

1 **Is contract monitorability in social services possible?**

2 **Abstract**

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

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

19 **Introduction**

20 In recent decades there has been a shift in the way public services are organised. Many of the
21 reforms undertaken can be traced back to the set of ideas known as New Public Management
22 (NPM) (Hood 1995). A central idea in NPM is to take elements from the market sphere such
23 as competition, decentralised decision-making and consumerism and incorporate them into

24 the public sector. Reforms which have sprung out of the NPM movement include so-called
25 purchase-provider splits, consumer choice models and contracting. Of these, contracting is
26 probably the most common (Gilbert 2002). Contracting, or out-sourcing, has been employed
27 not least in relation to social services, where governments typically want to maintain public
28 financing in order to secure equitable access but believe that competition and private
29 entrepreneurship make their provision more cost-efficient. However, contracting out social
30 services has also raised objections. One relates to the difficulties of governments to ensure
31 that the quality of services provided by private actors corresponds to the standards and goals
32 set by public regulators. Given the fact that private actors often are firms with profit demands,
33 they face strong incentives to reduce costs by lowering quality standards. In addition, the
34 character of social services is such that it is often hard to specify in contracts both what “good
35 quality” is and to assess if agreed-upon quality standards have been met (Blank 2001;
36 Johnston and Romzek 1999). Yet, if contracting is to function as an efficient method of
37 governance, contracts must be constructed in such a way that public authorities can hold those
38 actors accountable who shirk from their contracting obligations by reducing the quality of the
39 services they provide. This is important not least in the social services, where users may be
40 weak and vulnerable due to illness or old age and therefore unable to protest or demand
41 improvement if quality levels are low. Thus, it is essential that contracts in this area are
42 written in such a way that makes it possible for public authorities to supervise, or monitor, the
43 quality of out-contracted services.

44 In this paper we put forward the concept of *contract monitorability* as a way to capture the
45 nature and quality of public-private contracts in this regard. We argue that depending on how
46 contracts are written and, more specifically, how quality requirements are formulated,
47 contracts can have varying degrees of monitorability. A contract with high monitorability has
48 a large number of quality requirements that are specific and measurable. Contrarily, a contract

49 with low monitorability has many quality requirements with a low degree of specificity,
50 which implies that they are vaguely stated and difficult to measure, or assess. The concept of
51 contract monitorability is employed in the paper through an empirical analysis of public-
52 private contracts containing over 1,000 quality requirements in the area of residential elder
53 care in Sweden. The results of the analysis show that only a small share of the quality
54 requirements in the contracts (6%) were fully monitorable. About 70% of the quality
55 requirements were partly monitorable, which can be understood as them being possible to
56 monitor at a very basic level (yes or no), while they were not measurable in the sense that it
57 was not possible to determine the *degree to which* the quality dimension had been met. Most
58 remarkably, nearly a fourth (23%) of the quality requirements in the contracts were
59 monitorable at all, due to vague and non-committal word phrasing. The analysis also indicates
60 that it especially difficult for public authorities to formulate monitorable quality requirements
61 in areas that are integral to social care work, such as user encounters or the inherent quality of
62 the care process itself, while more “technical” aspects of the service, such as documentation,
63 staffing levels and the nutritional value of meals, are easier to describe in ways that makes
64 their fulfilment possible to assess.

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

72 Sweden can be considered a ‘most likely case’ for writing monitorable contracts in elder care.
73 First, social service contracting has been practiced in Sweden for a relatively long time,

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

91 **Contracting: A theoretical overview**

92 In recent decades, contracting has become one of the most common ways of introducing
93 market mechanisms and private alternatives in the public sector (Domberger 1998; Young
94 2000). Contracting can be defined as a practice whereby public agencies delegate the task of
95 providing public services to private organisations in exchange for financial rewards (Walsh
96 1995). One of the most frequent questions asked in contracting literature is how contract
97 relations are managed and whether it is possible for governments to maintain control over the

98 content and quality of the services that they delegate to private actors (Brown, Potoski and
99 Van Slyke 2006; Bloom, Standing and Lloyd 2008). Another central question in the
100 contracting literature is how to design contracts to create the right incentives for the service
101 producer (Walls 2005).

102 In recent decades there has been a significant increase of resources spent on monitoring and
103 evaluation of public policies (Abramson 2001). ‘Monitoring’ here refers to activities that
104 public authorities undertake with the purpose of examining whether private contractors carry
105 out the tasks agreed upon in the contract. The central role of monitoring in contractual
106 relations is captured by the well-known principal-agent model, which is based on the idea that
107 a principal (in this case a public authority) gives an agent (in this case a private contractor)
108 tasks to carry out on the principal’s behalf. Importantly, the model assumes that the agent has
109 better knowledge of tasks to be carried out, but also different goals from those of the
110 principal; a situation that can create problems since the principal only has limited control over
111 the agent. The difficulty in principal-agent relationships is thus to ensure that the agent
112 actually does what the principal wants, for instance provide services of a certain quality,
113 without ‘cheating’ (Donahue 1989; Robinson 2001). One way to ensure this is to formulate
114 the tasks at hand as clearly as possible in the contract between the principal and agent,
115 specifying also the qualities associated with their satisfactory completion. The challenge,
116 however, lies in finding ways to make sure the tasks are performed in a proper manner
117 without specifying in too much detail *how* they should be carried out, as this might lead to the
118 agent’s *own* superior knowledge about the tasks at hand not being utilised effectively
119 (Weissert 2001; Savas 2000). Additionally, it is also a necessity that the principal oversees, or
120 monitors, whether or not the agent meets the stipulated quality requirements (Romzek and
121 Johnston 2002; Amirkhanyan 2010; Abramson 2001).

122 In practice, monitoring contractors tends to be a costly and time-consuming activity,
123 especially in areas where there are significant information asymmetries, or where it is hard to
124 gain information about the quality of goods and services provided. A specific challenge
125 associated with monitoring, or audit, is that such activities may become concerned primarily
126 with qualities which can be measured, rather than the basic goals and values associated with
127 the task in question (Power 1997). The monitoring actor, i.e., the principal, therefore needs to
128 carefully consider what kind of performance, or quality indicators, it employs so that
129 monitoring processes do not affect the agent's work in an undesirable manner. The
130 monitoring of public-private contracts also places demands on the contracts themselves. As
131 argued by Amirkhanyan, *contract clarity*, or the specification of the tasks to be carried out
132 and their quality aspects, is an essential pre-condition for effective monitoring (Amirkhanyan,
133 Kim and Lambright 2007). The problem is that in reality, contracts between public authorities
134 and private actors rarely fulfil these requirements. Contracts that contain every possible aspect
135 of a relationship ("complete contracts") can be considered an ideal-type category, which can
136 never be achieved in practice due to imperfect information and uncertainty (Artz and Brush
137 2000; Oliver and Moore 1999). It is basically impossible, or at least very costly, for a contract
138 to specify every imaginable situation that could arise during the term of the contract (Brown,
139 Potoski and Van Slyke 2007; Hendrikse and Veerman 2001).

140 The observation that the complexity of the real world makes it too costly, if not impossible, to
141 describe all possible aspects in a contracting relationship is the foundation for the theory of
142 incomplete contracts (Brown et al. 2007; Hendrikse and Veerman 2001). An incomplete
143 contractual relationship is distinguished by a high degree of uncertainty regarding the process
144 and generally contains repeated transactions between the principal and the agent (Romzek and
145 Johnston 2005; Sclar 2000). Incompleteness in a contract means that not all possible
146 situations can be described ex ante when constructing a contract which eventually may give

147 rise to opportunistic behaviour by the agent ex post (Hart and Moore 1999; Hendrikse and
148 Veerman 2001; Segal 1999). When some aspect of a service is non-contractable, i.e., not
149 specified clearly in the contract, it is difficult for the principal to show that the agent does not
150 provide the level of quality demanded in the contract. As a result, the agent's incentive to
151 reduce costs increases, which by extension may lead to a reduction in quality (Domberger and
152 Jensen 1997). The risks associated with incomplete contracting are especially salient in areas
153 of so-called "soft" services like personal or social services, where given shifting human needs,
154 tasks are complex and the level of flexibility in carrying them out must be high (Johnston and
155 Romztek 1999; Van Slyke 2003). Such services are also special in the sense that their quality
156 is determined in large measure through the nature of the interaction between staff and service
157 recipient, that is, by processes and relationships that are both hard to specify beforehand in
158 contracts or evaluate at a later stage.

159 **Quality in elder care**

160 In order to write contracts that safe-guard the quality of contracted-out services to the elderly,
161 the contracting authorities must have a clear understanding of what constitutes 'quality' in
162 this service and how this can be assessed. Many scholars have tried to formulate a meaningful
163 and general definition of quality in elder care, discovering that, as the concept is
164 multidimensional by necessity, this is a complicated task. Different stakeholders in the area
165 may also have different understandings about quality. Efficiency, equality and accessibility
166 are examples of quality dimensions that may be important for politicians and administrators,
167 while health care personnel may be more interested in medical outcomes, and users
168 themselves emphasise user-centred care qualities such as respect for individual integrity,
169 continuity in staffing and user involvement in decision-making (Wensing et al. 1998).

170 There has, however, been an extensive academic discussion over the past 10 years on how to
171 define and measure quality in residential care for the elderly (sometimes also referred to as
172 nursing home care). Ranges of different types of indicators have been developed in order to
173 measure and quantify such services. Much of the discussion on appropriate measures for
174 health care quality draws on the work of Avis Donabedian (1980). His quality model states
175 that quality in this type of service can be measured in terms of *structure*, *process* or *outcome*.
176 Structural measures are organisational characteristics such as number of staff, opening hours
177 or the educational level of employees. Process measures are more closely related to the care
178 services provided, i.e., the activities carried out by staff, such as meals served or the
179 distribution of medication. Lastly, outcome measures are associated with the results, or
180 outcome, of the services provided, for example the residents' health and well-being.
181 According to Donabedian (1980), there is a causal relationship between the structure, process
182 and outcome quality criterion, which means that improvement in, for instance, process
183 measures, will lead to better outcome quality as well.

184 Donabedian's approach has been widely used in the literature on quality of residential elder
185 care, where it is often asserted that qualitative services in this area must be based on a
186 combination of all three dimensions. Structural quality indicators have been as important in so
187 far as they give weight to staffing levels (Harrington et al. 2000) while others have questioned
188 the existence of a straight-forward relationship between staffing levels and quality outcomes
189 (Hyun Shin and Bae 2012; Spilsbury et al. 2011). Process quality indicators often measure
190 what activities are carried out, but not the appropriateness of these activities in relation to the
191 needs of the elderly (Castle 2008). Outcome criteria have often been thought to be the most
192 stringent and in some sense 'best' indicators of quality but, as several researchers have
193 pointed out, they may present severe difficulties in measurement, especially since there can be
194 a considerable time lag between the care outcome and the services that led to it (Brook,

195 McGlynn and Shekelle 2000). Furthermore, it is not obvious what “outcomes” should be in
196 the case of nursing home care, where the health of the users invariably declines over time
197 even if the quality of care is high. In practice, therefore, quality measurement in residential
198 elder care typically rely on a mixture of quality criteria, including such varying indicators as
199 mortality data, usage of medication, number of employees per elderly, user ratings,
200 prevalence of pressure ulcers, staff education, incident reporting procedures, nutrition and
201 hydration (Nakrem et al. 2009; Challis, Clarkson and Waburton 2006; Fahey et al. 2003).

202 **Contracting for elder care in Sweden**

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

215 When a residential home for the elderly is contracted out in Sweden, local authorities must
216 follow the law on public procurement (*Lagen om offentlig upphandling, LOU*). This implies
217 that when it decides to contract out a residential home for the elderly, a municipality cannot
218 freely choose who the provider should be, but has to allow for free competition by publishing

219 a call for tender where the type of service to be procured, quality requirements of the service
220 and the selection criteria used in order to select the winning bidder is specified (Bjurman
221 2003; Forsberg 2004). Competition for public contracts in elder care can be based on three
222 different selection models: price competition, quality competition, or a mix of those
223 (Lunander and Andersson 2004). In the following section we present a case study where
224 contracts between four selected municipalities (two in each) and private elder care providers
225 in Sweden are analysed, asking what kinds of quality requirements they contained and
226 whether these were in effect possible to monitor.

227 **The case study: Towards an analytical framework for analysing** 228 **contracts in elder care**

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

242 By quality requirements (*kvalitetskrav*), which are the central units of analysis, we refer to
243 specific agreements about the content and quality of the services to be provided to the elderly

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

254 The analysis examines contracts from four municipalities (two from each) which all began to
255 contract-out residential elder care almost immediately after the Swedish legislation change in
256 1992 and which all have a relatively large share of their residential homes run by private
257 contractors (between 20-80%). In this sense, the selected municipalities can be seen as “most
258 likely” cases: they have a relatively long and extensive experience of contracting in this area.
259 The ‘most likely’ case selection logic implies that if outcomes are poor, it is likely that other
260 municipalities with less favourable circumstances will perform as bad or worse; in other
261 words that the findings can be generalised to the whole population (King, Keohane and Verba
262 1994). Apart from sharing certain characteristics that makes them most-likely cases, the
263 chosen cases also differ from each other in important respects. Following a so-called
264 “maximum variation sampling” logic in this regard (Teddlie and Yu 2007; Sandelowski
265 2010), we have chosen municipalities which differ with regard to geography, size, economy,
266 and political majority. The studied municipalities were located in different parts of the
267 country, had different degrees of urbanisation (large city, middle-size city, small town in rural
268 area) and size (with populations ranging from 39,000 to 136,000) and shifting political

269 majorities. As these differences diminish the possibility that any of these structural or political
270 conditions can explain the outcomes, this case selection logic further strengthens the
271 possibility to generalise the results to the whole of Sweden.

272 *Monitorability: A Framework of Analysis*

273 In order to assess the monitorability of the quality requirements, the requirements were
274 classified into three different categories depending on how monitorable they were perceived
275 to be (compare with Almqvist 2001). In the first category are those requirements, which
276 cannot be monitored, that is, which are formulated in such a loose and general fashion that it
277 is impossible to determine whether or not they have been met. This category was labelled
278 “*non-monitorable*.” Requirements placed in this category were general in nature and vaguely
279 described. The requirements state, for instance, that the provider should strive for certain
280 general values. In some cases, the criteria are designed as actual requirements but are so
281 unspecific that it is impossible to assess whether or not the agent has fulfilled the
282 requirements, for instance: “The care should be of good quality.” In the second category we
283 place requirements formulated in such a way that they could be monitored by giving a ‘yes’ or
284 ‘no’ answer to whether or not they have been fulfilled. In this sense, the requirements in this
285 category are possible to monitor in a dichotomous way but are still non-measurable. This
286 implies that it is possible for the municipality to determine whether such a requirement has
287 been met in a dichotomous way, by answering a ‘yes’ or ‘no’ question, but not to measure it
288 and assess to *what extent* it is satisfied. Such requirements are labelled ‘*partly monitorable*’ as
289 we see them as monitorable in a more crude sense, where limited information about the
290 quality of a service is given. Examples of requirements placed in this category are: “There
291 should be certified nurses among the staff.” This makes it possible for the municipality to
292 determine whether there are certified nurses within the staff at all (‘yes’ if there is one or
293 more, ‘no’ if there is none) but not to demand information about actual numbers, or whether

294 there is an appropriate number on duty at any given time. In this sense, the requirement
295 allows for a certain level of crude monitoring, but not full assessment, or measurement, of the
296 quality of the service with regards to the availability of medically trained staff.

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

319 of monitorability in that it makes the quality requirements more precise and provides for a
320 more detailed exchange of information between public authorities and contractors.

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

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

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

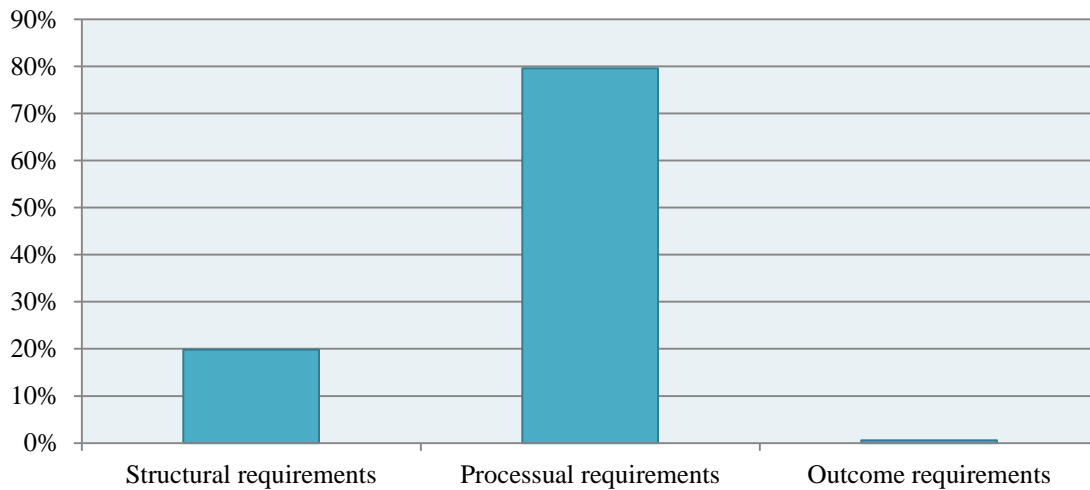
339 **Table 1. Classification of the quality requirements based on area covered**

	Frequency	Share
Care work and social activities	151	15%
Organisation and staffing	120	12%
Health care and rehabilitation	96	10%
Documentation and implementation plans	93	9%

Incident reports	74	7%
Formal skills and knowledge	68	7%
Diet and nutrition	73	7%
Building and equipment	45	4%
Information to care receiver/relatives	39	4%
Cooperation with the municipality	42	4%
Cooperation with relatives/others	45	4%
Aids and medical equipment	33	3%
Care receivers' influence and complaint procedures	24	2%
Laws, taxes and economy	19	2%
Human resources	24	2%
Security and crisis management	25	2%
The provider's own monitoring	19	2%
Environment	15	1%
Total	1,005	100%

340

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



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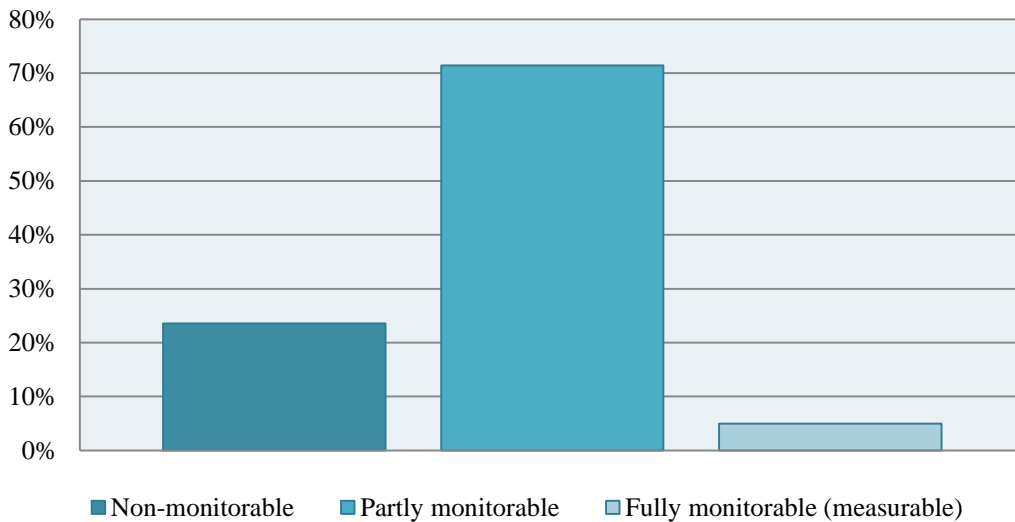
352 **Figure 1. Distribution of requirements according to Donabedian's quality dimensions.**

353

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

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

361



362

363 **Figure 2. The quality requirements classified by monitorability**

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

368 *“Elderly must have access to good health care.”*

369

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

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

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

379

380 *“The service provider shall have procedures for notifying the care manager when the*
 381 *individual is in need of a representative.”*

382 In each of these cases, the requirements would have been measurable and hence more precise
 383 if specifications regarding how often, when or to what degree the requirements should be met.
 384 For instance, in the first example, the requirement could have been formulated as: “An
 385 incident report should be analysed and monitored *within a week*.”

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

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

391
 392 *“Night fasting should not exceed 11 hours.”*

393
 394 *“Nurses should be within the accommodation seven days a week with at least 11 hours*
 395 *of active duty.”*

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

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

	Non- monitorable (1)	Partly monitorable (2)	Fully monitorable (3)	Total	Mean
Laws, taxes and economy	1 (5%)	16 (84%)	2 (11%)	19	2.05
Organisation and staffing	16 (13%)	85 (71%)	19 (16%)	120	2.03
Documentation and implementation plans	2 (2%)	88 (94%)	3 (4%)	93	2.01
The provider’s own monitoring	1 (4%)	17 (89%)	1 (5%)	19	2.00
Deviation reports	2 (3%)	71 (96%)	1 (1%)	74	1.99
Diet and nutrition	15 (21%)	44 (60%)	14 (19%)	73	1.99

Aids and medical equipment	1 (3%)	32 (97%)	0 (0%)	33	1.97
Security and crisis management	1 (4%)	24 (96%)	0 (0%)	25	1.96
Cooperation with the municipality	2 (5%)	40 (95%)	0 (0%)	42	1.95
Information to care receivers/relatives	3 (8%)	36 (92%)	0 (0%)	39	1.92
Building and equipment	8 (18%)	35 (78%)	2 (4%)	45	1.87
Environment	2 (13%)	13 (87%)	0 (0%)	15	1.87
Formal skills and knowledge	12 (18%)	54 (79%)	2 (3%)	68	1.85
Care receivers' influence and complaints procedure	7 (29%)	14 (58%)	3 (13%)	24	1.83
Human resources	4 (17%)	20 (83%)	0 (0%)	24	1.83
Health care and rehabilitation	36 (38%)	57 (59%)	3 (3%)	96	1.66
Cooperation with relatives/others	26 (58%)	19 (42%)	0 (0%)	45	1.42
Care work and social activities	98 (65%)	53 (35%)	0 (0%)	151	1.35
Total	237 (24%)	718 (71%)	50 (5%)	1005	1.81

403

404 As seen in Table 2, the highest proportions of ‘fully monitorable’ requirements were found in
405 the areas of documentation, laws, taxes and finances, and organisation and staffing. This can
406 be explained by the fact that these areas contain activities that are relatively easy to describe
407 in a precise manner. Most requirements in the second category ‘partly monitorable’ were
408 found in areas like documentation, incident reporting, aids and medical equipment, security
409 and crisis management and information to care receivers and relatives. Similarly, these types
410 of requirements often seem to refer to formal matters such as adherence to national
411 regulations or working routines. If we look at which areas the non-monitorable requirements
412 dominate, we find areas such as care work and social activities, where 65 percent of the
413 requirements were found to be non-monitorable, and cooperation with relatives and others,
414 where 58 percent of the requirements were identified as non-monitorable. An example of a
415 non-monitorable requirement relating to care work and social activities is: “The service
416 provider shall work actively for a smooth and quick handling on arrival and departure of
417 residents.” While this may seem to be a reasonable requirement, it is still hard to monitor, as it

418 is difficult to imagine how the municipality should be able to assess whether or not the
419 provider worked actively for something.

420 **Concluding discussion**

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

433 When breaking down the monitorability of the requirements based on which area of activity
434 they refer to, further interesting results appeared. The analysis shows that it is particularly
435 difficult for the municipalities to formulate monitorable requirements in areas like social care
436 and cooperation with relatives. This implies that it is more difficult to formulate monitorable
437 requirements in areas that are specific to elderly care, such as inherent ‘caring’ qualities, than
438 areas that are more generic such as staffing, financial records and documentation. In this
439 sense, our findings point at a contradiction between the logic of contracting and the values
440 that can be said to constitute good quality in elderly care. Qualitative elderly care is created
441 largely in the encounter between staff and care receivers. Contracting, on the other hand,

442 assumes that the quality can be formulated through requirements that are general, lucid and
443 easy to follow-up on. It can be noted that also medically oriented quality criteria, such as
444 pressure ulcers or pattern drug usage, fail to capture ‘soft’ caring qualities like staff attitudes
445 and personal encounters.

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

461 Taken together, the results of the study raise the question of whether it is reasonable to try to
462 formulate monitorable, or measurable, quality requirements in an area like residential elder
463 care. As demonstrated by the contract analysis, it is difficult to capture the most important
464 quality aspects of this service in a contract in a way that makes it possible to hold providers
465 accountable for service quality. It can also be argued that the strive for measuring quality
466 criteria creates overly formalised and bureaucratic monitoring procedures, which in the best

467 case add little to quality developments, in the worst case hamper it, as it detracts from quality-
468 enhancing activities that may be non-monitorable but more relevant (Braithwaite, Makkai and
469 Braithwaite 2007; Mors 2014). In light of incomplete contracting theories, which maintain all
470 contracts in areas like the social services are incomplete, one could also ask whether ‘hard’
471 contracting as practiced in Sweden, is an appropriate way to govern elder care services.

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