to success at national level. In 1990, two new laws brought about important changes in Poland's social welfare system, but conditions have developed and new regulations are needed. Further social policy legislation in 2004 provided for social contracts.

UK

Independent expert **Peter Wright**, from St Thomas' Hospital, London, focused on the health risks of social exclusion. Evidence shows that work is good for people, and for their health. For 90% of people in 90% of jobs, health improves when they are in work, and deteriorates when they are unemployed. Equally, people on disability pensions, unemployed or long-term inactive display better health when they get a job.

Many of those who leave work before the standard pension age already show some signs of disability. Among lone parents in the UK, the incidence of mental health problems is three times higher than in the general population.

He highlighted some of the barriers to moving into work, including the distance to be travelled, and the need to get people closer to the workplace. The labour market is also significant. The UK is lucky that in recent years labour market conditions have been favourable, and this has facilitated support for a return to work for people whom it would not otherwise have been economically justified to help. This in turn means that authorities in the UK are now dealing with individuals even further from the labour market, and this group is very difficult to assist.

For example, people on incapacity benefit for 18 months to two years are more likely to retire or die than return to work. People just coming onto benefits (known as 'the flow') are easier to help than those already on benefits for a number of years ('the stock').

Merging services is one way of approaching problems of coordination. Experience in Australasia shows that it takes some years to complete a physical merger. After that, an equal amount of time is needed to overcome problems and get people to work together. In Australia and New Zealand, for example, the good results they hoped for did not occur at once.

Another approach is the adoption of individual budgets: the idea that people with disabilities should be able to control the services they receive (as in the 'personal reintegration budget' in the Netherlands). The underlying question is how much control should be retained at national level, how much locally, and how much ceded to individuals themselves (for instance through the issue of vouchers)? Individual budgets are a challenge for service providers because it means managing a market of informed people who are making choices about what they buy. Dr Wright was interested to know how much say individuals have in Delta.

Discrimination legislation complicates the relationship with employers, as under EU law they have to change the job to meet the needs of the employee. How can an individual employer in a small or medium-sized enterprise (SME) make the sort of adjustments required, even with advice?

Greece

Athanasios Gatzogias from the Ministry of Health and Welfare underlined the need for research into users' opinions of the measures undertaken, and to take account of human dignity. They can only be judged to be a success when they receive approval from the individuals they support.

Comments by European stakeholder representatives

European Social Network – see Annex 4

John Halloran explained that the European Social Network (ESN) is a network of directors of social services in 24 countries across Europe, and introduced some of its activities: promoting social inclusion through good quality social care and partnership with service users, and the exchange of best practice.

The themes it addresses are

- access to quality services,
- anti-discrimination and integration,
- social and employment activation,
- child poverty and welfare,
- long-term care (older people and those with disabilities)
- social services and social inclusion

He reminded participants that the EU in 2007 will focus on child poverty and welfare.

Social services are increasingly including employment services, with the aim of promoting social inclusion. Joblessness is closely related to social exclusion, and the division between social services and employment is being questioned. It would be beneficial all round if they were more closely allied. The problem remains of how to help people who can never work.

Mr Halloran's presentation was based on comments from ESN members and the network's thematic inclusion work. He listed three areas of concern about the Swedish system: the client as priority, the problems of inter-agency working, and the missing stakeholders: employers and trade unions.

Clients are the **primary stakeholders**, and consulting those for whom the services are being reorganised – both individually and collectively – must be a top priority. People have complex problems and services should supply what they need, not what staff think they need. Individuals must have maximum opportunities for social activation. Their potential is often much greater than we imagine, said Mr Halloran, taking disabled people as a specific example. There is still a long way to go to achieve integration: "Where are the disabled people in the European Commission?" he queried. Personal follow-up is also crucial because if jobs are not sustainable it can compound the individual's social exclusion.

Inter-agency work can have a real value, especially for people with multiple and complex problems, if it is carried out in the right way, but this means finding the appropriate response to clients' needs not only between services but also within services, including health workers, GPs, psychologists etc.

Good coordination goes beyond putting staff in the same building or sharing budgets, because organisations tend to have a single operational path in terms of management, funding mechanisms, professional backgrounds etc, and find it hard to embrace change. It is important therefore to introduce joint training for managers and professionals.

ESN members had raised questions about some aspects of financial coordination: who is ultimately in charge, how are conflicts resolved and who determines directions and priorities, and where are the performance indicators?

Mr Halloran emphasised the problem of the **employer** as the missing stakeholder. What can be done to ensure that economic growth is tied into social protection? For example, if Delta worked more closely with local employers it could identify skills gaps and help to fill them. Subsidised work placements could be arranged, and employers made more aware of Delta's services and open to adapting their workplaces.

Having raised these questions as issues for discussion, he asked finally whether the Swedish model might even be too cautious, wondering if there might be more to gain from the total transfer of responsibility to a single agency, or lessons from experiences in Norway, Germany and the Netherlands.

European Federation of National Organisations working with people who are homeless (FEANTSA) – see Annex 5

Dearbhal Murphy introduced the work of FEANTSA: an NGO comprising a network of over 100 organisations – many of them umbrella groups of service providers – with the key aim of ending homelessness in Europe. It was launched in 1989 on the initiative of national organisations, and is core-funded by the European Commission. Her contribution drew on the experiences of FEANTSA members across the EU.

Delta's target group tallies with FEANTSA's own clientele of homeless people, who often suffer from multiple social and health problems, and therefore its work is very relevant to the federation's

objectives. FEANTSA has long supported the principle of 'joined-up' services. There is little tradition of working holistically in many European countries, she observed, and it is difficult to get people to look beyond their own immediate areas of responsibility. For example, homeless people are often discharged by health services, with no follow-up to check on their welfare.

NGOs have a big role to play in the problem of homelessness. There is an increasing trend for public authorities to outsource services in this area. Therefore NGOs should be fully involved in structures like Delta. Housing is an important element to include in social inclusion activities, since when people are homeless it is difficult to resolve any of their other problems.

Services should be working together in such a way that one agency can act as a 'gateway' to others, so as to meet a variety of different needs as efficiently as possible.

Ms Murphy raised a number of questions about Delta, from the perspective of the homeless sector, focusing on the role of NGOs, how Delta deals with housing problems, and what are the gateways into the system?

She said the perspective taken by the peer review discussion papers suggests the main aim of financial coordination is to promote integration into the labour market. However, there could be a more general objective of social integration. Joined-up working is more effective in general and could, for example, reduce reliance on emergency services, thus reducing costs in the long run. In her view, it should be possible to develop skills that would lead to long-term rather than immediate integration into work.

It is important to maintain a focus on prevention when dealing with people with multiple needs such as loss of housing and loss of employment.

She concluded that Delta seems to be a good way of bringing together services and doing away with administrative hurdles. The sharing of premises and team meetings is a simple but effective way of promoting cooperation.

Presentation of the Discussion Paper – see Annex 6

Thematic expert **Rienk Prins** introduced his presentation highlighting specific aspects of financial coordination in a European context and raising topics for discussion.

He said that Delta is unique in two respects:

1. It was launched in 1997 and was thus one of the earliest experiments in coordination of services in Sweden;
2. It is one of the few examples where systematic evaluation has been carried out.

The strong points of financial coordination in Sweden include years of experience, the reduction of demarcation problems and administrative hurdles, and a clear formal framework established by the 2004 legislation. Appropriate target groups are people on long-term sick leave, homeless and disabled people, and those with multiple problems.

The common barriers to better cooperation experienced in many countries include funding restrictions, cultural differences between organisations, regional variations, differences in priority target groups and strict demarcation of responsibilities.

Ireland, UK and Poland have already made attempts to resolve these problems through inter-agency cooperation or multi-agency teams, national coordination committees, joint bridging programmes and bringing together employment and rehabilitation services. While full results are not available, experience in Ireland shows that the benefits include better communication, better knowledge of the range of services and peer support between agencies, while the ongoing difficulties stem from a lack of shared information, organisational barriers, and poor client participation.

Mr Prins posed a number of questions:

- what type of activities to prioritise, covered by three categories: preventive, social and occupational?
- Employers make no financial input to the Swedish model. What should be the role of employers, and how can their commitment be increased? For example, should the social partners and NGOs form an advisory committee?
- What lessons have been learnt about making teamwork more effective?
- What support structures are required? For example, the Netherlands is compiling a single database for all social assistance beneficiaries. Would an information campaign help to make potential clients more aware of what is available to them? What training is necessary for staff?

Discussion themes – drawing on peer group comment papers

Mr Prins identified six themes:

1. Aims and scope

How to undertake prevention work; should the main objective be employment or employability?

2. Policy issues

Deciding priorities, allocating budgets, accountability.

3. Implementation and operation

Time scales - effective coordination takes years to work;

How to identify good performance indicators – is a monitoring system required and how can outputs be compared?

Would a single agency be more effective?

At what stage do clients enter and does the system satisfy their needs?

What is the impact on health care costs (given that Delta, for example, does not 'buy in' services) and are health professionals more difficult to integrate?

4. Role of other stakeholders

How to boost the involvement of employers, NGOs and social partners? For clients on long-term sick leave, social workers in Delta invite employers to a meeting, which they usually attend, so employers are involved at individual case level, as well as having responsibilities in law. Should there be a greater priority for 'user-led' definitions of need? Are rehabilitation plans drawn up in consultation with the client?

5. Transferability

Is the model relevant to other countries with different institutional arrangements, such as UK and Ireland? Can it be extended to other target groups? If greater responsibility is transferred to the client does this favour better-educated users?

6. Perspectives

What changes are foreseen in Delta? What happens in areas where agencies decide not to take part in financial coordination? Are there benefits to allowing different models in different countries or should practice be uniform?

Discussion

Mr Envall reported that costs in Delta activities have not been measured. In a different part of Sweden a health care project has measured costs for health care and showed that investments in coordination were recovered very swiftly.

Mr Wollberg said the employment versus employability question is important and relates to how the labour market functions. Are there alternative labour markets for people who cannot secure a job or operate 100%? The more authorities work together the more they can promote employability and even change labour market conditions.

Mr Tveiten highlighted the importance of starting with the rights of individual clients when defining needs, and asked whether Delta can influence the local labour market.

Mona Stål from the Swedish Ministry of Industry, Employment and Communications said welfare services are 'the victims' in so far as they depend on the labour market without being able to control it. Aims must be adapted to circumstances: it is easier to get people into work when the labour market is strong, but at the same time it is always possible to bring people nearer to employment.

Mr Halloran pointed out that employment need not be the sole focus and it is legitimate for people to be encouraged to fulfil their potential in other ways, while at the same time respecting their right to have a job. He felt there should not be a conflict between employment and employability. Authorities often have economic development departments and can influence the sort of businesses that set up in their area. Those responsible for employment generation should be active partners in social inclusion initiatives, as well as social protection agencies.

The question was raised as to whether local authorities have a responsibility to set a good example in employment practices.

Ms Chylek said in Poland there were many projects involving cooperation between local authorities, NGOs and social partners at grass-roots level. Social welfare and employment staff cooperate on a daily basis, for example to find out whether individuals are receiving benefits, but this is not required legally. Discussion is underway on developing a legal framework covering every local authority. A common database merging information from social services and labour offices is one of the priorities and is going to be supported by the ESF.

Ms Mehlman queried how examples of local good practice can be used to influence national policy. In the context of the European Commission's EQUAL programme, work is underway in Ireland on how to mainstream from local to national level, but this is very difficult and there is more evidence of what does not work than of what does.

Activities focus on three areas: drug rehabilitation, ex-offenders, and young people – with good local initiatives but lack of clarity about national involvement. There is a national policy group run by the Ministry of Labour, but attendance is not strong.

Leo Sheedy from the Irish Department of Enterprise, Trade and Employment drew attention to Ireland's national disability strategy, which is a major undertaking comprising new legislation, assessment of needs, access to information, a new centre of excellence and inter-departmental joined-up thinking on delivery of services. It is necessary to identify disincentives and barriers, and ways of activating people with disabilities.

Dr Wright drew attention to the Jobcentre Plus Pathways to Work initiative in the UK, bringing together employment and local health services. As regards local coordination, local authorities are funded by a government department (the Department for Communities and Local Government) and the quality of their services is assessed by the Audit Commission. They are now being encouraged to work with all local stakeholders, including those concerned with employment through Local Strategic Partnerships, which produce a Local Area Agreement on how they will co-operate to improve the situation of the local population. As part of the Agreement, they should develop an employment strategy using the tools they have, including measures to develop the local labour market. "We are using the experience we have to go stage further," said Dr Wright, including developing a range of indicators.

Focusing on support mechanisms for financial coordination, **Mr Envall** said the Working Group on New Forms of Cooperation is currently producing a handbook. Delta has a good website, with guidelines and other documents used for reference in setting up new CAs.

A twice-yearly conference, to which CAs can send two representatives each, is now growing so big that it may be more difficult to organise in future. On a point of clarification, he said the partners do not spend 5% of their budgets on financial coordination, as suggested in one of the peer review papers.

Site visits

In the afternoon the peer review participants divided into two groups and visited the Delta project on the island of Hisingen in Göteborg. The city has one municipality but six districts: two of them involved in Delta, together with primary health care, employment and social insurance services. Hisingen has a population of 125,000, of which 80,000 are of working age (16-64). Some 15,000 of these are either unemployed, disabled, or on social benefits. Around 1,900 people have been on welfare for more than 10 months. Delta's client group is about 4,000 people a year, facing difficulties such as mental illnesses, musculoskeletal disorders, complex social problems or at risk of long-term ill health.

*One group heard a presentation by the **Coordination Association** (see Annexes 3 and 7), in which process facilitator **Cecilia Abrahamsson** described how an activity develops out of an idea for responding to a specific need. Nearly 100% of ideas become activities, but a smaller percentage is taken over by the authorities as regular measures.*

Bringing people together in multidisciplinary teams creates new knowledge and skills, and also greater flexibility. Clients access Delta services in different ways, but those entering via the socio-medical strand tend to have more social capital and are therefore more successful.

Most if not all Delta clients are unemployed, and the aim is to get them 'job-ready'. For those with a job and on sick leave, Swedish law obliges the employer to draw up a rehabilitation plan within one month.

The second group visited one of the Delta occupational activities, the **Labour Market Plaza**, designed for unemployed youngsters on social welfare or people who are not ready to take employment immediately. A lot of people have problems contacting employment services, and young jobless find it difficult to get into the labour market. A case manager is responsible for each individual, and clients' periods of unemployment are reduced. People seldom remain with the Plaza for more than 12 months. Recent figures show 51% in occupational activities for less than six months, 23% for less than 12 months, and 26% for longer. Some 40% of clients in occupational activities get jobs, and a further 5% secure subsidised employment, but are nonetheless off welfare and paying taxes. Some 23% leave without a clear explanation.

Feedback from site visits

The peer review participants commented on the high level of support and commitment among Delta staff, who obviously share common values and joint goals, as well as the creative range of activities and the willingness to address the needs of users. Forming an individual programme for each client means that employment may not always be the end result, but the opportunity is always "on the desk". The contractual process means that clients are involved in making decisions about their future, but **Mr Halloran** was still not sure whether the main objective was to secure work or general well being. **Ms Mehlman** said what mattered was whether people on the ground felt they were getting a better service.

Mr Prins remarked that there seems to be a lack of performance indicators and benchmarks and **Mr Janssens** hoped that the 2008 evaluation would produce comparable data. **Dr Wright** pointed out that attempts to obtain feedback from former clients had brought a poor response.

While some members of the peer group queried whether the project will be sustainable in ten to 15 years time, others found it well resourced. **Ms Chylek** said that following the site visit she understood why continuity of funding is so important. In Poland, projects are financed by external sources so projects usually come to an end after a few years, at the most. **Ms Murphy** commented on the apparent shortage of NGO involvement in Sweden, and others wondered about the possibility of wider consultation.

Dr Wright was concerned about the lack of clear criteria for including or excluding individuals which would complicate any evaluation, given that only a small proportion of social welfare recipients are in Delta.

Day 2

Key elements of the strategy and explanations

Following a series of questions arising out of the site visits, the Swedish hosts (Peter Wollberg, Elis Envall, Bettina Kashefi and Ola Andersson) gave some further background information on financial coordination.

A legislation for financial coordination is required because Swedish municipalities and county councils have a high degree of autonomy and taxation takes place at three levels. Therefore they need legal authority to work together.

The target group is laid down precisely in the Act and comprises the 5% of the working population (20-64 years) with specific problems, although there are no rules for how long someone needs to be sick-listed or unemployed to qualify. The main criterion is that clients require the services of more than one authority. They may be admitted (to socio-medical activities) after presenting at a primary health care centre, or when referred by an authority, but there are no precise conditions.

Employment or employability? The aim is to get people into the labour market, but that may require two stages, and can be either sheltered or open employment. Around 10% of clients go into further training, and can get loans or claim benefits to pay for educational costs.

Who deals with non-Delta clients? Improved cooperation now exists between services (social insurance, health care, employment), outside financial coordination, so it is up to the local partners to decide how other claimants are handled (just under 75% in Hisingen). Cooperation has always been needed, but financial coordination exists for people with special difficulties. There are many forms of non-formal cooperation, and some areas feel they do not need financial coordination.

In Norway, 17% of those seeking social assistance are estimated to have multiple needs, stated Gunnar Tveiten.

In Hisingen among the 15,000 people of working age outside the labour market, 4,000 are in Delta, and 2,000 of these go to the Labour Market Plaza, which is just one of 10 activities, working with people nearer to the labour market.

Göteborg is the second largest municipality in Sweden. Smaller authorities, for instance in the north of the country, find cooperation easier and have less need of financial coordination. Sweden has discussed merging smaller municipalities, as in Denmark, but this is unlikely to happen.

Individual services have their own databases, but Swedish legislation does not allow for **shared data**, although there is a move to build up a cross-sector database with clients' permission. For the future, the new government wants to involve more municipalities in financial coordination, but perhaps in a looser structure with fewer partners. Across Sweden, about 80% of people on long-term benefits are immigrants.

Key element 1 – Prevention activities

Prevention focuses on people who are already in Delta, and especially on the 'flow' of recently unemployed, to prevent them becoming 'stock'. Primary health care is also a form of prevention. As in the Netherlands, although not in many other Member States, it is not legal in Sweden to fire an employee on grounds of sickness.

Bengt Sibbmark from the Swedish Ministry of Health and Social Affairs outlined the steps that follow sick leave. Individuals who cannot return to work will eventually be transferred from employment to a service that can help them. In Sweden people can receive sickness benefit when they are unemployed and not able to look for a job – this comes from social insurance.

Key element 2 – Involvement of employers

Norway: Gunnar Tveiten gave more details of the Tripartite Agreement for inclusive workplaces (the so-called IW Agreement). In 2001 the government decided to take a different and unusual route, shifting part of the responsibility for sickness absence onto the social partners, in order to reduce movement from the labour market onto benefits. The Tripartite Agreement 2001-2005 sought to

establish the workplace as the main forum for preventing sickness absence, with the aim of cutting the number of workers on sick leave by 20% on the second quarter of 2001, securing work for people with disabilities, and extending working life and preventing early retirement.

Companies were obliged to draw up a mandatory follow-up plan after eight weeks' sickness, and could enter a cooperation agreement with the national insurance administration.

IW businesses cover 60% of the workforce and benefit from special regulations and support from newly established work centres under the national insurance administration. It includes organisational development, assistance and other measures, such as compensation for employers who adapt their workplaces to the needs of people with health problems (30 euro per day for up to 36 weeks), and refunds for occupational health services and preventive measures (e.g. organisational, psycho-social or ergonomical innovations) in IW businesses.

The results from a mid-term evaluation in 2003 were rather disappointing and sickness absence continued to increase. The agreement stayed in force until 2005 but some tightening took place in 2004. For example, a doctor's evaluation was required after eight weeks. In late 2004, the absence rate fell sharply.

The agreement was renegotiated in 2006. The government wanted to increase further the burden on employers, but the social partners refused, leading to a compromise deal. Changes mean that the plan of action must be in place after six weeks, not eight, and the employer must organise a meeting with a doctor within 12 weeks. Penalties for non-compliance were increased.

The role of doctors as gatekeepers has been a major issue. Under the new agreement doctors must give an extended evaluation of the patient after six weeks. Doctors who do not comply can lose their sickness absence certificate.

Netherlands: Lennart Janssens reiterated that the Netherlands imposes financial incentives on employers to prevent sick leave and disability, but not unemployment. Employers are responsible for the first two years of workers' illness, and must pay wages (70-100%) until they return to work, regardless of whether the ailment is work-related. After 12 weeks, the employer, employee and occupational therapist must draw up a rehabilitation plan. If they fail to do so, the two-year period may be extended. Employers must also establish plans for sickness prevention at company level. The rules apply equally to SMEs, but they can purchase insurance to cover the costs. Some subsidies are available for companies to employ disabled people.

UK: Peter Wright said Job Centre Plus was launched to reverse the trend of shifting hard-to-handle clients from job centres to benefit offices in a bid to meet employment targets, and to offer more proactive help for difficult groups such as lone parents and disabled people.

Since 1974, the level of long-term disability benefits have increased and become higher than those of benefits for unemployment, offering an incentive to become registered disabled. Furthermore, people were anxious to avoid losing disability income as they moved closer to employment, so the government introduced a transition payment to ease returning to work.

He felt it was a good idea in principle to merge benefit and employment services, but the survival of different working cultures means this does not resolve all problems immediately, and the full effects take time to develop.

Current reforms in the UK will mean radical changes, bringing disability and unemployment payments into line. There will be a separate structure for the 10-15% of severely disabled people. The rest will be obliged to make an effort to find work, and will receive extra payment for this effort.

New groups of trained advisers will help to get lone parents into work. Lone parents have particular needs, relating to mental health problems, for example.

He drew attention to the time required to develop a common working culture. Staff must be reskilled, and this new skills mix is visible in Delta. In the UK the government is keen to put services out to tender, meaning that Jobcentre Plus will be 'in competition' to provide services.

Tricia Griffiths from the UK Department for Work and Pensions confirmed the high proportion of lone parents in the UK, and said that Delta's approach in this area had definite transferable aspects. Since reforms in 1997, 2.3 million people have moved into work, and Job Centres are more welcoming places. Services must now be 'evidence-based', with proof of what works and what does not. She said that Ms Kashafi had indicated that she would be interested in visiting the UK to assess comparable approaches.

Relevance and transferability aspects of the policy

Feedback from workshops

1. All the peer countries acknowledged that finding the best way to coordinate the different services required to help the most socially excluded individuals, furthest from the labour market, is a pressing issue. Solutions range from voluntary cooperation at local level to the statutory merger of departments at national level.
2. Some of the participants were doubtful about whether financial coordination could be applied to a centralised benefits system, but in so far as it offers a model of a joined-up, horizontal rather than vertical process, this could indeed be transferred. Peer group members were also impressed by the enthusiasm they found among Delta staff.
Norway, however, would not need to introduce financial coordination. Under its centralised system nearly all funding comes from central government, with the recent merger providing for stronger cooperation. However, Delta can offer lessons on how to make practical, day-to-day cooperation on delivery of services work better. At local level there are significant differences in the 'Nordic model' as implemented in Sweden, Denmark and Norway.
3. It is a good approach for supporting people with multiple needs. Comparison was drawn with the **Polish** enterprise development scheme for bringing disabled people into the labour market. It has created 11 work clubs, to prepare disabled people for work in 44 large, open enterprises employing some 45,000 people. The approach is similar to Delta, but aimed at one specific group of clients. It is important to operate at a local level, and more input from NGOs would be beneficial. In Poland they are partners.
4. Secure, long-term resources and central support provide for continuity of activities and staffing, and this is very important. The local funding element facilitates coordination and co-location.
5. The financial coordination system unfolds over a period of time and therefore allows for a gradual change in working cultures. It takes years to transform attitudes, For instance in the **UK**, the move away from the very centralised system introduced after the Second World War towards greater involvement for local authorities has been slow. "We have to persuade politicians to be patient," observed Dr Wright.
Doctors and clinicians are notoriously unwilling to adapt working practices. Delta implies a change of attitude since it calls on GPs to shorten treatment times in order to keep people in work.

6. Spreading the message that responsibility must be shared. **Greece**, for example, has a very complex welfare system with no networking between departments covering health and employment. Many people are unaware of their rights. Greece depends on considerable EU funding and welcomes assistance in introducing good practice in these areas. It was suggested that reforms could be proposed within the next EU funding period.
7. There was widespread agreement that Delta is an innovative example of good practice. Financial coordination already works to unite providers, but the Delta project offers another proactive layer that helps to achieve results.
8. The way Delta selects clients was not very clear and therefore difficult to replicate. But the approach could be introduced for a defined target group.
9. Local schemes like Delta should be able to feed back into national policy development. In **Ireland** there is a tendency to regard local initiatives as "all good" and national ones as "all bad". A better interface between the two levels would be helpful.

Other potentially transferable aspects included:

- Cross-service case conferencing;
- Offering employment advice as a standard feature of social assistance;
- Increasing take-up of projects.

Proposals to the host country

The peer group made a number of suggestions as to how Delta might be improved:

1. Selection criteria should be better defined. Staff apparently use an 'instinctive' approach, but transparency and objectivity is important to ensure that clients are not subject to discrimination or social exclusion at this stage as well.
2. A greater input for NGOs and the social partners.
3. More emphasis on securing the active engagement of employers.
4. Evaluation needs to be more evidence-based, with indicators, benchmarking and quantified results.
5. Look at ways of increasing client involvement. Evaluation should survey users and take account of people's experience. To get a clear picture, it is necessary to track not only those with successful outcomes but also clients who drop out.
6. Create a budget for the 'buy in' of services that might not be directly available (this practice works in Ireland).
7. Draw up a model for deeper analysis of results, in addition to the evaluation process.
8. Adopt measures to publicise Delta, e.g. through a directory of success stories to show to policy-makers.
9. More horizontal exchange of experience (peer review?) between projects around the country. It is important to use a creative approach to disseminate good practice from one place to another.
10. Consider extending the model to take in other government services such as housing and education.
11. Social workers might be encouraged to spend one day a month in local workplaces, in order to experience jobs and get to know employers.

Final session and conclusions

Involvement of NGOs: participants pointed out that NGOs can add value to the design and evaluation of services. Immigrant bodies can often help to gain access to or inform clients – as happened when Sweden launched a campaign on female genital mutilation. Will the forthcoming EU Services Directive have any impact, in increasing the number of service providers so that local authorities could, for example, contract NGOs to supply services? Delta could set up specific activities to ‘spin off’ to NGOs.

The Swedish Ministry had a ‘user delegation’ on social inclusion, which was consulted on policy, but NGOs in general are not so active in Sweden as in some other Member States. **Mr Envall** promised to look at this issue and how it could be incorporated into the structure of financial coordination. He pointed out that up to now the newly established CAs have not been spending a lot of money, but there are plans to increase expenditure, leading to some concerns about the impact on budgets in the future.

Mr Prins suggested offering incentives to employers to get people back into work. He also urged a wider dissemination of results and experiences, among Member States and peer review participants. Finally, he wondered whether there could be a bigger role for social workers in employment issues. In the Netherlands, large companies used to employ social workers because they could communicate with the workforce better than personnel managers.

Mr Envall agreed that some social workers in Sweden used to specialise in personnel administration, but have now been replaced by ‘human resource consultants’. “It’s worth thinking about the need for social work competency in these areas,” he concluded.

Mr Halloran suggested it would be useful to bring together and disseminate the results of earlier peer reviews on similar topics, such as coordinating services or mobilising local actors.

Bettina Kashefi thanked all the participants and said that she had found the two days very interesting: “I have learnt a lot from all of you.”

She highlighted three conclusions for the Swedish hosts:

1. the need for evaluation of the programme, with clear indicators;
2. the legislative framework is important for the stability of financial coordination projects;
3. it is important to link national policy objectives to what is going on at local level.

The ultimate goal of financial coordination is employment, but on the way, “employability is a necessity” – the programme stands on two legs. Unsubsidised work would be better than sheltered work, but is not always possible. She promised to take the lessons she had learnt back to the Ministry of Health and Social Affairs.

Hugues Feltesse thanked the Swedish hosts for their hospitality and for the preparatory work that had helped to focus the discussion so constructively.

Putting the peer review in context he mentioned several key points:

1. Through the European Commission’s Open Method of Coordination (OMC), it is vital to promote an integrated, multi-dimensional approach to tackling social exclusion. The Commission has drawn attention to the need for Member States “to develop integrated and coordinated responses to multiple disadvantages so as to ensure synergies between the different policy domains identified in the common objectives which underpin the social inclusion process”.

2. The Lisbon Agenda makes it necessary to extend working life, promote quality jobs, and build a more cohesive society in the EU.
3. In the 25 Member States' new National Action Plans, universal employment policies are often not adequate to integrate the most vulnerable groups.
4. A targeted approach is therefore required, and some NAPs have underlined the need for interaction and synergies between social and employment services.
5. All over Europe, a lot of small-scale projects are underway, many with EU funding (e.g. through the EQUAL programme). However, as the Commission President José Manuel Barroso emphasised this year, it is now necessary 'move up a gear' to address the main objectives at EU level.

He outlined the key lessons from the Swedish experience of financial coordination:

1. A bottom-up approach brings services closer to the needs of users;
2. It provides a good balance between universal services and a targeted approach, so as to avoid missing people with complex problems and needs;
3. The innovative aspect of the Swedish policy – financial coordination – is just one part of a process which boosts capacity for the common identification of problems and for finding ways to address them;
4. While Delta improves local service delivery, it is important that it has support at national level and a strong monitoring process;
5. An appropriate timescale allows for real change to take place. It is a mistake to expect results from short-term measures introduced "between elections". Such a time frame is inadequate when long-term cultural adaptation is required.
6. It is necessary to build capacity for new flexibility and partnerships for the provision of benefits and services.

We now have to examine how to go further, said Mr Feltesse. We need to share more information, experiences and tools for coordinated working and promote new skills among workers. How can this be done concretely, so as to avoid misunderstandings? Joint working has to be well managed. We need to integrate these issues into the social dialogue. Without a relationship between employment and the social integration of people with problems, and the commitment of all relevant actors, it will be very difficult and there will be barriers.

We need better common definitions in order to understand levels of success. For example, regulations surrounding sick leave vary from one country to another.

We need to replicate the peer review programme at different levels, and capitalise on good practice. We have to think about new ways of shared information management, with the many different actors involved. The OMC is a good means of support, through transnational projects and studies.

Perhaps financial coordination forms the basis for a new social policy model that could be applied to other issues such as homelessness, poverty, and the social exclusion of children. How can we use this experience?

Closing the meeting, **Peter Lelie** from the European Commission DG Employment, Social Affairs and Equal Opportunities, (unit for inclusion, social policy aspects of migration, streamlining of social policies), noted that the issue of monitoring and evaluation had arisen frequently during the meeting, and within the OMC on social protection and social inclusion this is seen as crucial. It is a subject for

mutual learning in its own right, so as to enable decision-makers accurately to assess the impact of policies.

The latest guidelines on social protection and social inclusion emphasise arrangements for monitoring and evaluation. The Commission is currently examining all the reports with a view to putting forward a new initiative.

In 2007 there will also be a peer review at the level of the Social Protection Committee on child poverty. Many countries have highlighted this problem. The Committee has set up a working group on child poverty and well being, and sent a questionnaire to Member States to find out more about monitoring and evaluation mechanisms. The peer review will look at two angles, with not only a discussion on strategies but also a comparative analysis of monitoring and evaluation mechanisms. This could feed into later peer reviews. The crucial question is how we are measuring the impact of what we are doing, concluded Mr Lelie.