

# Summary

Every year in Sweden, around 8 000 young people are placed in a home for care or residence (HVB). In most cases, this is because of their own behavioural problems, such as drug abuse or crime. Unaccompanied refugee minors also account for a growing proportion of such placements. It is the municipal social services that decide which children or teenagers are to be placed in an HVB. Consequently, the municipalities act as buyers in the market for institutional care. Since 1 June 2013, the responsibility for supervising HVB care has rested with a new government agency, the Health and Social Care Inspectorate.

The purpose of this report is to discuss the conditions for drawing up and implementing contracts between municipal social services and HVBs. The theoretical perspective is mainly provided by economic contract theory. The report focuses on four contract problems.

The first problem is that in institutional care, as in many other care services, it is difficult to specify what constitutes good quality and to then link this to measurable targets (Forkby and Höjer, 2008; SKL, 2010). According to economic theory, this entails a risk that neither private nor public HVBs will try sufficiently hard to improve the quality of their services.

The second contract problem is that after they have cared for the young people for a certain time, the institutions providing care know more about the young people's care needs than the social services. This makes youth care an example of what economists call a 'credence good' – a service where the buyer has to rely on the seller's expertise. The institutions' information advantage gives their managers scope to exaggerate or understate young people's need for continued care. As the institutions are paid per day of care, private HVBs in particular have an incentive to exaggerate the need for care, in order to prolong periods of care. In a report based

on data from Vinnerljung et al. (2001) on young people placed in care in the early 1990s, I argue that this difference in economic incentives can explain why the average duration of care was twice as long in private as in public HVBs (Lindqvist, 2008).

The third contract problem is that the social services have relatively weak incentives to act forcefully in their capacity as buyers of care and to plan care. Weak economic incentives do not necessarily mean that the social services do not care about the outcome of care: social norms, professional ethics and a genuine desire to help the young people placed in care presumably play a major role in how the social services act. Nonetheless, there is some evidence that the social services – at least historically – have made few demands regarding the quality of youth care (Swedish National Audit Office, 2002; Sallnäs, 2005) and that there has been inadequate follow-up of the measures taken (SKL, 2012).

The first three contract problems centre around the fact that different actors can have interests that do not coincide with socially optimal outcomes. However, there is a fourth contract problem that is not related to incentives and accountability: the lack of knowledge about the effects of different types of measures (Vinnerljung et al., 2001; Forkby and Höjer, 2008; SKL, 2010). The problem here is that neither the social services nor HVB staff know what forms of measures result in favourable outcomes for the children and young people placed in care. One major reason for the lack of knowledge in this area is that for ethical and practical reasons it is difficult to conduct randomised experiments in which young people are assigned by chance to different types of measures.

What, then, can be done in practice to improve institutional care? In this report, I highlight the need to create a comprehensive register of residential care.<sup>4</sup> Such a register can be used to better

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<sup>4</sup> A similar proposal has previously been put forward by the Swedish Association of Local Authorities and Regions (SKL, 2010, p. 59), which writes that: “One alternative [to follow-up by the municipalities] would be for the National Board of Health and Welfare to extend the HVB register so as to make it a register of all knowledge gathered about HVBs. A structure could be created in this register in which the three responsible parties each contributed their own parts [...]. If the municipalities’ follow-ups, the results collected and supervision reports compiled by the National Board of Health and Welfare, and the care providers’ evaluations were collected in the national HVB register, the register could be used towards placing the work of the social services on an evidence-based footing.” Under this proposal then, information from individual HVBs would also be included in the register, which is a point discussed only briefly in this report. However, the reason for this is not that I do not consider it desirable to supplement a register with information from HVBs, but that

measure the quality of different HVBs, monitor trends concerning the duration of care placements, and in the longer term contribute to the development of more evidence-based social services.

Currently, there are two separate national registers containing information about care of young people at HVBs. The first – the HVB register – is administered by the Health and Social Care Inspectorate and contains information about HVBs operating in Sweden, but lacks information about the young people in care at each individual institution. The Register of measures for children and young people is administered by the National Board of Health and Welfare, assisted by Statistics Sweden. This register contains basic information about the young people placed in HVBs and other residential care, but lacks information about the reasons for placement in care and the institution in which they are placed. Meanwhile, the municipalities' case management systems contain many details about the young people placed in HVBs. However, at present this information is not saved in a form that allows it to be used in monitoring at an aggregate level. An inter-municipal project is also in progress (the UBU project), in which some 25 municipalities are building up a free-standing database that enables the social services to exchange their experience of the quality of different HVBs.

The information on HVB care that is collected today is therefore scattered between various different registers and actors. The proposal for creating a comprehensive register sets out from the assumption that the information that is currently collected would have greater value if it was also compiled in a single national register. In practical terms, such a register can be achieved by having the National Board of Health and Welfare or the Health and Social Care Inspectorate merge the HVB register and the Register of measures for children and young people. This merged register could then be supplemented with more detailed information on young people's backgrounds and data on terminated placements from the municipal case management systems.<sup>5</sup>

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it seems natural to begin the construction of a register by merging the information already available in registers kept by authorities and municipalities.

<sup>5</sup> The proposal to expand the Register of measures for children and young people with information on the young people's backgrounds was previously presented by the National Board of Health and Welfare (2009b; 2012), which argued that the Register of measures for children and young people should be expanded with information such as reasons for measures and non-institutional measures.

A few examples of potential uses for the register are given below, with a focus on remedying, to some extent, the four contract problems discussed above:

- Information about quality as perceived by the social services and by young people placed in different HVBs can be collected in the register. This information can then be compiled for each HVB and made available to the social services via an output portal just as is now done in the UBU project. This will enable the social services to obtain more exact information about the quality of each individual HVB than if they simply rely on their own experience. Information about the perceived quality of different HVBs can then be used by the social services in procurement processes or when deciding whether to extend contract periods. This will strengthen incentives for HVBs to strive for quality.
- Information about outcomes of care during and after a placement (e.g. care breakdown or crime) can be compiled for each HVB. This data can then be used in various ways, for example, as background information for the supervisory activities of the Health and Social Care Inspectorate.
- The possibility of compiling information about periods of care per HVB provides some possibility of limiting the risk of excessively long (or short) periods of care. For example, information about the average duration of care at different HVBs can be made available to the social services or used by the Health and Social Care Inspectorate in its supervisory activities.
- The register would enable the Inspectorate to improve its follow-up of the actions of the social services with regard to the planning and implementation of care, and in terms of outcomes for the children and young people placed in care. This information can be used as a basis for social services supervision or included in public performance reports for social services at the municipal level.<sup>6</sup>

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<sup>6</sup> The Swedish Association of Local Authorities and Regions and the National Board of Health and Welfare have collaborated since 2009 on public performance reports on health care and social services. The purpose of public performance reports is to contribute to developing and improving quality and efficiency in social services activities. The main source of data for the public performance reports is an online questionnaire addressed to municipalities.

- A register can provide answers to questions on the types of measures that are most appropriate for children and young people with different backgrounds: which methods of treatment yield the best results, which aspects of quality (e.g. support in schoolwork or facilitation of contacts with biological parents) are particularly important, which types of young people should (and should not) be placed in the same institution and the effect of privatization on the quality of care.

The report also discusses two possible risks of a national quality register.

The first risk consists of the fact that the register would contain sensitive information, which could violate the privacy of young people placed in care. However, the personal data in the register would be covered by the customary secrecy provisions for health care. This means that information that makes it possible to identify individuals (such as name or personal identity number) would only be accessible to a very small group of officials. I therefore argue that the register would entail relatively little risk of a violation of privacy. In addition, I underline that the risks that do nonetheless exist must be weighed against the great lack of knowledge about institutional care, and the consequences this has in terms of inefficiency, low quality and unnecessary placement in care.

The second risk is that the use of data from the register could have undesired consequences for the functioning of the market. One example is that HVBs might endeavour to avoid placements of young people that they suspect could result in poor evaluations. One way of reducing this risk is to take account of the young people's problems at the time they were placed in care when compiling information about the perceived quality of social services. It is also worth emphasising that information on quality taken from the register should be a supplement – not a substitute – for the assessment that the social services themselves make of each HVB.

In conclusion, I argue that in the longer term, the possibility of supplementing the register with information about non-institutional measures should be considered. This idea has also been proposed by the National Board of Health and Welfare (2009b; 2012). This would improve the ability to follow the 'care chain' for children and young people and to obtain a better picture

of the scope of social services measures for children and young people.

Naturally, introducing a comprehensive register as described above would not be for free. However, in my opinion, it can be done at relatively low cost. It is also fully possible to introduce the register in gradual stages. The reason why the register should be relatively inexpensive is that it would build on merging registers that already exist. The greatest obstacle is probably that the municipalities' current case management systems often do not function satisfactorily (SKL, 2013). This makes it difficult to extract data for forwarding to the National Board of Health and Welfare, for example. However, these problems have already been noted by the Swedish Association of Local Authorities and Regions and the National Board of Health and Welfare, and work is in progress to remedy them.