

B5 | THE 'NEW' KAROLINSKA HOSPITAL: HOW PPPS UNDERMINE PUBLIC SERVICES¹

Conservative economists often berate low and middle-income countries (LMICs) for their failure to pursue neoliberal reforms while restructuring healthcare services. The failures are sought to be explained as being caused by inefficient and corrupt financial and administrative systems in these countries. However evidence indicates that neoliberal reforms in restructuring healthcare services, such as Public Private Partnerships (PPPs), are inherently flawed and represent a transfer of public resources to the private sector and do not lead to any increased efficiencies. In this chapter, we illustrate this by tracing the story of the 'new' Karolinska hospital in Stockholm.

The Stockholm County Council (SCC), at the beginning of this millennium, unveiled plans for a 'world class' hospital in the city – the new Karolinska hospital. While renovating the existing hospital would have cost 4-5 billion SEK – Swedish Krona (approximately US\$ 500 million) (Ennart and Mellgren, 2016, p. 64), the plan to build a new hospital was projected to cost billions of crowns more. The project was conceived as a PPP. This chapter traces the process through which the project was conceived, and is being implemented.

Vision of a new Karolinska

The provision of healthcare services in Sweden is divided between the central government, 20 county councils and 290 municipalities. The county councils are responsible for provision of primary and secondary healthcare services and representatives to the councils are elected every four years. Healthcare is financed by municipal taxes, contributions from the central government and modest user-fees.² The Karolinska hospital is the largest hospital in Stockholm with approximately 15,000 employees and is closely linked to the top medical university in Sweden – the Karolinska institute.³ The vision of the 'new' Karolinska included that of a hospital with deeper ties between clinical care and research. The SCC proposed a PPP to finance and construct the new hospital – an approach that had not been tried in Sweden earlier.⁴

The PPP involved contracting a private company to finance, construct and maintain the hospital and in exchange the company was to receive an annual payment from the public authority. It was claimed that as the financial arrangements would be finalized in advance, delay in project implementation would cost the company, and this would act as a check on time overruns (Bordeleau C 2014). The SCC agreed to go ahead with the project on receipt of three

competitive bids from private contractors. However, the city council received only one bid.⁵ The city council hired Gullers, a private consultancy firm, to provide guidance regarding if the project should continue. The city council was strongly advised not to proceed (Ennart H and Mellgren F 2016 p.82). Doubts were raised regarding the project's financial viability as the contracted private entity would need to raise loans at a higher rate than what the government could if the latter were directly involved in managing the project. In spite of such doubts the SCC accepted the bid received. In 2010 an agreement was signed by the council with Skanska (a multinational construction and development company based in Sweden) and the British investment fund, Innisfree. Together they created the 'Swedish Hospital Partners (SHP)', a venture company that was to guarantee satisfactory completion of the project.

From the inception of the project it was clear that the council's decision was driven by a neoliberal ideological bias which had 'faith' in the 'efficiency' of the private sector.

Hidden costs and secrecy

During the final negotiations between SCC and Skanska and Innisfree, several important changes were made in the contract that dramatically increased costs. The contract, as initially conceived, was broken down into over a hundred additional contracts over and above the main contract. These included, for example, work related to construction of the laboratory, offices for the administration, medical equipment and the telecommunication system. This method of systematically extracting parts out of the initial agreement and creating additional contracts is a well-known ploy in PPPs. In typical PPPs costs increase with every additional contract while the process becomes less transparent. In the case of the Karolinska hospital council members and officials negotiating the agreement had very limited capacity to scrutinise the calculations provided by Skanska, thus making it impossible to negotiate better terms.⁶

The entire deal has been shrouded in secrecy. The agreement itself was designated as 'confidential' both before and after it was signed. This confidentiality clause related to the agreement extended to members of the SCC, who risked high legal penalties if they discussed the agreement with experts or the media. The terms of the agreement have become available very gradually in the past years after several rounds of legal proceedings in court.

Well after the agreement was signed members of the SCC started realizing that the project may not be financially viable. After visiting several European high-end hospitals the council realized that the projected cost of the hospital was much higher than for similar ventures in many other European countries. While the price per square meter for similar ventures in Denmark and Norway were approximately 20,000–30,000 SEK (approximately US\$ 2500–3500) the price at New Karolinska was estimated to be 46,000 SEK (US\$ 5,000)

(Ennart and Mellgren, 2016, p. 138–139). As a result of these concerns, in 2012, McKinsey was commissioned to investigate the high costs related to the project. Curiously, McKinsey recommended that at least a quarter of planned investments in other public hospitals be postponed to accommodate the high public costs incurred for the Karolinska hospital. This would mean not addressing the urgent need for more beds in these hospitals. (Ennart and Mellgren, 2016, p. 140).

Crisis in hospital care in Sweden and the new Karolinska Sweden is a high income country, which has over the years, invested in building a strong welfare system. Yet it is in the midst of a crisis in hospital-based care, involving shortages of hospital beds and staff and overflowing emergency rooms. Sweden ranks third from the bottom among OECD countries and ranks at the bottom among all countries in the EU as regards availability of hospital beds per 1000 inhabitants (OECD, 2017). When beds are physically available, utilization is low due to shortages of staff, especially of nurses. Shortage of nurses is related to low wages and low increments in wages, and tough working conditions. As a result waiting times can be very long for patients seeking care. Though financial resources are available, issues linked to low wages for staff and their working conditions are not prioritized, while funds are diverted to consulting firms and expensive contractors. The new Karolinska does not address this growing crisis and in fact the number of beds planned for the new hospital is less than in the existing hospital.⁷

Furthermore the new hospital, conceived as a speciality care centre, would mainly cater to patients requiring critical care or those with rare disorders. This means that a bulk of patients in need of care, including the elderly, will not be able to access care from the new hospital. The elderly, who form the bulk of patients in Sweden's emergency rooms and hospitals, will not be treated at the new Karolinska but at other hospitals in Stockholm which are already overcrowded. At the same time, the expansion of staff, beds and medical equipment at hospitals that treat patients, not welcome at the 'new world-class hospital', is lagging behind. These hospitals are not expected to reach full capacity until years after the new Karolinska hospital is commissioned. The additional cost incurred in expanding capacity in other hospitals is estimated to cost the SCC an additional 33 billion SEK (approximately US\$ 3.5 billion).⁸

Consultants, conflict of interest and profit-hungry contractors So if money spent in building the 'new' Karolinska is not going to increase the number of hospital beds available for patients in need, where is it going? In addition to money spent in hiring expensive contractors, large amounts of money are being spent to hire management consultancy firms. SCC paid 1.2 billion SEK (approximately US\$ 140 million) to consultants between 2012–2014, who billed SCC at the rate of 2300 SEK per hour (approximately US\$ 250)

(Ennart and Mellgren, 2016, p. 57; Westin, 2015). Boston Consulting Group (BCG) has been central in the implementation of a new management model called ‘value based solutions’ at the new Karolinska. For this BCG was paid 618,270 SEK (approximately 70,000 US\$) per week. Interestingly McKinsey had bid for the same contract at a quoted rate of 406,100 SEK (approx. US\$ 45,000) per week (Westin, 2015). Perhaps it is not a coincidence that the current program director of Karolinska hospital is a past employee of BCG (Ennart and Mellgren, 2016, p. 58). The journal *Vårdfokus* estimates that the sum Karolinska overpaid to consultancy firms, over and above the allocated budget between 2012–2014 is approximately 186 million SEK (approximately US\$ 20 million USD) – which corresponds to the wage bill of 400 full-time nurses for a year (Westin, 2015).

Another consultancy company in bed with the SCC is Pricewaterhouse-Coopers (PwC). PwC has been one of the major promoters of PPPs since the mid-1990s and its consultant, Paul De Rita, was the leader of the expert group who conducted a ‘neutral’ investigation into the financing model chosen by the SCC for the New Karolinska (Ennart and Mellgren, 2016, p. 242). It is thus not surprising that he endorsed the PPP-model as being best suited best to run the Karolinska hospital project. PwC has also assisted Swedish Hospital Partners (SHP) to set itself up in the tax haven of Luxembourg (Ennart and Mellgren, 2016, p. 181). (For a detailed discussion on the role of management consultancy firms in the health sector, see Chapter D3.)

Karolinska is not an isolated example The PPP model has been extensively used in the UK to build and manage hospitals. An example is the Barts Health Trust in London which consists of St Bartholomew Hospital and Royal London Hospital. Since its reconstruction in 2010 the hospital is owned by Skanska and Innisfree and consultancy for the contract was provided by PwC. There are several similarities with the new Karolinska hospital.

How has the Barts Health Trust been performing? In 2015 the trust incurred a loss of 1.8 billion SEK (approximately US\$ 200,000,000). It was, as a consequence, forced to reduce the number of employees by 10 per cent. Two-hundred beds were not functional due to lack of staff and the trust failed to deliver promised services in several areas. Surveys show that only one third of the employees would recommend someone to work at Barts Health Trust, the third lowest number of all hospitals in the UK. All employees had been forced to sign contracts that prevented them from making statements about the situation at the hospital. Due to its dire economic situation, Barts Health Trust had been put under the administration of the British health authorities⁹.

The contracts of several other PPP-hospitals in the UK have been terminated by the government. The compensation paid by the government to terminate the contracts was huge but the costs would have been even greater (for decades to come) if the government had not terminated the contracts. (BBC News,



Image B5.1 St Bartholomew's Hospital in London, which was privatised ([https://commons.wikimedia.org/wiki/Attributions: St_Bartholomew%27s_Hospital%26%20.JPG#/media/File:St_Bartholomew%27s_Hospital%26%20.JPG](https://commons.wikimedia.org/wiki/Attributions:St_Bartholomew%27s_Hospital%26%20.JPG#/media/File:St_Bartholomew%27s_Hospital%26%20.JPG) by MaryG90; License: CC BY-SA 3.0, <https://creativecommons.org/licenses/by-sa/3.0/>)

2012). An analysis of the first six PPP-hospitals in Scotland showed that the cost of financing the hospitals is on average double of what it would have been through the traditional route.

While the criticism of the PPP-model and public mistrust grew in the UK, in the early 2000s, the model became an important 'export product'. The British government cooperated closely with several lobby organizations with the aim of facilitating the entry of British investment funds, consultants and construction companies into new markets in low- and middle-income countries (Holden, 2009). Globally, lobbying for PPPs in the hospital business has been successful and these are being promoted through the International Monetary Fund, World Bank and EU. One example is in Lesotho where half the country's health budget goes towards funding a large PPP venture in the capital city (Oxfam, 2014).

The new Karolinska anno 2017 So how much has the new Karolinska actually cost the SCC and the taxpayers in Stockholm? This is not an easy question to answer. In 2002 the predicted cost of the building was 5.3 billion SEK (approximately US\$ 600 million) (Ennart and Mellgren, 2016, p. 152). At the time of the signing of the agreement it was revealed that the total cost had increased to 14.1 billion SEK (approximately US\$ 1.6 billion). Just a few days later the project manager admitted that the actual cost would be

22 billion SEK (approximately US\$ 2.5 billion).¹⁰ This did not include the cost of maintenance (of which SHP has a monopoly) or the interest on loans. The ruling political party in the SCC claims that the bill for constructing and building the hospital and its maintenance until 2040 will be 52 billion SEK (approximately US\$ 6 billion) while former member of the SCC claims that the bill will end up at 69 billion SEK (approximately US\$ 8 billion) due to high interest rates and the fact that not all costs are included in the final bill (Ennart and Mellgren, 2016, p. 29).

Actually no one knows the final price tag, not even the SCC's own accountants who, after an investigation into the finances of the new Karolinska project, concluded that the SCC has very little control over future costs. What cannot, however, be denied is the enormous cost incurred by the people of Stockholm who will be financing the venture till 2040, as per the agreement. In 2015 approximately 59 per cent of the Swedish population was for a ban against profit-making within welfare.¹¹ On the other hand Skanska and Innisfree will, in all likelihood, sell their shares at a premium.

As Innisfree is a venture capital company, one can assume that a considerable sum of taxpayers' money will end up in tax havens. Between 2007 and 2012 private for-profit providers services bought by county councils Sweden increased by over 50 per cent (Dahlgren, 2014). The Swedish economist Göran Dahlgren investigated, in 2014, the experience of profit-driven healthcare reforms in Sweden and concluded that private for-profit healthcare services resulted in reduced efficiency and unequal access to healthcare services while putting additional strain and draining public healthcare resources (Dahlgren, 2014). One can only hope that some lesson will be learnt and that the new Karolinska is both the first and last PPP venture of its kind in the Swedish welfare state.

Notes

1 Most of the material in this chapter is collected from the extensive in-depth investigations done by the Swedish journalists Henrik Ennart och Fredrik Mellgren and presented in the book 'Sjukt Hus' published by Ordfront förlag (Ordfront publisher) in 2016. We acknowledge the generous offer by the authors to use the material and share a short version of the story of New Karolinska with an English speaking audience.

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5 *ibid*

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