Is contract monitorability in social services possible?

Abstract
When contracting out services to private actors, public authorities must be able to ensure that the quality of services provided by these is satisfactory. To be able to achieve this, it is important that public authorities formulate quality requirements that are precise and well-defined thus making them possible to monitor. In this paper we examine how local governments in Sweden write quality requirements when contracting-out residential elder care. Quality requirements in eight different public procurements are analysed, assessing their degree of monitorability. Most requirements were classified as partly monitorable, i.e., written in a way that makes it possible in a crude way to determine if they are fulfilled, but not to assess this in any detail. The analysis showed, moreover, that nearly a fourth of the requirements were non-monitorable. That is, they were written in an imprecise, vague manner, which made it impossible to determine whether or not they were fulfilled. The results indicate a clash between the logic of competitive contracting and the logic of achieving quality in elder care, leading to the question of whether contracting is an efficient way to govern such services.

Keywords: Sweden; contracting; public procurement; eldercare; quality; monitorability; nursing homes; social services

Introduction
In recent decades there has been a shift in the way public services are organised. Many of the reforms undertaken can be traced back to the set of ideas known as New Public Management (NPM) (Hood 1995). A central idea in NPM is to take elements from the market sphere such as competition, decentralised decision-making and consumerism and incorporate them into
the public sector. Reforms which have sprung out of the NPM movement include so-called purchase-provider splits, consumer choice models and contracting. Of these, contracting is probably the most common (Gilbert 2002). Contracting, or out-sourcing, has been employed not least in relation to social services, where governments typically want to maintain public financing in order to secure equitable access but believe that competition and private entrepreneurship make their provision more cost-efficient. However, contracting out social services has also raised objections. One relates to the difficulties of governments to ensure that the quality of services provided by private actors corresponds to the standards and goals set by public regulators. Given the fact that private actors often are firms with profit demands, they face strong incentives to reduce costs by lowering quality standards. In addition, the character of social services is such that it is often hard to specify in contracts both what “good quality” is and to assess if agreed-upon quality standards have been met (Blank 2001; Johnston and Romzek 1999). Yet, if contracting is to function as an efficient method of governance, contracts must be constructed in such a way that public authorities can hold those actors accountable who shirk from their contracting obligations by reducing the quality of the services they provide. This is important not least in the social services, where users may be weak and vulnerable due to illness or old age and therefore unable to protest or demand improvement if quality levels are low. Thus, it is essential that contracts in this area are written in such a way that makes it possible for public authorities to supervise, or monitor, the quality of out-contracted services.

In this paper we put forward the concept of contract monitorability as a way to capture the nature and quality of public-private contracts in this regard. We argue that depending on how contracts are written and, more specifically, how quality requirements are formulated, contracts can have varying degrees of monitorability. A contract with high monitorability has a large number of quality requirements that are specific and measurable. Contrarily, a contract...
with low monitorability has many quality requirements with a low degree of specificity, which implies that they are vaguely stated and difficult to measure, or assess. The concept of contract monitorability is employed in the paper through an empirical analysis of public-private contracts containing over 1,000 quality requirements in the area of residential elder care in Sweden. The results of the analysis show that only a small share of the quality requirements in the contracts (6%) were fully monitorable. About 70% of the quality requirements were partly monitorable, which can be understood as them being possible to monitor at a very basic level (yes or no), while they were not measurable in the sense that it was not possible to determine the degree to which the quality dimension had been met. Most remarkably, nearly a fourth (23%) of the quality requirements in the contracts were monitorable at all, due to vague and non-committal word phrasing. The analysis also indicates that it especially difficult for public authorities to formulate monitorable quality requirements in areas that are integral to social care work, such as user encounters or the inherent quality of the care process itself, while more “technical” aspects of the service, such as documentation, staffing levels and the nutritional value of meals, are easier to describe in ways that makes their fulfilment possible to assess.

The analysis in the paper demonstrates the usefulness of the monitorability concept, as this provides a tool for assessing whether existing contacts are, in effect, useful for holding private contractors accountable. The findings, which point to that the level of contract monitorability is relatively low in the area of elder care in Sweden, illustrate, moreover, how difficult it is to write monitorable contracts in the area social services, as the inherent characteristics of such services makes them ill-suited both to be specified beforehand and subject to quality evaluation at a later stage.

Sweden can be considered a ‘most likely case’ for writing monitorable contracts in elder care. First, social service contracting has been practiced in Sweden for a relatively long time,
starting in the late 1980s. Second, unlike many other countries, Sweden employs a relatively strict form of contracting in the area of elder care, going beyond, for instance, what is demanded by EU competition law. When local governments contract out residential services for the elderly in Sweden they have to follow general competition law, which regulates the procurement process in detail. This relatively legalistic form of contracting, where price competition plays a key role and disputes are solved by judicial bodies, implies that the specific wording in the contracts play a central role in defining the tasks of the contractors as well as holding them formally accountable. Domestic competition law also demand that contracting periods are relatively limited so regular competition for public contracts is ensured. Contracting-out social care in Sweden can thus be classified as hard contracting, i.e., were the focus is on formal legal measures, competition and control, rather than cooperation or long-term relations (Dawson and Goddard 1999; Ferlie and Geraghty 2005). It can therefore be argued that contracts in this area in Sweden can be expected to have higher level of monitorability (or, at least, not lower) than contracts in countries using softer, or less legalistic, modes of contracting. This implies that if contracts are found to have a low levels of monitorability in Sweden, it can be expected that the situation is similar, or worse, in other comparable countries.

**Contracting: A theoretical overview**

In recent decades, contracting has become one of the most common ways of introducing market mechanisms and private alternatives in the public sector (Domberger 1998; Young 2000). Contracting can be defined as a practice whereby public agencies delegate the task of providing public services to private organisations in exchange for financial rewards (Walsh 1995). One of the most frequent questions asked in contracting literature is how contract relations are managed and whether it is possible for governments to maintain control over the
content and quality of the services that they delegate to private actors (Brown, Potoski and Van Slyke 2006; Bloom, Standing and Lloyd 2008). Another central question in the contracting literature is how to design contracts to create the right incentives for the service producer (Walls 2005).

In recent decades there has been a significant increase of resources spent on monitoring and evaluation of public policies (Abramson 2001). ‘Monitoring’ here refers to activities that public authorities undertake with the purpose of examining whether private contractors carry out the tasks agreed upon in the contract. The central role of monitoring in contractual relations is captured by the well-known principal-agent model, which is based on the idea that a principal (in this case a public authority) gives an agent (in this case a private contractor) tasks to carry out on the principal’s behalf. Importantly, the model assumes that the agent has better knowledge of tasks to be carried out, but also different goals from those of the principal; a situation that can create problems since the principal only has limited control over the agent. The difficulty in principal-agent relationships is thus to ensure that the agent actually does what the principal wants, for instance provide services of a certain quality, without ’cheating’ (Donahue 1989; Robinson 2001). One way to ensure this is to formulate the tasks at hand as clearly as possible in the contract between the principal and agent, specifying also the qualities associated with their satisfactory completion. The challenge, however, lies in finding ways to make sure the tasks are performed in a proper manner without specifying in too much detail how they should be carried out, as this might lead to the agent’s own superior knowledge about the tasks at hand not being utilised effectively (Weissert 2001; Savas 2000). Additionally, it is also a necessity that the principal oversees, or monitors, whether or not the agent meets the stipulated quality requirements (Romzek and Johnston 2002; Amirkhanyan 2010; Abramson 2001).
In practice, monitoring contractors tends to be a costly and time-consuming activity, especially in areas where there are significant information asymmetries, or where it is hard to gain information about the quality of goods and services provided. A specific challenge associated with monitoring, or audit, is that such activities may become concerned primarily with qualities which can be measured, rather than the basic goals and values associated with the task in question (Power 1997). The monitoring actor, i.e., the principal, therefore needs to carefully consider what kind of performance, or quality indicators, it employs so that monitoring processes do not affect the agent’s work in an undesirable manner. The monitoring of public-private contracts also places demands on the contracts themselves. As argued by Amirkhanyan, contract clarity, or the specification of the tasks to be carried out and their quality aspects, is an essential pre-condition for effective monitoring (Amirkhanyan, Kim and Lambright 2007). The problem is that in reality, contracts between public authorities and private actors rarely fulfil these requirements. Contracts that contain every possible aspect of a relationship (“complete contracts”) can be considered an ideal-type category, which can never be achieved in practice due to imperfect information and uncertainty (Artz and Brush 2000; Oliver and Moore 1999). It is basically impossible, or at least very costly, for a contract to specify every imaginable situation that could arise during the term of the contract (Brown, Potoski and Van Slyke 2007; Hendrikse and Veerman 2001).

The observation that the complexity of the real world makes it too costly, if not impossible, to describe all possible aspects in a contracting relationship is the foundation for the theory of incomplete contracts (Brown et al. 2007; Hendrikse and Veerman 2001. An incomplete contractual relationship is distinguished by a high degree of uncertainty regarding the process and generally contains repeated transactions between the principal and the agent (Romzek and Johnston 2005; Sclar 2000). Incompleteness in a contract means that not all possible situations can be described ex ante when constructing a contract which eventually may give
rise to opportunistic behaviour by the agent ex post (Hart and Moore 1999; Hendrikse and Veerman 2001; Segal 1999). When some aspect of a service is non-contractable, i.e., not specified clearly in the contract, it is difficult for the principal to show that the agent does not provide the level of quality demanded in the contract. As a result, the agent’s incentive to reduce costs increases, which by extension may lead to a reduction in quality (Domberger and Jensen 1997). The risks associated with incomplete contracting are especially salient in areas of so-called “soft” services like personal or social services, where given shifting human needs, tasks are complex and the level of flexibility in carrying them out must be high (Johnston and Romztek 1999; Van Slyke 2003). Such services are also special in the sense that their quality is determined in large measure through the nature of the interaction between staff and service recipient, that is, by processes and relationships that are both hard to specify beforehand in contracts or evaluate at a later stage.

**Quality in elder care**

In order to write contracts that safe-guard the quality of contracted-out services to the elderly, the contracting authorities must have a clear understanding of what constitutes ‘quality’ in this service and how this can be assessed. Many scholars have tried to formulate a meaningful and general definition of quality in elder care, discovering that, as the concept is multidimensional by necessity, this is a complicated task. Different stakeholders in the area may also have different understandings about quality. Efficiency, equality and accessibility are examples of quality dimensions that may be important for politicians and administrators, while health care personnel may be more interested in medical outcomes, and users themselves emphasise user-centred care qualities such as respect for individual integrity, continuity in staffing and user involvement in decision-making (Wensing et al. 1998).
There has, however, been an extensive academic discussion over the past 10 years on how to define and measure quality in residential care for the elderly (sometimes also referred to as nursing home care). Ranges of different types of indicators have been developed in order to measure and quantify such services. Much of the discussion on appropriate measures for health care quality draws on the work of Avis Donabedian (1980). His quality model states that quality in this type of service can be measured in terms of structure, process or outcome. Structural measures are organisational characteristics such as number of staff, opening hours or the educational level of employees. Process measures are more closely related to the care services provided, i.e., the activities carried out by staff, such as meals served or the distribution of medication. Lastly, outcome measures are associated with the results, or outcome, of the services provided, for example the residents’ health and well-being. According to Donabedian (1980), there is a causal relationship between the structure, process and outcome quality criterion, which means that improvement in, for instance, process measures, will lead to better outcome quality as well.

Donabedian’s approach has been widely used in the literature on quality of residential elder care, where it is often asserted that qualitative services in this area must be based on a combination of all three dimensions. Structural quality indicators have been as important in so far as they give weight to staffing levels (Harrington et al. 2000) while others have questioned the existence of a straight-forward relationship between staffing levels and quality outcomes (Hyun Shin and Bae 2012; Spilsbury et al. 2011). Process quality indicators often measure what activities are carried out, but not the appropriateness of these activities in relation to the needs of the elderly (Castle 2008). Outcome criteria have often been thought to be the most stringent and in some sense ‘best’ indicators of quality but, as several researchers have pointed out, they may present severe difficulties in measurement, especially since there can be a considerable time lag between the care outcome and the services that led to it (Brook,
Furthermore, it is not obvious what “outcomes” should be in the case of nursing home care, where the health of the users invariably declines over time even if the quality of care is high. In practice, therefore, quality measurement in residential elder care typically rely on a mixture of quality criteria, including such varying indicators as mortality data, usage of medication, number of employees per elderly, user ratings, prevalence of pressure ulcers, staff education, incident reporting procedures, nutrition and hydration (Nakrem et al. 2009; Challis, Clarkson and Waburton 2006; Fahey et al. 2003).

**Contracting for elder care in Sweden**

Contracting has been practiced within the elder care area in Sweden since 1992, when a legal change made it possible for the municipalities to employ this mode of governance within the social services. Prior to 1992, the provision of care to the elderly was a virtual public monopoly in Sweden, with very few private providers. Since then, there has been a significant increase in the proportion of private care providers. In 2012, around 20 percent of all elder care services were being provided by private actors, in most cases for-profit firms (Erlandsson et al. 2013). The Swedish elder care system is financed by income taxes and is universal in that it covers all citizens who need services regardless of income or insurance. The municipalities are the main actors responsible for providing and financing the services in the Swedish system. Enjoying considerable autonomy, each municipality can independently decide how to organise the care provided to elderly residents, including the decision of whether to employ private contractors (Erlandsson et al. 2013).

When a residential home for the elderly is contracted out in Sweden, local authorities must follow the law on public procurement (*Lagen om offentlig upphandling, LOU*). This implies that when it decides to contract out a residential home for the elderly, a municipality cannot freely choose who the provider should be, but has to allow for free competition by publishing
a call for tender where the type of service to be procured, quality requirements of the service and the selection criteria used in order to select the winning bidder is specified (Bjurman 2003; Forsberg 2004). Competition for public contracts in elder care can be based on three different selection models: price competition, quality competition, or a mix of those (Lunander and Andersson 2004). In the following section we present a case study where contracts between four selected municipalities (two in each) and private elder care providers in Sweden are analysed, asking what kinds of quality requirements they contained and whether these were in effect possible to monitor.

The case study: Towards an analytical framework for analysing contracts in elder care

As we have seen, specifying relevant quality criteria for residential elder care and formulating requirements regarding these which are possible to monitor is a challenge for public contracting authorities. The question asked in the case study, therefore, is how local public authorities in Sweden cope with this task. Specifically, what kinds of quality requirements are formulated in the contracts, and to what extent are these monitorable? The methodological approach of the study is a qualitative content analysis. To be able to analyse the material, we first identified the quality requirements in each contract and grouped them into different categories. This categorising was made inductively but corresponds well to the concepts, which are regularly used to describe elder care (Nakrem et al. 2009). Thereafter, we conducted a deductive content analysis (Elo and Kyngäs 2008) based on an analytical framework in which we classified all quality requirements based on degree of monitorability and whether the quality requirements focused on structure, process or outcome quality (see below for further details).

By quality requirements (kvalitetskrav), which are the central units of analysis, we refer to specific agreements about the content and quality of the services to be provided to the elderly
residents formulated in the contracts. The quality requirements are usually formulated by the 
municipalities in the call for tender, but as they are also part of the final contract between the 
parties, it is clear that the private providers have agreed to honour them. Examples of quality 
requirements are that the staff should have a certain level of training, or that the hours 
between the serving of the last meal in the evening and the first meal the following morning 
(nightly fast) should not exceed a certain number or that the elderly should have access to 
rehabilitation activities. Quality requirements can also refer to values, such as respect for the 
individual integrity of the users of their own active involvement in their daily care. The 
contracts, eight in total, each contained between 50 and 200 quality requirements, giving a 
total sum of 1,005 quality requirements to be analysed.

The analysis examines contracts from four municipalities (two from each) which all began to 
contract-out residential elder care almost immediately after the Swedish legislation change in 
1992 and which all have a relatively large share of their residential homes run by private 
contractors (between 20-80%). In this sense, the selected municipalities can be seen as “most 
likely” cases: they have a relatively long and extensive experience of contracting in this area. 
The ‘most likely’ case selection logic implies that if outcomes are poor, it is likely that other 
municipalities with less favourable circumstances will perform as bad or worse; in other 
words that the findings can be generalised to the whole population (King, Keohane and Verba 
1994). Apart from sharing certain characteristics that makes them most-likely cases, the 
chosen cases also differ from each other in important respects. Following a so-called 
“maximum variation sampling” logic in this regard (Teddlie and Yu 2007; Sandelowski 
2010), we have chosen municipalities which differ with regard to geography, size, economy, 
and political majority. The studied municipalities were located in different parts of the 
country, had different degrees of urbanisation (large city, middle-size city, small town in rural 
area) and size (with populations ranging from 39,000 to 136,000) and shifting political
majorities. As these differences diminish the possibility that any of these structural or political conditions can explain the outcomes, this case selection logic further strengthens the possibility to generalise the results to the whole of Sweden.

*Monitorability: A Framework of Analysis*

In order to assess the monitorability of the quality requirements, the requirements were classified into three different categories depending on how monitorable they were perceived to be (compare with Almqvist 2001). In the first category are those requirements, which cannot be monitored, that is, which are formulated in such a loose and general fashion that it is impossible to determine whether or not they have been met. This category was labelled “non-monitorable.” Requirements placed in this category were general in nature and vaguely described. The requirements state, for instance, that the provider should strive for certain general values. In some cases, the criteria are designed as actual requirements but are so unspecific that it is impossible to assess whether or not the agent has fulfilled the requirements, for instance: “The care should be of good quality.” In the second category we place requirements formulated in such a way that they could be monitored by giving a ‘yes’ or ‘no’ answer to whether or not they have been fulfilled. In this sense, the requirements in this category are possible to monitor in a dichotomous way but are still non-measurable. This implies that it is possible for the municipality to determine whether such a requirement has been met in a dichotomous way, by answering a ‘yes’ or ‘no’ question, but not to measure it and assess to what extent it is satisfied. Such requirements are labelled ‘partly monitorable’ as we see them as monitorable in a more crude sense, where limited information about the quality of a service is given. Examples of requirements placed in this category are: “There should be certified nurses among the staff.” This makes it possible for the municipality to determine whether there are certified nurses within the staff at all (‘yes’ if there is one or more, ‘no’ if there is none) but not to demand information about actual numbers, or whether
there is an appropriate number on duty at any given time. In this sense, the requirement allows for a certain level of crude monitoring, but not full assessment, or measurement, of the quality of the service with regards to the availability of medically trained staff.

In the third category, we place requirements which we see as *fully monitorable*; that is, when it is possible to determine also the extent to which a quality requirement formulated in the contract has been met. These requirements are thus formulated in a way that makes them measurable and quantifiable, which implies that it is possible to determine the degree to which the requirements are fulfilled by the provider, and if not, how far actual quality standards are from the target. This provides considerably more information both about the quality objectives of the principals, e.g., what this actor really wants, and the quality of the service performed. An example of a fully monitorable quality requirement is: “Each care receiver must have an individual care plan ready within two weeks of him or her moving in to the residence.” In this case, the municipality can also monitor how long it actually took for each care receiver to get a care plan. It should be noted that although we classify measurable requirements as ‘more’ monitorable, all requirements cannot be expected to be measurable or fully monitorable. For example, “A record must clearly clarify if a user for some reason did not get the assistance granted and the reason for this” is a requirement which is categorised as partly monitorable, but it is precise and clear and it is difficult to come up with a formulation that would render it measurable. However, in the instances when it *is* possible, which are most cases, we argue that measurable requirements can be considered more monitorable. E.g., consider the requirement “The provider should hold residents’ councils (*förtroenderåd*),” which is classified as partly monitorable. If the formulation instead had been “The provider should hold a residents’ council at least four times a year,” it would be classified as *measurable* and thus fully monitorable. Measurability in the sense of specifying “how much”, or “how often” or “within what time frame”, can thus be seen as providing for a higher degree
of monitorability in that it makes the quality requirements more precise and provides for a more detailed exchange of information between public authorities and contractors.

Before assessing the monitorability of the requirements formulated in the contracts we will examine the content of the requirements (what kind of activities do they refer to and what type of quality they refer to). In the last part of the analysis we also investigate what type of requirements, e.g., structure, process or outcome, are most monitorable.

**What kind of quality requirements were in the contracts?**

Of the 1,005 quality requirements analysed, most refer to ‘care work and social activities’ (15 percent), organisation and staffing (12 percent) and ‘health care and rehabilitation’ (10 percent). Examples of requirements in the category ‘care work and social activities’ were: “The care receiver’s social, psychological, physical and cultural well-being should be met” and “The care receiver should be able to maintain his or her integrity and be treated with respect.” Requirements related to organisations and staffing typically concerns staffing levels and the training of the staff. An example of a requirement found in this category was: “The service provider shall ensure that the business is staffed around the clock, both weekdays and weekends, so that appropriate care and safety is guaranteed.” The rest of the requirements found in the contracts are evenly distributed between smaller categories such as documentation (9%), incident reporting routines (7%), nutrition (7%), facilities and technical equipment (4%), information to care receivers and relatives (4%), care receiver influence and co-determination (2%) and cooperation with the municipality (4%) (see Table 1).

<table>
<thead>
<tr>
<th>Table 1. Classification of the quality requirements based on area covered</th>
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<tbody>
<tr>
<td>Area</td>
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<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td>Care work and social activities</td>
</tr>
<tr>
<td>Organisation and staffing</td>
</tr>
<tr>
<td>Health care and rehabilitation</td>
</tr>
<tr>
<td>Documentation and implementation plans</td>
</tr>
<tr>
<td>Incident reports</td>
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<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>Formal skills and knowledge</td>
</tr>
<tr>
<td>Diet and nutrition</td>
</tr>
<tr>
<td>Building and equipment</td>
</tr>
<tr>
<td>Information to care receiver/relatives</td>
</tr>
<tr>
<td>Cooperation with the municipality</td>
</tr>
<tr>
<td>Cooperation with relatives/others</td>
</tr>
<tr>
<td>Aids and medical equipment</td>
</tr>
<tr>
<td>Care receivers’ influence and complaint procedures</td>
</tr>
<tr>
<td>Laws, taxes and economy</td>
</tr>
<tr>
<td>Human resources</td>
</tr>
<tr>
<td>Security and crisis management</td>
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<tr>
<td>The provider’s own monitoring</td>
</tr>
<tr>
<td>Environment</td>
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<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

When it comes to the type of quality that the requirements concern, there is a strong overrepresentation of requirements relating to processual quality. As shown in Figure 1, an overwhelming majority, nearly 80%, of the requirements in the contracts relate to process quality. Process requirements are most common in all areas of requirements, but particularly dominant in areas such as documentation, care work, incident reporting, and cooperation with the municipality. The analysis shows that structural quality requirements are also relatively common in 20 percent of all requirements. Examples of structurally oriented quality requirements are requirements which ask the producers to guarantee that facilities are suitable for the care work, or that the staff should have a certain level of training. Requirements that concerned outcome quality were very few, only 0.6 percent (see Figure 1).
Figure 1. Distribution of requirements according to Donabedian’s quality dimensions.

Were the requirements written in a way that makes monitoring possible?

The results of the second part of the analysis, concerning the monitorability of the requirements, point to the fact it was possible to monitor most of the requirements (71%) at least partly, but not fully, and that a significant amount of the requirements (nearly 25%) were at all not monitorable. The share of the requirements that were classified as fully monitorable was very small, only 6% (see Figure 2 below).
The quality requirements classified by monitorability

The requirements that were classified as non-monitorable had the character of goals or values to strive for, rather than requirements to be met. One example is a requirement like: “Personal responsibility and commitment should be encouraged and protected.” Further examples of criteria that were classified as non-monitorable include:

“Elderly must have access to good health care.”

“The individual care plan should have a central role in planning efforts.”

As can be seen, the requirements in this category were vaguely worded, making it hard to determine whether or not they have been met. How does one, for example, determine if the individual care plan has played a “central role” in “planning efforts”? When it comes to the category of “partly monitorable,” most requirements in this category were formulated so it was relatively clear what should be done, and possible to determine in a dichotomous way (yes or no) whether it had been done, but not assess how often or to what extent, which in reality made the requirement weaker. Examples of requirements placed in this category were:

“An incident report should always be analysed and monitored.”

“The service provider shall have procedures for notifying the care manager when the individual is in need of a representative.”
In each of these cases, the requirements would have been measurable and hence more precise if specifications regarding how often, when or to what degree the requirements should be met. For instance, in the first example, the requirement could have been formulated as: “An incident report should be analysed and monitored within a week.”

As for the third category of monitorability, “fully monitorable,” very few requirements (6%) could be placed in this category. Examples of such requirements, which were formulated in such a precise and concrete way that their fulfilment could be measured, were:

“The service provider shall establish a care plan within four weeks after the care receiver has moved in.”

“Night fasting should not exceed 11 hours.”

“Nurses should be within the accommodation seven days a week with at least 11 hours of active duty.”

Finally, we address the question of whether some types of requirements are more monitorable than others. If so, this would indicate that it is easier to formulate monitorable requirements in some areas than others. To answer this question, we related the type of requirement (or which type of activity it referred to) to the three categories of monitorability. Non-monitorable requirements were given a value of 1, partly monitorable requirements the value of 2 and fully monitorable requirements the value of 3 (see Table 2).

**Table 2. All requirements, categorised by area and monitorability**

<table>
<thead>
<tr>
<th>Area</th>
<th>Non-monitorable (1)</th>
<th>Partly monitorable (2)</th>
<th>Fully monitorable (3)</th>
<th>Total</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laws, taxes and economy</td>
<td>1 (5%)</td>
<td>16 (84%)</td>
<td>2 (11%)</td>
<td>19</td>
<td>2.05</td>
</tr>
<tr>
<td>Organisation and staffing</td>
<td>16 (13%)</td>
<td>85 (71%)</td>
<td>19 (16%)</td>
<td>120</td>
<td>2.03</td>
</tr>
<tr>
<td>Documentation and implementation plans</td>
<td>2 (2%)</td>
<td>88 (94%)</td>
<td>3 (4%)</td>
<td>93</td>
<td>2.01</td>
</tr>
<tr>
<td>The provider’s own monitoring</td>
<td>1 (4%)</td>
<td>17 (89%)</td>
<td>1 (5%)</td>
<td>19</td>
<td>2.00</td>
</tr>
<tr>
<td>Deviation reports</td>
<td>2 (3%)</td>
<td>71 (96%)</td>
<td>1 (1%)</td>
<td>74</td>
<td>1.99</td>
</tr>
<tr>
<td>Diet and nutrition</td>
<td>15 (21%)</td>
<td>44 (60%)</td>
<td>14 (19%)</td>
<td>73</td>
<td>1.99</td>
</tr>
</tbody>
</table>
As seen in Table 2, the highest proportions of ‘fully monitorable’ requirements were found in the areas of documentation, laws, taxes and finances, and organisation and staffing. This can be explained by the fact that these areas contain activities that are relatively easy to describe in a precise manner. Most requirements in the second category ‘partly monitorable’ were found in areas like documentation, incident reporting, aids and medical equipment, security and crisis management and information to care receivers and relatives. Similarly, these types of requirements often seem to refer to formal matters such as adherence to national regulations or working routines. If we look at which areas the non-monitorable requirements dominate, we find areas such as care work and social activities, where 65 percent of the requirements were found to be non-monitorable, and cooperation with relatives and others, where 58 percent of the requirements were identified as non-monitorable. An example of a non-monitorable requirement relating to care work and social activities is: “The service provider shall work actively for a smooth and quick handling on arrival and departure of residents.” While this may seem to be a reasonable requirement, it is still hard to monitor, as it
is difficult to imagine how the municipality should be able to assess whether or not the provider worked actively for something.

**Concluding discussion**

The main research question asked in this paper was whether or not contracts between public authorities and private actors in the area of residential elder care in Sweden can be regarded as ‘monitorable.’ This question is central to our understanding of how contracting works in the area of social care and to what extent the necessary preconditions exists for this type of governing arrangement to deliver qualitative and cost efficient services. If contracts cannot be monitored, it creates stronger incentives for the private providers to deliver services with an inferior quality. The results of the present study show that nearly 25 percent of the requirements were classified as non-monitorable while around 70 percent of the quality requirements were classified as partly monitorable in the sense that it was possible to determine whether or not they were met, but not to measure the degree to which they were fulfilled. Only about six percent of the claims were found to be fully monitorable, that is it was possible to measure, or determine in a quantitative way to what extent they had been met.

When breaking down the monitorability of the requirements based on which area of activity they refer to, further interesting results appeared. The analysis shows that it is particularly difficult for the municipalities to formulate monitorable requirements in areas like social care and cooperation with relatives. This implies that it is more difficult to formulate monitorable requirements in areas that are specific to elderly care, such as inherent ‘caring’ qualities, than areas that are more generic such as staffing, financial records and documentation. In this sense, our findings point at a contradiction between the logic of contracting and the values that can be said to constitute good quality in elderly care. Qualitative elderly care is created largely in the encounter between staff and care receivers. Contracting, on the other hand,
assumes that the quality can be formulated through requirements that are general, lucid and easy to follow-up on. It can be noted that also medically oriented quality criteria, such as pressure ulcers or pattern drug usage, fail to capture ‘soft’ caring qualities like staff attitudes and personal encounters.

This paper also examined what type of quality the requirements formulated in the contracts between the municipalities and the private providers. The analysis showed that an overwhelming majority of the requirements were related to structure and process types of quality. Less than one percent of the requirements related to outcome measures, or in other words, what the providers achieve in their work. The fact that the requirements mainly focused on process and structural quality dimensions means that one of the main arguments for contracting out social services can be called into question. As we have seen, a central argument for contracting out public services is that this will not only lead to cost savings, but also to quality improvements, in that it will enable private actors, presumed to be more ‘entrepreneurial’ and innovative, to develop new and qualitatively better ways of providing the services. For this innovation to come to pass, however, quality requirements should mainly focus on outcome measures. As noted above, when principal uses structural and process quality requirements to control agents, it prescribes how the agent should carry out its tasks rather than what end result it should strive for; a circumstance which might limit the entrepreneurial potential of the agent.

Taken together, the results of the study raise the question of whether it is reasonable to try to formulate monitorable, or measurable, quality requirements in an area like residential elder care. As demonstrated by the contract analysis, it is difficult to capture the most important quality aspects of this service in a contract in a way that makes it possible to hold providers accountable for service quality. It can also be argued that the strive for measuring quality criteria creates overly formalised and bureaucratic monitoring procedures, which in the best
case add little to quality developments, in the worst case hamper it, as it detracts from quality-enhancing activities that may be non-monitorable but more relevant (Braithwaite, Makkai and Braithwaite 2007; Mors 2014). In light of incomplete contracting theories, which maintain all contracts in areas like the social services are incomplete, one could also ask whether ‘hard’ contracting as practiced in Sweden, is an appropriate way to govern elder care services.

**Funding**

This work was supported by ___ [________].

**References**


