



Sweden 2006

Integrated Services in Rehabilitation – on Coordination of Organisation and Financing

Synthesis Report

Rienk Prins
ASTRI



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



Executive summary

The most socially excluded individuals often suffer from not one but a whole range of problems, including unemployment, homelessness, bad health, poor educational qualifications, poverty and drug or alcohol abuse. In the various European Union Member States, many of these issues are dealt with by different departments or at different levels of public administration (national/regional/local), creating a risk of lack of continuity in social inclusion efforts, and of individuals being passed from one body to another or being missed altogether.

In its report *Social Inclusion in Europe 2006*, the European Commission draws 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”.

Since the 1990s, the Swedish government has launched a number of projects aimed at promoting an integrated, multidimensional approach to social inclusion, and thereby offering better services to individuals in need. A Peer Review meeting took place in Gothenborg, Sweden, on 4-5 December 2006 to assess the initiative: *Integrated Services in Rehabilitation – on coordination of organisation and financing*.

The policy under review allows for financial coordination on a voluntary basis at local level between social insurance offices, primary health care services, municipal social services, and employment boards. Each allocates an equal amount to a pooled budget, administered by an independent Coordination Association. The part of the national government authorities – the employment boards and the social insurance offices – is financed by the Social Insurance Office.

By September 2006 there were 41 coordinating associations across Sweden. The scheme targets the estimated 5% of the working population with specific or multiple problems.

The review focused in particular on the Delta project in Hisingen, Gothenborg, launched in 1997 in advance of the legislative framework provided by the 2004 Financial Coordination of Rehabilitation Measures Act. The peer group visited Delta’s offices and one of its activities, the nearby Labour Market Plaza. Delta deals with about 4,000 clients per year and has a budget of SEK 44 million in 2006. Evaluation so far indicates that it lowers social welfare costs, and the majority of clients are satisfied.

The representatives from most peer countries acknowledged, that rehabilitation service provision to the most socially excluded has a high priority. Many countries try solutions with various coordination structures, which vary from better communication and information channels to merging of services and one stop shop constructions, where the client is dealing with one official or consultant. Consequently, the comparatively long Swedish history of implementing financial coordination was a stimulating source of information and basis for exchange of experiences.

Some of the participants were doubtful about application of financial coordination in their country. Their system is more centralised than the Swedish system, where county and municipality have considerable

financial autonomy. Notwithstanding, the Delta model offers for each country valuable insights into the day-to-day cooperation on delivery of services.

Further the question was discussed how to involve the employer in the process of labour reintegration. Delta pays attention to the employers as they are invited to information meetings (which they attend) and also in individual cases they are approached by Delta staff. For most peer countries the involvement of the employer, apart from the legal obligations, is a point of concern.

Some representatives favoured a role of NGOs in cooperation models with various stakeholders. Swedish representatives indicated that there is no tradition of NGOs playing a role in service delivery. In other countries NGOs may have various positions as to advising on rehabilitation policies, advocacy of clients or involvement in service delivery.

If routine or unstructured cooperation is poor and not fruitful the introduction of a new collaborative structure shows to need time. The financial coordination system unfolded over a period of time and therefore allowed for a gradual change in working methods and cultures.

Experimenting and implementing coordination structures further requires constant monitoring and regular evaluation. The Swedish project has shown to be systematically evaluated. Success parameters, however, may need further attention.

There was widespread agreement that Delta is an innovative example of good practice. Coordinated or integrated service delivery shows to be better equipped to identify and to serve the needs and demands of clients with complex problems, than when stakeholders work isolated, focussing on their (current) competencies and responsibilities. It may be difficult to apply in countries with more centralized support and benefit structures.

1. The national context

1.1. Actors and responsibilities

As in most EU countries, in Sweden the provision of rehabilitation measures is a responsibility of various actors. Main 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 aims and objectives of these various actors 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.

Employer's responsibilities are limited to occupational rehabilitation interventions that can be implemented as part of the organisation's own employment and social policy.

The principal responsibility for the Swedish social insurance system lies with the government. The administration is carried out by the Swedish Social Insurance Agency, a central government authority with local and regional offices. The agency is responsible for the coordination and supervision of the rehabilitation interventions implemented.

The overall responsibility for health and medical care services rests with 18 county councils, two regions and one municipality. The health and medical care services are responsible for the provision of medical rehabilitation: medical care, treatment and rehabilitation. The health and medical care services also should provide data for assessing rehabilitation needs and designing suitable interventions from other actors (e.g. social insurance agency).

Sweden's 290 municipal councils have the responsibility for social rehabilitation. They should ensure that all residents in the municipality receive the support and assistance they need. Municipal responsibility regards the elderly, disabled people, children and young people, immigrants, and people with substance abuse problems. The individual's social rehabilitation may include advice, support, services, employment and treatment.

Labour market policy is administered by the National Labour Market Administration, which is responsible for job placement activities, occupational rehabilitation and training aimed at helping people find a job. The agency comprises the National Labour Market Board and 20 county labour boards, the latter incorporating the local Public Employment Service offices.

1.2. Towards better integrated and coordinated rehabilitation

It was noted in Sweden that if each actor follows his own targets this may lead to conflicting priorities, with implications for the individual. Rehabilitation measures showed not to reach their intended target or did not have the desired effect. The same was observed when one actor takes over ongoing rehabilitation from another: important information can be lost if rehabilitation planning to involve more than one actor, is poor or inadequate. This particularly proved to be the case in the rehabilitation of people who suffer from a combination of medical, physical, social and work-related problems. Clients "fell between two chairs" and ended up in an indeterminate 'grey zone', when the interventions considered necessary were not entirely covered by one actor's area of responsibility. This could lead to a vicious circle involving many actors and ineffective interventions as a result.

It was concluded that actors must better coordinate their activities. Collaboration and coordination are therefore essential in ensuring that people with multiple problems and needs still receive rehabilitation. Consequently, since the mid-1990s a number of pilot projects have been undertaken, involving various actors and forms of financial coordination. 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 observations from this period. Financial coordination is voluntary and involves four parties: the Social Insurance Agency, county councils, county labour boards and one or more municipal councils. The major aims are:

- a more efficient and effective response to the rehabilitation needs of individuals and thereby help in restoring their ability to engage in gainful employment;
- cost-effective use of available resources, by partially combining the resources of the four major actors and areas.

The target group for financial coordination comprises persons in need of coordinated rehabilitation interventions from several collaborating parties, which will 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.

The finances for the coordinated rehabilitation interventions are provided by the parties involved; they are required to contribute in equal amounts. The part of the national government authorities is financed by the Social Insurance Office. A coordinating body, the so-called “coordination association” (in which the collaborating parties are represented) is a legal person in public law, which lays down goals and guidelines, and finances rehabilitation measures.

1.3. Current situation and perspectives

Experts from the Ministry of Health and Social Affairs indicated that by September 2006 about 41 coordination associations had been established, involving 80 municipalities and 12 counties. The fact that there are not more is based on the voluntary character of the model, which means that all four parties must agree to participate. Moreover, the development of the cooperation model shows to take time, as it involves negotiations (on guidelines, organisation, procedures, target groups and priorities). It is expected that another 10 coordinating associations will be created in the coming months.

Authorities in Sweden have two options for rehabilitation services: either financial coordination or a looser form of non-financial cooperation. The latter also can achieve a lot, but lacks the structure and coherence found in the financial coordination model. As 23% of the population is dependent on benefits, the government considers financial coordination as essential to get people with multiple problems back into work. The newly elected Swedish government regards more flexibility as necessary: therefore the financial coordination system is considered as an important tool for re-integrating people into employment.

Since 2003 a governmental “Working Group on New Forms of Cooperation” monitors the results of cooperation and financial coordination. Furthermore, the Swedish Agency for Public Management (SAPM) is carrying out an assessment. The outcomes show that activities are in line with the aims of the legislation, and associations have effective working practices, but budgets and therefore the scope of interventions vary widely. It is considered too early for overall conclusions on the success of the model. A final evaluation report will be available in May 2008.

2. Links to EU policy and strategies

The Peer Review procedure is an important tool of the Open Method of Co-ordination. In March 2006, the European Council adopted a new framework for the social protection and social inclusion process. The OMC’s in the fields of social inclusion and pensions, and the ongoing process of co-ordination in the field of health and long term care were integrated in the Open Method of Coordination on Social Protection and Social Inclusion.

One of the major objectives of the OMC is the promotion of social cohesion, equality (between men and women) and equal opportunities for all. This should be realized by means of social inclusion policies and by social protection systems that are accessible, adequate, financially sustainable and adaptable, and efficient. Moreover, the policies should stimulate good governance, transparency and the involvement of stakeholders (in the design, implementation and monitoring of policy). The major objectives in the field of social inclusion regard:

- access for all to the resources, rights and services needed for participation in society;
- active social inclusion of all;
- social inclusion policies should be well coordinated and involve all levels of government and relevant actors, including people experiencing poverty.

Furthermore, in the European context the need to co-ordinate the actions of various stakeholders for increasing social inclusion, is widely acknowledged. Within the EU Inclusion Strategy all the relevant bodies should be mobilised to combat poverty and social exclusion. This should be done by promoting dialogue and partnership between all the relevant bodies, public and private. Also the communication on the new start for the Lisbon strategy (*Working together for growth and jobs, 2005*) stresses multi-actor participation. Moving people from unemployment or inactivity back to employment requires a modernisation of social protection systems. In its report *Social Inclusion in Europe 2006*, the European Commission draws 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”.

The Delta project shows that this modernization objective has already been noticed and strived for since 1997: when the first changes in the budgetary framework as well as the institutional context (structures and procedures) have been introduced, aiming to improve the cooperation of various actors, which all have responsibilities in the field of social rehabilitation.

The Peer Review demonstrates that the Swedish model of financial coordination of social rehabilitation tries to meet the aims of the OMC on Social Protection and Social Inclusion in many respects:

- a. The budgetary model, the tasks as well as the organization of work aims to contribute to improve social cohesion of vulnerable groups in society, in particular persons with multiple problems in the area of employment and health. Clients who in the past were not served adequately by the providers, because of the organisations of responsibilities and budgets, now are more directly addressed and approached;
- b. The financial coordination model fulfils the aim of transparent and structural involvement of various stakeholders (namely those in the area of social security, employment, social assistance and health care). They not only are participant in the current financial framework and operational organization, but are also involved in the development and experimentation of new structures, working practices and interventions. The voice of the clients has been covered in various evaluation studies;

- c. The financial coordination also deals with coordinating actors with responsibilities on various levels of policy (national government, county, municipality). The model shows that financial and common responsibility structures can be made for actors with various scopes of responsibilities;
- d. The financial coordination model also allows a broad focus on one of the target groups mentioned, as the communication from the commission stresses that “action is (also) needed for young people”. Several of the preventive measures taken in the Delta project regard young unemployed citizens with multiple problems (e.g. mental health problems and dependency on substance abuse);
- e. The financial coordination model also includes health care providers. Evaluations by professionals as well as patients during the implementation of the new structures indicate that access has been improved for categories of clients that previously were not served adequately. All participants in the coordination structure may take the initiative to suggest health care interventions for their target groups.

In his introductory word during the Peer Review Mr. 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), recalled that mobilising local actors was also the subject of an earlier Peer Review programme in April 2004, when local agreements to stop segregation in vulnerable metropolitan areas were examined (see <http://www.peer-review-social-inclusion.net/peer-reviews/2004/review-7>). Now inter-agency working for the rehabilitation of people on long-term leave or unemployment and suffering was examined, taking account of a variety of medical, physical, mental, social and work-related problems which have to be approached. He 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. Consequently, the issues this Peer Review meeting addressed are of prime importance for the European Commission.

3. Good Practice: Integrated Services in Rehabilitation - on Coordination of Organisation and Financing

3.1. Delta Project in Hisingen: some organizational and financial features

The coordination association Delta on the island of Hisingen was launched in 1997. Hisingen belongs to the municipality of Gothenburg and comprises six city districts, of which two participate in the Delta model. Delta was started as a pilot project within the framework of the Socsam legislation and was made permanent in 2005 through the establishment of the coordination association Delta.

It was the purpose of the project to find out 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.

After some adaptations in the organizational structure following an evaluation in 2001, currently the organisation of the Delta model includes various actors and structures:

- a. the *board of the coordination association*, which consists of representatives from the County Labour Board in Västra, the Gothenburg Council, the County Council in Västra and the social insurance agency in Västra. All institutions participating in the board provide equal parts of the budget. The part of the national government authorities is financed by the Social Insurance Office. The board sets priorities and assigns the budget to old and new activities;
- b. central support is provided by a *drafting committee*, consisting of local managers in Hisingen, with the task to prepare items of business for the governing board, and deal with other policy issues. This committee also gives feedback on new ideas which are developed by officials in different authorities;
- c. the *secretariat* of the board, which currently includes an officer in charge, a "process facilitator" and administrative support on a half-time basis for follow-up purposes. It is the aim to keep the administrative apparatus to a minimum, to ensure short decision pathways and having decision-makers within Delta never far from those involved in the activities;
- d. Further in each district *Delta groups* may operate; they consist of officers from the collaborating authorities. It is their task to identify residents' needs in each district that had not been met effectively by the authorities acting alone.

In the initial stage of the model a lot of time was devoted to the information process and project establishment. Another strategy, which was applied from the beginning, is the so-called 'Knowledge Delta' procedure: it ensures that every new measure or intervention in the Delta model is preceded by a comprehensive survey, involving all the authorities concerned. The strategy has 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 is based - as far as possible - on shared knowledge and experience.

The budget for the Delta model is approx. 4.7 million euro (2006). The main part is spent on activities (3.7 million), whereas funds for new projects (0.5 million), Knowledge Delta (0.3 million) and the organization (Association and secretariat, 0,2 million) cover the rest.

3.2. Target groups and activities

Hisingen has a population of 125 000 inhabitants, of which approx. 78 000 residents are in working age. About 15 000 of them are unemployed, disabled or on social benefits. The Delta model focuses on these clients whom the collaborating parties, acting on their own, have been unable to rehabilitate effectively. Currently some 4 000 Hisingen residents come in contact with different Delta activities each year. Their major underlying problems are related to mental health problems, musculo-skeletal disorders, complex social problems, or long term work incapacity. Target groups include sick listed and

unemployed persons, young people with mental health problems, young women and single mothers as well as immigrants and refugees who are far from the labour market.

Ongoing activities within Delta comprise three categories:

- a. *Preventive and promotional activities*, which regard interventions to prevent absence due to illness, combating social exclusion and helping people to become more securely established in Swedish society. Interventions and working methods include interviews and discussions, theme-based sessions, group activities, dissemination of information and education;
- b. *Socio-medical activities* aim to reduce waiting times and shorten patient treatment as well as to speed up the return to work/rehabilitation. Further it aims at reducing the costs of public income support systems, and enhance professional knowledge. Activities are conducted by inter-professional teams at six primary health care centres;
- c. *Occupational activities* aim to get people back into work more quickly, or into the right rehabilitation programme with less delay. Interventions also should reduce passivity and increase the self-confidence and self-awareness of participants. An example is the Labour Market Plaza (Arbetsmarknadstorget). The Labour Market Plaza is run by the social services and the local Public Employment Service office: they share the same premises and a joint reception area. It is designed for young unemployed on social welfare, or other categories of persons with considerable distance to the labour market.

The activities carried out within the financial coordination model as such do not regard decisions on benefits in individual cases. These decisions are taken by each officer in charge in his or her ordinary capacity to exercise public authority e.g. within the framework of the social services.

3.3. Evaluations

An evaluation of Delta carried out by Göteborg University (2001) showed that authorities often do not manage to organize interventions for persons in need of coordinated rehabilitation measures. Time, cooperation and common attitudes are lacking for such interventions.

The study demonstrated that the financial coordination model manages to create such a common responsibility, and it ensures structure and continuity in activities for clients with multiple problems. It also was found that the model has favourable results in terms of sickness benefit expenditures, social welfare costs, etc. The new organisational and collaborative structures and procedures had increased the knowledge and skills of project participants. A new way of working had been introduced, in which decisions based on a common approach emerged via new communication pathways. This increased professional experience also produced new ideas about ways to meet users and implement rehabilitation or treatment interventions. Also clients indicated that they had experienced the activities as positive. They felt to have been respectfully treated and had been taken seriously.

On the other hand, additional research - which only focussed on clients with musculo-skeletal disorders - found no evidence that the model resulted in better health or a reduction in sickness absence. Despite

the new working methods and procedures, patients at Delta's primary care centres received the same kind of treatment and rehabilitation as patients at control health care centres. The results showed no difference in change of health status between the groups.

Finally, an analysis of Delta's effect on cost trends in public income maintenance systems showed a tendency towards lower costs in Hisingen. The national evaluation (period 1997 till 2004) showed that coordinated interventions had been strengthened, with favourable results in Hisingen in terms of sickness benefit costs, social security benefit costs and long-term sick leave trends.

4. Relevance and transferability

4.1. Introduction

The last decade in various countries efforts have been made to provide better and more successful services to persons on sickness, disability or unemployment benefit. They aim to improve employability and employment of vulnerable groups, by various strategies like early and custom tailored interventions, demand based service provision, or better planned and coordinated service provision. The Delta model is an example of the latter category, where persons in need of initiatives and services from various providers fell between two chairs.

Representatives from several peer countries reported on attempts to improve cooperation of actions from various stakeholders, or to fill the gap between them regarding clients with multiple problems. It showed that there may be a variety of institutional constructions and number of stakeholders be participating in such new structures. The actors most often involved in structural cooperation models are the responsible authorities dealing with `compensation` and `integration`, namely social insurance agencies and employment services (e.g. Norway, the Netherlands, United Kingdom). A more extended construction shows additional inclusion of health care services, which seems to be less frequently applied, and currently is subject to pilot studies in the United Kingdom. The Delta model seems to be the most intensive and extended construction of multi stakeholder coordination, as also the municipalities are involved.

Consequently, the experiences and lessons from the Hisingen model evoked substantial interest, which was further stimulated by the fact that the activities and experiences have been well documented and evaluated. Consequently, the site visit and conversation with officials, the questions and answers, as well as the exchange of experiences contributed to fruitful discussions on impact and transferability.

4.2 Peer countries comments

Representatives from **Ireland** indicated that better cooperation of various governmental departments has been agreed for better service delivery to persons with disabilities. Furthermore, in the country there are many examples of good cooperation on the local level, which stimulate the government to think about it at national level. However, also the opposite situation can be found: lack of cooperation, duplication of services and gaps in service provision still may be persistent in some areas.

Since 2003 a “multi agency approach” has been started, using interagency teams, consisting of staff from Public Employment Services, Social Welfare, and Education and Health Services Executive. The review of this model (2004) showed various favourable results like: better communication between participating services, better knowledge on services and available expertise, as well as multi-agency support for clients. Difficulties also have been identified: they regard regional variations in cooperation, an increasing administrative burden of cooperation and incomplete coverage by all service providers. Also customer ownership problems arose, showing an ambiguity as to which stakeholder is ultimately responsible for the client.

These experiences lead to some questions about the Delta approach. Major questions regarded the implementation process (e.g. How to create a set of shared values? How are disputes solved?), relationships with other potential stakeholders (NGO’s, employers, labour unions) and quality monitoring and evaluation (what conclusions are drawn when evaluative studies show little differences in service provision between Delta en non-Delta service provision styles?).

The representative from **the Netherlands** recognised the need for better cooperation between actors involved in service delivery. In this field also some reforms have been introduced in the Netherlands, however, less stakeholders are involved than in Sweden. The major actors now more and more operating from one premises, with one intake and service desk, are the social insurance agency and the public employment service. The representative stressed that in Dutch policy the focus is more on (financial) incentives for various stakeholders: employers, job seekers, (private) job search and vocational rehabilitation service providers and public service providers. For instance: when a municipality manages to rehabilitate and transfer social welfare recipients into employment, a part of the allowances saved may be added to the municipality budget. And when a worker is sick listed the employer has to continue paying his/her wage up to a maximum of two years, which stimulates employers to take Return-to-work measures. In the Netherlands some further operational problems became clear when cooperation between various stakeholders was started: technical difficulties with the transfer of files or IT problems (stakeholders initially had no access to each others data files).

For **Norway** the Delta model appears very interesting, although the types of problems are a little different (low unemployment rates, high sickness absence and disability pension dependency rates). Norwegian representatives sketched the agreement between employers’ organizations, labour unions and government to reduce sickness absence and increase recruitment of persons with reduced work capacity. Further the new employment and welfare administration (from 2006) aims at a merger of three stakeholders: public employment services, social insurance agencies and municipal social services. On local level this will bring a “one stop shop” for the client. Initial experiences show that not only organizational structures have to change but also working procedures, when dealing with specific target groups (e.g. helping persons on disability pension back to work). Also various organization structures at local level are being tested (e.g. integrating new tasks in an existing structure, creation of a new project organisation, or starting a network organisation). The latter seems to be most effective, but evaluations are still ongoing. Norwegian experiences further showed the relevance of engaging employers as well as the role of internal personnel norms in firms with respect to the recruitment of persons with disabilities. Also experiences from some categories of disabled were reported who said that their wish to stay in employment was “overpowered” by the medical authority or social insurance officers. Finally,

Norwegian representatives stressed that questions may arise on how to guarantee the cooperation for the long term, as this showed to be difficult in their country.

The representatives from **Poland** also stressed the need of better cooperation between service providers in their country and noted from the Swedish experiences that it also activates stakeholders to think about local development of service provision. Cooperation between various stakeholders (social welfare, health and employment centres) so far has not been very successful in Poland.

Also in the **United Kingdom** various experiences have been gained with attempts to better cooperation in service provision to clients with sickness or disability. In JobcentrePlus, models services were combined, whereas in the Pathways to Work pilot, social security agencies may commission services provided by health care. From these experiences some questions and lessons have been identified in the paper from the United Kingdom. It is noted that robust evaluation is difficult to carry out in such projects. The Delta model would under current conditions be less feasible in the UK, where the system is more centralized. Furthermore, the United Kingdom representative considered the evaluating basis for the Hisingen experiences: positive opinions from clients and service providers would not be a sufficient basis in the UK for positive evaluations, when the impact on return to work is unclear.

The representative from **Greece** indicated that service provision in his country faces some elementary administrative problems, so coordination of various service providers still has not been a priority. The country has a very complex welfare system with no networking between departments covering health and employment. Moreover, many people are unaware of their rights, and the operation of social inclusion programmes depends on considerable EU funding.

The **Bulgarian** representatives stressed that in Bulgaria various measures have been taken to increase the employment and equal treatment of persons with disabilities. Incentives for employers are a major tool. The major responsibility for increasing employment of persons with disabilities is lying in the authority of the labour offices. Initiatives to improve service delivery by improving cooperation have not been mentioned.

4.3 EU stakeholders' organisations comments

The representative of the *European Social Network* (ESN, a network of directors of social services in 24 countries across Europe) presented the comments from ESN members and the network's thematic inclusion network. He listed three areas that evoke questions about the Delta system: the client as priority, the problems of inter-agency working and the missing stakeholders: employers and trade unions.

As clients are the primary stakeholders and target group for whom the services are being reorganised, their opinions on needs should have a clear position in the model. Now the model seems to rely mainly on what staff thinks clients need.

Inter-agency work certainly can have a real value, especially for people with multiple and complex problems. This means finding the appropriate response to clients' needs, not only between services but

also within services. Good coordination goes beyond putting staff in the same building or sharing budgets, but may also require joint training for managers and professionals from various institutions.

Also the absence of a role for the employer in the model is considered: placement into employment also depends on good relationships with the employers. Moreover, if Delta would work more closely with local employers, it could identify skills gaps and help to fill them, arrange subsidised work placements, support adaptation of work places and promote its own services.

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

The representative of the *European Federation of National Organisations working with people who are homeless* (FEANTSA) firstly noted that Delta's target group is similar to FEANTSA's own clientele of homeless people, who often suffer from multiple social and health problems. Consequently, for FEANTSA the coordination model is relevant to consider, moreover as homeless people are not approached by organisations working holistically, or looking beyond their own areas of responsibility. For example, homeless people are often discharged by health services, with no follow-up to check on their welfare.

As strong points of the Delta model – from the perspective of homeless persons - she identified the reduction of administrative obstacles, the promotion and realization of coordinated working and the strong formal basis for cooperation, which gives a basis for continuity.

The first question on the Delta model regards the position of NGOs: in many countries they have an important role in dealing with the problem of homelessness. Moreover, in several countries the public authorities more and more outsource services in this area to NGOs. Consequently, the question was stated whether NGOs should not be involved in the Delta structure.

Further some clarification was requested on the role of Delta regarding housing problems, as housing is an important element of social inclusion activities. Finally, the question was raised whether the main focus of Delta was only on integration into the labour market. Social integration should not focus only on employment, but also on employability, which may include development of skills that would lead to long-term rather than immediate integration into work.

4.4. Transferability

The representatives from most peer countries acknowledged, that rehabilitation service provision to the most socially excluded has a high priority. One type of solution regards better coordination of stakeholders which deal with different responsibility areas but focus on the same client. Many countries try solutions with various coordination structures, which vary from better communication and information channels to merging of services and one stop shop constructions, where the client is dealing with one official or consultant. Furthermore, the countries differ as to the strictness of the cooperation, ranging from voluntary cooperation at local level (Poland) to the statutory merger of departments at national level (Ireland).

Some of the participants (e.g. from Norway and the United Kingdom) were doubtful about the application of financial coordination in their country. Their system is more centralised than the Swedish system, where county and municipality have considerable financial autonomy. Notwithstanding, the Delta model offers for each country valuable insights into the day-to-day cooperation on the delivery of services. The Delta experiences also made clear how bottom up initiatives for new services to the clients can be developed, processed and integrated in the existing activities.

As to the role of the employer in the process of labour reintegration the question was stated how to integrate or involve employers. Delta also pays attention to the employers as they are invited to information meetings (which they attend) and also in individual cases they are approached by Delta staff. For most peer countries the involvement of the employer, apart from the legal obligations, is a point of concern. Some countries (Norway, Sweden and the Netherlands) reported obligations to provide a return to work plan (after 6-8 weeks of sickness absence of the employee) but they do not seem to work satisfactorily.

Some representatives favoured a role of NGOs in cooperation models with various stakeholders. In Poland, for instance, NGOs are partners in a project which is carried out on local level, aiming to increase employment of persons with disabilities. Swedish representatives indicated that there is no tradition of NGOs playing a role in service delivery. From the reactions from representatives from peer countries it became clear that NGOs have various positions as to advising on rehabilitation policies, advocacy of clients or involvement in service provision.

Several participants had received a good insight into the duration of implementation of new cooperation structures. If routine or unstructured cooperation is not poor and not fruitful the introduction of a new collaborative structure shows to need time. The financial coordination system unfolded over a period of time and therefore allowed for a gradual change in working cultures. As the United Kingdom representative indicated, especially participants from health care (doctors and clinicians) are often considered notoriously unwilling to adapt their working practices. Delta seems to have managed to achieve a change of attitude in the officials from health care centres.

There was widespread agreement that Delta is an innovative example of good practice, although it may be difficult to apply it in countries with more centralized support and benefit structures. Financial coordination facilitates to unite providers and the Delta project show that implementation of cooperative structures and working methods indeed can bring results in the rehabilitation of clients with multiple problems. This was also supported and reflected by the motivation and enthusiasm of the Delta staff in Hisingen.

5. Conclusions and lessons learned

The policy reviewed in Gothenburg allows for financial coordination at local level between four stakeholders: social insurance offices, primary health care services, municipal social services, and employment boards. The financial coordination aims to improve service provision for sick listed and unemployed persons, young people with mental health problems, young women and single mothers as well as immigrants and refugees who are far from the labour market.

In the Peer Review meeting it was concluded that Delta is an innovative example of good practice. The over ten year's history of developing, implementing and "running" the model of cooperation provides an abundance of experiences. They may be a fruitful source for further discussion on developing better service provision structures for persons with multiple problems needing adequate rehabilitation services.

Lessons from the Swedish model regard a basic principle (e.g. applicability of *financial* coordination in a country with mainly *decentralized* funding and policy structures), and various insights related to the design and implementation of cooperation structures:

- a. coordinated or integrated service delivery according to the Delta model shows to be better equipped to identify and to serve the needs and demands of clients with complex problems than when stakeholders work isolated, focussing on their (current) competencies and responsibilities. The Delta approach allows a bottom up adaptation of rehabilitation programmes, as daily work of multidisciplinary teams makes aware of needs not fully covered by the coordination partners separately.
- b. preparation and implementation of multi actor cooperation structures needs an appropriate timescale, which allows for real change to take place. It is a mistake to expect results from short-term measures introduced "between elections" when long-term adaptation of structures, culture (attitudes), expertise and working methods is required.
- c. whereas the coordinated rehabilitated policies are carried out on local level, a supportive structure on national level is needed for developing new institutional structures. Exchange of experiences between various regions using financial coordination models has been beneficiary to those regions where the process is starting.
- d. experimenting and implementing coordination structures further requires constant monitoring and regular evaluation. The Swedish project has shown to be systematically evaluated. Success parameters, however, may need further attention. Whereas client satisfaction rates, staff opinions and benefit expenditures indicate favourable results, it also was found that new working methods and interventions did not show relevant changes (yet) in medical care and interventions applied.