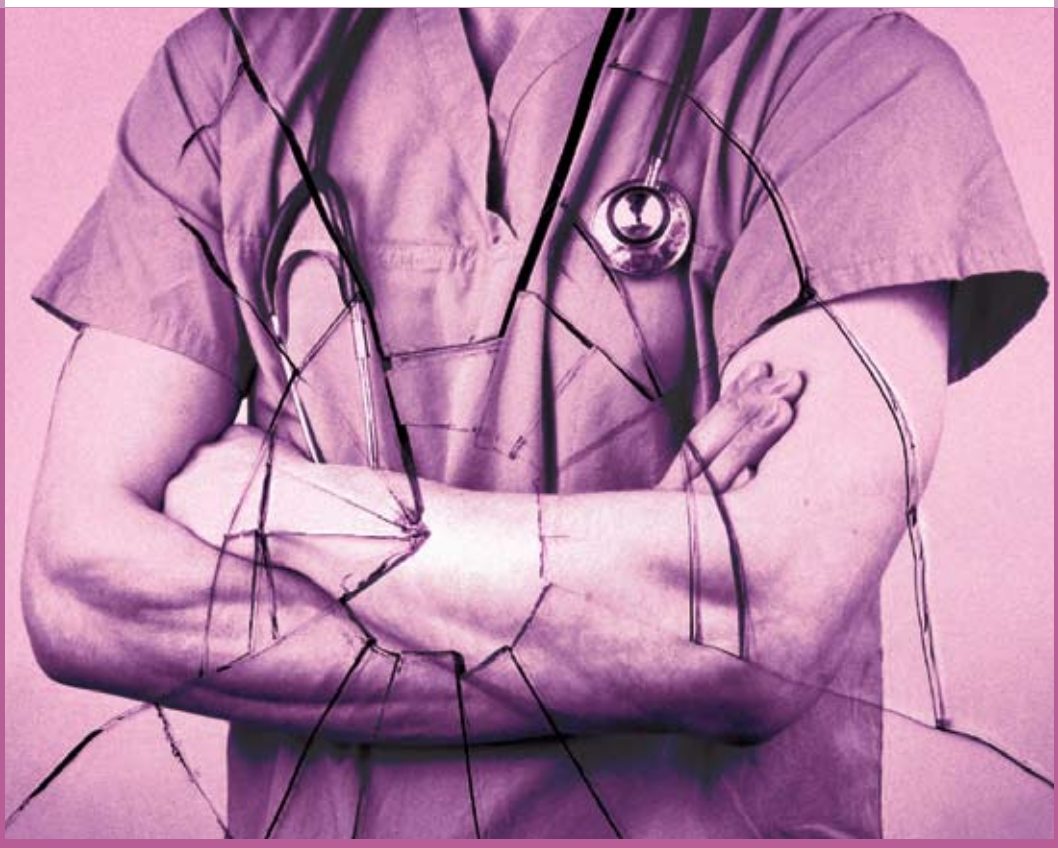
Non-Standard Work in the Healthcare Sector in South Asia

EMPLOYMENT IN HEALTHCARE MNCS

A CASE STUDY OF APOLLO HOSPITAL, DHAKA

Farida Akhter and Shima Das Shimu



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NON-STANDARD WORK IN THE HEALTHCARE SECTOR IN SOUTH ASIA

EMPLOYMENT IN HEALTHCARE MNCS A CASE STUDY OF APOLLO HOSPITAL, DHAKA

Author: Farida Akhter and Shima Das Shimu.

Farida Akhter is the Executive Director of Unnayan Bikalper Nitinirdharoni Gobeshona (UBINIG) /Policy Research for Development Alternative and Co-Convenor of Shashthya Andolon, a national health movement in Bangladesh. Shima Das Shimu is the Director of UBINIG and is engaged in social research particularly on health.

UBINIG is a policy research and advocacy organisation working since 1984 to support people's initiatives to take command over their own lives and livelihood in Bangladesh. It is a national community-based organisation for networking and policy advocacy, working with farmers, weavers, fishers, artisans and crafts persons, community health providers, rural entrepreneurs and other rural communities. UBINIG's main areas of work are health, agriculture, food sovereignty, women's rights, tobacco control, environment and biodiversity. In UBINIG, all activities are collective works. So although the report on working conditions of staff in Apollo Hospital, Dhaka Bangladesh has been conducted by Farida Akhter and Shima Das Shimu it has contribution of other UBINIG staff including its Managing Director, Farhad Mazhar.

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Public Services International, South Asia
61, I block, sector 10, Faridabad - 121006, Haryana, India
Phone: +91 (0) 129 2261175,
mail: kannan.raman@world-psi.org and susana.barria@world-psi.org

Public Services International
45 Avenue Voltaire, BP 9, 01211 Ferney-Voltaire Cedex, France
Phone: +33 (0) 450 40 64 64, mail: psi@world-psi.org, website: www.world-psi.org

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Executive Office: R7 Hauz Khas Enclave, New Delhi 110017
Phone: +91-11-40640516, Telefax: +91-80-25586284
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CONTENTS

NON-STANDARD WORK IN THE HEALTHCARE SECTOR IN SOUTH ASIA

The current set of publications under this series include the following:

Informalisation of Work: A Regional Overview covering the trends in informalisation of employment in the public healthcare sector in India, Nepal and Sri Lanka.

Informalisation and Trade Union Movement: A Case Study of Delhi exploring the evolution of the trade union movement in the sector against the backdrop of the continuous neglect of the public health sector.

Non-Standard Work and Quality of Healthcare Services providing a framework to understand the multiple paths through which growing informalisation of employment leads to the deterioration of the quality of services in the public healthcare sector, giving a stern warning against leaving this practice unchecked.

Informalisation of Work and Quality of Healthcare Services: A pilot study in Delhi, which delves into the experience of informalised workers in key public facilities in Delhi to give a compelling insight into the negative impacts of this practice for workers, and open avenues to think and understand how this in turn affects the institutions they work in and the health system more broadly.

Investing in Health: The Emergence of Healthcare Corporates in South Asia which provides a mapping of the nature of the private sector in Bangladesh, India, Nepal and Sri Lanka and its sources of financing.

Employment in Healthcare MNCs: A Case Study of Apollo Hospital, Dhaka which gives a compelling narrative of the exploitative working conditions in the sector, even amongst the most profitable companies in the sector.

Preface

Private hospital care has emerged over the last one and a half decade in Bangladesh. In an environment where regulation of the sector is lacking, the number of registered private hospitals, clinics, and diagnostic centres increased by 63 per cent to reach 13,341 by November 2015. The weakness of the public sector provides a space and opportunity for the private sector to operate, grow and consolidate. While local entrepreneurs from the fields of pharmaceuticals and diagnostics have expanded into multi-specialty hospitals, Indian companies are increasingly entering the country.

For Indian health-care chains interested to internationalise their operations, neighbouring South Asian countries are a first opportunity to flex their muscles, along with the countries of the Persian Gulf and, increasingly, select African countries. Within South Asia, Bangladesh has the most liberal Foreign Direct Investment (FDI) regime with no limit for equity participation and repatriation of profits and income, along with sizable tax holiday, tariff concessions on capital imports, remittance of royalty, and provisions that facilitates tax avoidance.

The model that is being exported from India is that of high cost care to patients, high returns to company, unfair profit sharing arrangements with employees, and low contribution to society. According to the Prowess data base that provides data for 89 Indian health-care companies, despite a total income of INR 169.8 billion in 2014, the share of income that is provided to the employees of these companies is rather low. In average, the share of employee salaries and benefits stood at 17.2% of total income in 2014. Outsourced jobs constituted 4.1% of total expenditure the same year. Further, health-care companies are not contributing the expected share to government revenues either, as taxes stood at 2.78% of total income.

The Apollo Group is one of the largest Health-care Multinational Companies from India in the region, with 43,557 employees, 9,554 beds capacity in 69 hospitals across India and abroad, as of 31 March 2016. In 2016, Apollo had a total Income of INR 61,123 million (US$ 907 million), of which salaries and benefits counted for only 16.2%. A key instrument to ensure the viability of this rather

exploitative model is the absence of workers' organisations that could demand fairer sharing of the profits of the company with employees and society, as well as resist abuses and irregularities in the treatment of patients.

This report shows that in the Apollo facility in Dhaka, Bangladesh, the work environment is openly inimical to trade unions as employees are told that 'groups' and 'politics' are not acceptable in the premises. It was reported that in 2016, as nurses agitated to demand fair recruitment rules in public health facilities, nurses working in this private facility that joined the movement were fired. Clearly the objection was not related to the demands that had no effect on the private sector, but were a preventive measure to ensure that organising did not seep into the facility. Bangladesh is a signatory of the Freedom of Association and Protection of the Right to Organise Convention (C087) and the Right to Organise and Collective Bargaining Convention, 1949 (C098) of the International Labour Organisation. Further, these rights are guaranteed under national laws. It is high time that these rights are reclaimed.

Susana Barria,
Public Services International

CHAPTER 1

INTRODUCTION

In 2008 after experiencing the glamorous charm of an elite private hospital, many of which have started appearing in Bangladesh since the rapid liberalisation of the service industry, a reporter from the English daily, *Daily Star* wrote:

> It is like entering a posh hotel. Outside the lawns are immaculately groomed. The visitor is greeted with a heartful smile and bow by the well-dressed guard. Inside the fully air-conditioned large lobby there are comfortable couches, a large screen television and a breathtaking interior. Large signs written in English tell you exactly where you can get the particular information you need. Smartly dressed attendants working round the clock make sure that not a speck of dirt appears inside the four walls. For a moment a visitor can forget that she is actually inside a hospital in Bangladesh. For a patient, if a part of the treatment is to feel that he is in a place where he will be taken care of, then these designer hospitals are doing a great job **(The Challenging Face of Healthcare, *Daily Star*, April 25, 2008)**.

This is an exploratory report of Apollo Hospital in Dhaka from the perspective of its staff/employees. Apollo is a 450-bed facility located in Basundhara on the outskirts of Dhaka city. The report also includes some preliminary observations on the privatisation of healthcare in Bangladesh.

METHODOLOGY

Investigative or in-depth research or collecting information from any international corporation, including the health industry, is a very difficult task as staff members are not allowed to talk to any outsider without the permission of the authorities. They are monitored by CCTV cameras so it is not possible to talk to them for more than 15 to 20 minutes at a stretch. Therefore, no notes can be taken during the interviews. Hence, this report relied mainly on informal discussions and noting down the answers after coming out of the hospital. Staff members working in Indoor services were almost impossible to reach; samewas the case with staff members in the pathology department.

In-depth interviews were done through semi-structured talks with staff members, making them feel comfortable about sharing information. The information given

by them had to be kept anonymous. However, there was interest among staff members to share their conditions and disappointments as nobody had ever asked them about their working conditions before.

Formal research can be conducted 'by seeking permission' from the authorities, but then the research is entirely monitored and must be to the authorities' satisfaction.

ABOUT APOLLO HOSPITAL

GENERAL INFORMATION

Apollo Hospital is located in the recently built Basundhararesidential area on the outskirts of Dhaka city. Basundhara is a privately owned residential-cum-commercial area managed by the real estate's private security system. Transportation including rickshaws,is controlled by Basundhara'ssecurity. Rickshaw pullers have to wear yellow jackets given by the group. Bus services are also arranged by the company within the area. The residents of this area mostly belong to the rich and upper middle classes. Some people from the poorer sections also live in the area and are a source of low paid labourfor theresidents. Several low cost hotels and guesthouses have also been set up to provide residential facilities to the hospital's staff members.

Apollo Hospital is the first and only Joint Commission International (JCI)[1] recognised hospital in Bangladesh. This 450-bed hospital has an emergency department, an out-door department and in-patient facilities.

Apollo Hospital is a joint venture of Apollo Hospitals Enterprise Limited and STS Holding Limited (a business conglomerate in Bangladesh which is active in the fields of readymade garments, construction, chemicals and other businesses) whichstarted operations in 2005.

Dr Ed L.Hansen, who has experience in hospital management in USA and Canada, is the chief executive director of the hospital; 57.5 per cent of the sharesin Apollo Hospital are held by locals and 42.5 per cent by foreigners. There is no provision for healthcare facilities for poor people at Apollo Hospital.

The hospital provides a complete range of the latest diagnostic, medical and surgical facilities for patient care. The hospital claims to have all the characteristics

1 Joint Commission International (JCI) is an accreditation system for patients from America to avail their insurance coverage in hospitals abroad. This system facilitates medical tourism by providing an assurance to patients that their cost of treatment abroad will be covered by their insurance back home.

of a world class private hospital with a range of services and specialists, latest equipment and technology. Recently it has also established a new cancer department.

THE DEPARTMENTS INCLUDE

■ Internal Medicine	■ Paediatric surgery
■ Cardiology	■ Paediatric Neurology
■ Cardiothoracic Surgery	■ Gynaecology & Obstetrics
■ Gastroenterology	■ Neonatology
■ Rheumatology	■ Orthopaedics
■ Neurology	■ Anaesthesia
■ Medical Oncology	■ Cardiac Anaesthesia
■ Neurosurgery	■ Radiology & Imaging
■ Neuroscience	■ Dermatology
■ Urology	■ Nuclear Medicine
■ General & Laparoscopic Surgery	■ Dentistry
■ ENT	■ Neuro Psychiatry
■ Ophthalmology	■ Histopathology
■ Paediatrics	■ Biochemistry.

Apollo Hospital has almost all the test facilities required in a modern hospital such as X-ray, ultrasound, CT scan, MRI and all laboratory investigations (histo-pathology/biochemistry/microbiology) etc.

Apollo is known for its elite character and expensive treatment that only the rich can afford. However, it is now also being used by those from the middle-income class people from other districts referred by doctors. Some are also using it as an alternative to seeking treatment outside Bangladesh.

OBJECTIVES

This study is not about Apollo's services to patients or the quality of healthcare that it offers. The study mainly finds out the conditions of the staff members working in the hospital. Although it is very difficult to conduct a formal study as staff members are not allowed to talk to any outsiders except those with patients for patient services, information was collected from them by talking to them informally and briefly. The information gathered provides the basis for a

preliminary analysis and gives some useful indications and guidelines for designing further research.

Taking Apollo Hospital as a case study, the objectives of this research are:

- Understanding the profile and working conditions of the medical and non-medical workforce in a healthcare MNC in Bangladesh;
- Highlighting the impacts of cost cutting measures in the 'wage bill' on workers' rights and quality of care;
- Understanding the impacts of healthcare MNCs on the healthcare system and patients' expectations with regard to healthcare provisioning; and
- Deriving learnings for organizing trade union strategies in the sector.

CHAPTER 2

PRIVATISATION OF HEALTHCARE IN BANGLADESH

In the early 1980s, prior to the implementation of the International Monetary Fund's (IMF's) Structural Adjustment Programme, healthcare was provided by public facilities and not-for-profit institutions. The provision of basic health services is a constitutional obligation of the Government of Bangladesh. Article 15 of the Constitution stipulates that Bangladesh shall secure 'the provision of the basic necessities of life, including food, clothing, shelter, education and medical care.' In addition, Article 18 of the Constitution asserts that 'the State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties….'

In line with this constitutional framework, the healthcare sector has developed policies and programmes which are implemented through the Ministry of Health and Family Welfare.

Despite constitutional obligations healthcare services have been privatised and the healthcare responsibility has been significantly shifted to the private sector. The idea of citizens' health as a collective responsibility implemented through policies, institutional and financial mechanisms of the state has been systematically dismantled.Instead, what has been asserted in both policy and practice is that access to health services is the responsibility of individuals, irrespective of his or her economic condition. Previously access to health services was considered a 'right' that citizens could claim from the state; it was also society's moral obligation to help the sick. The assumption and expectation that healthcare should be provided by the state and must not be reduced to a business or a way to earn profit eroded within a few decades, in spite of what was written in Bangladesh's Constitution.

Bangladesh got its independence in 1971 and started negotiations with IMF in 1972. In 1973 Bangladesh had its first experience of a policy dialogue with IMF.

The formal Structural Adjustment Programme (SAP) arrived in the 1980s. Explicit subordination of the domestic policy started manifesting in the guidelines and targets laid down in the Policy Framework Paper prepared by IMF and the World Bank in 1986. The Poverty Reduction Strategy Paper (PRSP) was initiated in the late 1990s; by that time public institutions and public service mechanisms had been more or less dismantled through structural and policy conditions to fit Bangladesh into the global capitalist order.

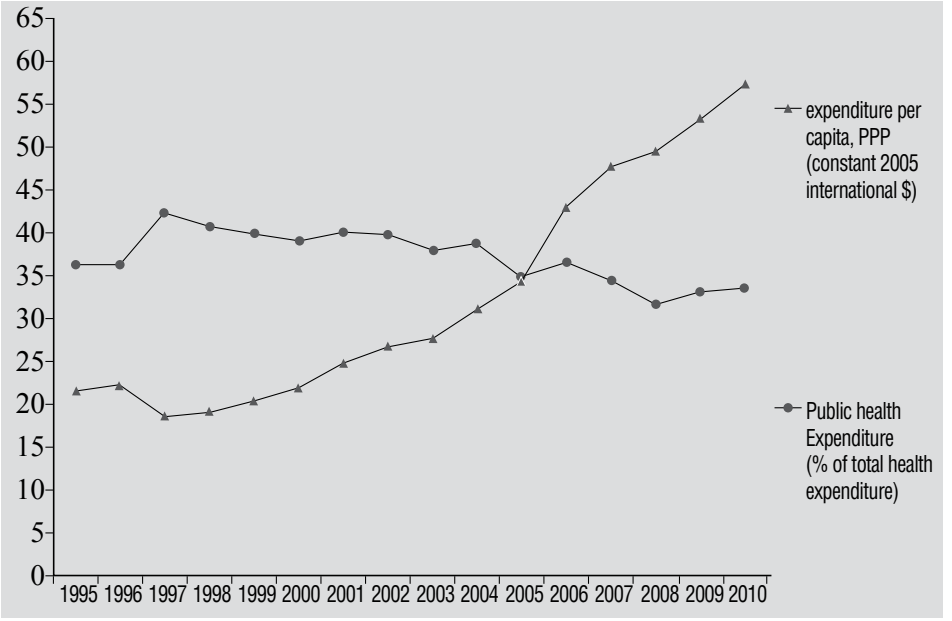
The general effect on healthcare was the gradual dominance of healthcare services as a marketable commodity and available on the basis of payment. This gradually dismantled and distorted the already weak public healthcare system which was replaced by the 'private sector.' The private sector includes the business community, private corporations and NGOs. The public healthcare system had its problems, the most significant of which was lack of funding and the disappearance of strategic operational notions such as primary healthcare, essential medicines andpeople's right to get health services. Previously, in addition to government run facilities public healthcare also meant charity clinics, NGO health services and traditional systems of healthcare. Thus, the diversity of the healthcare system with regard to its relation to the state was divided into two sectors: public and private.

The privatisation of healthcare was not dictated by the health needs of the people or failure of the public healthcare system. Instead, social and economic conditions were created for a market for health services. It was not an organic process either. In fact, public healthcarewas systematically neglected in order to create the conditions for the commercial health sector to emerge. The World Bank's prescription of health policy reforms in the early 1990s made countries like Bangladesh accept health service as a private good rather than a basic human right.[1] The policy approach to reforms in the health sector is largely determined by the suggestions contained in the structural adjustment programmes of the 1980s that facilitated the prevalence of the market model over the state model of development.

According to the latest Bangladesh National Health Accounts, Bangladesh spent US$ 2.3 billion on health, or US$ 16.20 per person per year, of which 64 per centcame from out-of-pocket payments (MOHFW, 2010). The World Health

1 The World Bank's *World Development Report 1993: Investing in Health* provides a detailed understanding of the World Bank's prescriptions for the role of the private sector in healthcare provisioning in developing countries.

Figure 2.1: Health expenditure per capita versus public health expenditure



(Rashidul Alam Mahumud, Marufa Sultana, Abdur Razzaque Sarker, 2015, pp. 97-101)

Organisation's (WHO's) estimates differ and indicate that Bangladesh spent US$ 26.60 per capita in total. Public healthcare expenditure constituted 26 per cent of total public expenditure.

Total healthcare expenditure and private healthcare expenditure as a share of GDP has been increasing rapidly since 1997, but public healthcare expenditure has remained stable since 1995. Private healthcare expenditure was highly correlated with the total health expenditure. The share of public healthcare expenditure had a downward movement after 1996 (Figure 2.1).

As SAP, GATS and various other privatisation policies for healthcare have deepened there has been an increase in the number of private hospitals and clinics in addition to government healthcare service providers. In 1991 there were 610 government hospitals (68 per cent) and there were 280 private clinics (32 per cent). In 2006, the situation reversed. The number of government hospitals was only 676 (40 per cent), while the number of private hospitals was 1,005. In two decades, the number of government hospitals grew by only 11 per cent, while the private hospitals grew by 259 per cent (BBS, 2006). According to the Directorate General of Health Services (DGHS) (2013), there were 2,983 private hospitals,

5,220 private diagnostics and 45,485 beds in private hospitals (Bangladesh Bureau of Statistics (BBS), 2014).

There is a severe shortage of doctors and nurses in public hospitals. The current nurse-doctor ratio of 0.4 (2.5 times more doctors than nurses) is far short of the international standard of around three nurses per doctor. There is also a gross imbalance in the doctor-technologist ratio, the ideal being five technologists for one doctor. According to WHO's estimates, Bangladesh has a staggering shortage of 60,000+ doctors, 2,80,000 nurses and 4,83,000 technologists. In Bangladesh, both the number of nurses per 1,000 population and the nurse-to-doctor ratio are among the lowest in the world (Akhter, 2013)

The nurse-doctor ratio is different in private hospitals and they also have to deal with a lot less patients. Therefore, there is no comparison between private and public hospitals.However, this is an indicator of how health services are geared towardsthe commercial sector, appropriating available professional health professional resources, whichare mostly trained using national investments in healthcare education. Many doctors in public hospitals also work in private hospitals. The same doctors who work in private hospitals look after patients and provide medicines in public hospitals. This allows them to spend only about a minute per patient. Despite such a situation, availability of health services in government hospitals is at least an option that is fast vanishing due to an increase in the number of private hospitals (Akhter, 2008).

REGISTRATION OF PRIVATE HOSPITALS

For setting up a private clinic or hospital, the owner has to apply to the Directorate Health Office for registration. The application is processed and after the official procedure a team from the DG's office does an inspection of the clinic. After the inspection the team submits a report to the concerned authority. The concerned authority considers whether the private clinic or hospital should be registered. At the time of applying detailed information in terms of qualifications, adequacy of staff member, sufficient and proper equipment, adequate accommodation facilities and space and sanitary conditions should be given. The registration authority can refuse to register the application if any person in the clinic or nursing home is found unfit, whether by reason of age or otherwise or if the nursing home or hospital is not under the management of a qualified medical person or does not have adequate space, equipment, etc. Other regulations also apply to hospitals or nursing homes such as those referring to or related to buildings,

drainage and sanitary facilities, as well as laws regarding employees' provident fund, minimum wages, maternity and working conditions. In addition to these, hospitals registered as trusts or public societies have to follow the legislation formed for trusts and public societies.

Going abroad for treatment is a common practice among the rich. The Tata Memorial Centre, especially for cancer treatment (Mumbai) and the BM Birla Heart Institute (Kolkata) and Apollo hospitals in India are options. So setting up elite luxury hospitals in Bangladesh is a profitable business model as it is seen as a better option for those who can afford higher costs of treatment whether in Bangladesh or outside. There are broadly two categories of private hospitals in Bangladesh today: (super) specialty 'posh' hospitals meant for the rich. Among these the most well-known are the Dhaka Apollo Hospital, Square Hospital, United Hospital, and LabAid. All these are local hospitals.

The second category of private hospitals mainly provides services to people belonging to the middle-income group; hospitals such as IbnSina, Popular Hospital and a few others belong to this group. The number of private hospitals is more, at least 30 hospitals can be found in Dhaka city alone. Some specialised hospitals in Dhaka are the Bangladesh National Heart Foundation Hospital, Gastro-liver Hospital, Dhaka Renal Centre & Polyclinic, and Crescent Gastro-Liver Hospital.

Although there are more private speciality hospitals operating in the country, trips for treatment outside the country have not reduced significantly in the last 10 years. Many foreign hospitals have local recruiting agents and they actively contact patients and make arrangement for treatment trips outside Bangladesh. This is also the reason why treatment trips have not reduced. Agents of BumrungradHospital in Bangkok, Mount Elizabeth Glineagles Hospital in Singapore, and a few hospitals in India are operating in Bangladesh.

Galaxy Healthcare Services, a local agent's office is working in Gulshan, Dhaka on behalf of these foreign corporate hospitals. Caretaker Health is another local agent in Dhanmondi, which facilitates and makes contacts for patients in different hospitals in India.

In 2007, around 45,000 Bangladeshi patients went to India, 15,000 to Bangkok, 4,000 to Singapore and another 5,000 to other countries for medical treatment. In

2007 the number of medical visas granted to Bangladeshis by India, Thailand and Singapore increased.

PROFIT MAXIMISATION: HOSPITALS AND DIAGNOSTIC LABS

Medicalisation of healthcare is an old problem, whichhas been characterised by technological developments eliminating the role of close and personal observations by healthcare professionals as also a study of symptoms and patients' complaints. The present day treatment is technically diagnostic-based. The doctor does not understand the disease until certain 'tests' are done. These diagnostic tests have to be done at certain diagnostic laboratories, which are as expensive as some of the hospitals. Private hospitals have either their own labs attached to the hospital or they have contracts with certain diagnostic laboratories. Corporate hospitals such as Apollo, Square, United, Lab Aid and some others have their own diagnostic facilities. On average, about 60 per cent of the private hospitals send their patients for 'tests'to two or three specific diagnostic labs and 40 per cent of the hospitals send patients to only one specific lab. This means that hospitals having their own facilities send patients to other diagnostic laboratories for a few tests such as a CT scan and MRI.

According to the Directorate General of Health Services, Ministry of Health & Family Planning, in 2007, there were 2,068 private hospitals and 1,500 private diagnostic centres.

In 2007–2008 new applications were submitted to the DG Health Office for setting up another 939 private diagnostic centres and clinics.

SKILLED HEALTH PROFESSIONALS: NATIONAL INVESTMENT BUT PRIVATE APPROPRIATION

One of the claims of the private hospitals is that they are enabling the retention of medical doctors in the country. An official of a private hospital claimed that 'one of the biggest roles that the private hospitals have played is in stopping the brain drain that was taking place from our country.' They also claim that Bangladeshi doctors living abroad are also coming back because of the availability of jobs in private hospitals (*Daily Star*, April 25, 2008).

According to Dr Zafrullah Chowdhury, the founder of GonoShasthya Kendro (People's Health Centre),'Children from well-off families are virtually getting medical education for free; they are not being urged to give to the country in

return for what they are getting… one has to pay only 5 taka to stay at a medical college hostel including all utilities while the girls working in garment factories have to pay around 700 to 800 takas for a room in the slums.'

DrZafrullah says that while students only have to pay a nominal fee, the government does not send them to the villages where most of the population lives. As soon as they pass their exams the government creates opportunities for them to pursue Fellow of College Physicians and Surgeons (FCPS) abroad. 'The government should also create more opportunities for students from the villages to come and study in the medical colleges here' (*The Daily Star*, April 25, 2008).

While the private hospitals claim that they are able to stop brain drain and bring back NRB doctors, it is also true that there is a drain of doctors from public hospitals to private ones. Most private hospitals (80 per cent) capitalise on the availability of 'professors' from public hospitals in evening hours. Corporate hospitals bring doctors from private medical colleges, which do not necessarily provide better quality in medical education. Specialist doctors in Apollo Hospital are paid very well and their minimum salary range is BDT 150,000-400,000 per month. Even the salary of a general physician is BDT 40,000-45,000 per month. On the other hand, the salary range of specialist doctors in the government hospitals is BDT 13,000-25,000. Obviously,this is much lower than what they earn through private practice. Corporate hospitals have contracts with the doctors that they recruit that they cannot practice in other hospitals.

Private hospitals are also engaging foreign doctors, particularly from India, thereby creating jobs for doctors from other countries. In Apollo Hospital alone, there are 22 Indian senior specialist doctors.

The doctor-patient ratio in private hospitals is 1: 10 while at the national level it is 1:3,500. So there is a shortage of both doctors and nurses in public hospitals. The same doctors are looking after more patients and providing treatment. This allows them to spend only about a minute per patient (Akhter, 2008).

COST OF TREATMENT

The cost of treatment in private hospitals is certainly beyond the reach of the common people. The cost includes payment for bed or cabin, usually in the range of BDT 1,500-3,000 per day.[2] Hospital owners have a 'hotel-policy' with regard

2 1 EUR is approximately 84 BDT.

to services provided for patients in a cabin that is air-conditioned and has a television and sofa. Treatment charges, including operation charges vary between BDT 25,000 to BDT 1 lakh depending on the kind of disease.

AN EXAMPLE OF TREATMENT COSTS IN APOLLO

The rent for a single cabin bed is a minimum of BDT 3,500-5,000 per day. There are more high rated luxury cabins also. Medical treatment costs are also high. For example, for a patient with typhoid admitted in Apollo Hospital for seven days it will cost a minimum of BDT 60,000. A moderate operation charge (hysterectomy, cholesestectomy) is minimum BDT 100,000-160,000. A minor appendix operation costsa minimum of BDT 60,000. In OPD, a patient has to spend a minimum of BDT 800-1,200 to see a doctor. This is only the doctor's fee. Investigation tests cost more than they do in other hospitals. The fee for a specialist doctor's first visit is BDT 1,000 and the second visit costs BDT 500 daily.

Charges for a bypass cardiac operation (CABG) begin at a minimum of BDT 250,000-350,000, as soon as the patient is admitted. The actual costs are often kept vague and may cross BDT 500,000, depending on the illness.

The higher costs are justified by comparing them to the costs in hospitals abroad and the poor atmosphere in public hospitals. Private hospitals claim that they are giving massive logistical support, therefore the costs are higher. According to Dr Zafrullah Chowdhury, 'They did make a lot of investments but they also made a lot of unnecessary investments. I don't think their charges are justified.' The justification for higher costs in private hospitals is that the services are better at least in terms of cleanliness, availability of beds (because only few people compete for them) and response of the nurses as compared to government hospitals. Middle-income patients have to sell off their assets for life saving treatment in a private hospital (An exploration of privatisation of healthcare service in Bangladesh by Farida Akhter, UBINIG, 2008. The information provided in the paper is based on UBINIG's own studies on privatisation of healthcare since 1998).

Admitted patients have two options: either they can stay in a cabin on payment or they can stay in a ward. There are three types of cabins: VIP cabins with daily rent of BDT 22,000, the two other cabins are available at a daily rent of BDT 14,000 and BDT 11,000.Two patients can share a single cabin. In such case one patient will pay BDT 7,000 and, BDT 5,500 per day respectively.

Doctors are available when there is an emergency but a fee is charged for every visit. A doctor's fee is BDT 2,000-3,000 for each visit (higher rate of fee may be charged depending on the type of disease).

ICU facility is available for patients on payment. The rent of an ICU is quite high (the exact amount was not available).

Treatment costs are also very high in Apollo Hospital. For specialist doctors for cardiology, kidney, gastro-intestinal,cancer andmedicine the first appointment fee is BDT 1,500-2,000. A GP takes BDT 1,000 for the first appointment. For the second visit with the report of a pathology test the specialist charges BDT1,000 for giving a prescription.

Cancer treatment too has started at Apollo Hospital and may cost BDT100 million without any assurance of cure.

For gastro-intestinal treatment in the hospital one patient's family paid BDT 3.5 million for four months of treatment; the patient finally died in the hospital.

A diabetic patient with a high sugar level was admitted to the hospital's ICU, and later shifted to a cabin for 10 days. The total costs were BDT 5 lakh (0.5 million).

CHAPTER 3

STAFF OF APOLLO HOSPITAL

1. SECURITY WORKERS

There are 60 security workers in Apollo Hospital. The hospital engages security workers through the Integrated Security Services Limited (ISSL –an outsourcing company supplying security workers). The monthly salary of each worker is BDT 9,000. In addition, the hospital gives BDT 2,000 a year to a worker who offers the best service.

His/her duties involve security and 'behaving nicely' with the patients. The security workers work in 12-hour shifts. Though they work in Apollo Hospital their accountability is to ISSL, Banani. Security workers are not permanent staff members of the hospital. The yearly contract of a security worker can be renewed if ISSL wants to.

After the July 2016 terrorist attacks in Holey Artisan Bakery in Gulshan, Apollo contacted a new security company, Coller Stone.

Apollo Hospital has an annual agreement with ISSL for engaging security workers. Security staff members are not offered any overtime allowances. These workers have no idea about a trade union. They are drawn from poor and lower-middle income families. Most of them have studied only up till the primary level.

They do not have any other benefits (like an Eid bonus). There is no provision of a weekly holiday. They also do not get any medical allowance if they are sick. The hospital does not give them free medicines.

However, in case of minor illnesses, some physicians offer prescriptions, without charging anything. They need to buy medicines themselves.

2. CUSTOMER CARE OR TROLLEY MEN

At times patients have to use wheel chairs for pathological tests, or for shifting from one floor to another or when they are discharged. Trolley men are needed at

these times. Relatives or other attendants are not allowed to touch the trolleys. There are clear orders in this regard. There are 10 trolley men on each floor or 50 trolley men in Apollo Hospital.

Trolley men work in 12-hour shifts. The hospital engages them directly. The minimum qualification for being a trolley man is SSC. In addition, a trolley man needs to have two years' of experience in any other hospital. Trolley men are permanent staff members of Apollo Hospital. Their monthly salary is BDT 9,000. They also have other facilities – BDT 20 for breakfast, BDT 50 for lunch and BDT 10 for an evening snack.

Trolley men are drawn from poor and lower middle classes. They have not heard of a labour union in Apollo Hospital. They do not have any weekly holiday.

3.HOUSEKEEPING OR CLEANERS

Cleaners work in three departments: emergency, outpatient and wards and cabin. There are 60 workers engaged as cleaners. Women and men work here in equal numbers. These workers are permanent staff members of Apollo Hospital. They work in 12-hour shifts. They are supposed to perform night duty for three days in a week. Each cleaner gets BDT 9,000 as a monthly salary. They need to have two years' of experience at the time of appointment. Priority is given to those with experience in any other hospital or clinic. They do not have any trade union.

4. GARDENERS

There are eight gardeners in Apollo Hospital. They are permanent staff members who get a monthly salary of BDT 8,000. They work for eight hours a day. They do not get any other facilities.

5. PATIENT CARE ASSISTANTS

There are ward boys in all hospitals or general clinics. The ones in Apollo Hospital are called **Patient Care Assistants** (PCAs). Apollo Hospital'smanagement recruits the PCAs. They need to have3-5 years' experience for appointment. Their monthly salary ranges between BDT 12,000 and BDT 18,000.

6. CUSTOMER CARE OFFICERS (CCOS)

Both men and women are appointed as **Customer Care Officers (**CCOs). The minimum qualification for this post is graduation. In addition, two years' experience is also necessary. CCOs are permanent staff members of Apollo

Hospital. They have to compulsorily attend one and a half months of initial training after appointment. They get permanent appointment after this training and they enjoy all the facilities as staff members of Apollo Hospital. They get BDT 100 for breakfast, lunch and evening snacks. Their monthly salary is BDT 20,000 – BDT 25,000. They work in 8-hour shifts. There is no trade union.

7. NURSES

Both male and female nurses work in Apollo Hospital. There are 1,700 nurses (both male and female), 50 per cent of whom are from India (mainly from Delhi, Mumbai, Chennai and Kolkata) and the rest are Bangladeshis. Nurses need three years' experience and have to get three months of in-service training. Although the requirement for a nursing post is five years' experience, but usually the hospital hires those with three years of experience. Those from India have a starting salary of BDT 50,000 that goes upto BDT 1,50,000. For Bangladeshi nurses the minimum salary is BDT15,000 going up to a maximum of BDT 50,000. Bangladeshi nurses are hired even at salaries lower than BDT 15,000. Their duties are no different from those performed by Indian nurses. They have normal duties of eight hours in OPD services with four hours of overtime, making it 12 hours of duty per day. But those who work in the operation theatres have six hours of duty at a time. They work in shifts.

GENERAL INFORMATION ABOUT STAFF MEMBERS/EMPLOYEES

Table 3.1 gives the socioeconomic background of staff members. The age range of staff members in Apollo Hospital is given in Table 3.2.

A majority of the staff members/employees were found to be in the age group of 25-35 years. The hospital has a lesser number of staff members over 36 years of age. The gender distribution of staff members is given in Table 3.3.

Earlier there were only men in security services but after the July 2016 terrorist attack, women security staff members are also being recruited. However, only men are hired for duties, which are performed in shifts and need overnight stay at the front desk of the hospital.

Although one man was interviewed from customer care, the hospital also has female customer care staff members. They also perform other duties but are called customer care staff members. They may also take patients in trolleys but are not called trolley men.

Table 3.1: Socioeconomic categories

Category of Staff members/employees	Poor*	Lower middle**	Middle
SUPPORT SERVICE			
Gardener	1		
Security	2	2	
Housekeeping	2	2	
PATIENT SERVICE			
Patient Care Assistants (PCA)	1		
Nursing		2	
ADMINISTRATION			
Customer Care		1	
Billing Officer			1
BD***/Receptionist		1	

Note: *The poor are identified by level of education (no schooling), family in a rural area and only one earning member. They perform 'low-grade' work in the hospital, for which lower middle or educated persons may not apply.

**Lower middle staff members have schooling (primary to secondary level), have more than one earning member in the family and have more than one source of income. They are less vulnerable than the poor. They are given 'better'grade jobs.

***BD includes offering advice to out-patients, providing information about the counters for availability of services and giving information to patients from 9 am to 2:30 pm at the Information Centre, Dhanmondi.

Table 3.2: Age range of staff members

Category of Staff members/employees	<25 years	25 – 35 years	36+ years
SUPPORT SERVICE			
Gardener			1
Security	2	1	1
Housekeeping		2	
PATIENT SERVICE			
Patient Care Assistants (PCA)		1	
Pharmacist		1	
Nursing		2	
ADMINISTRATION			
Customer Care		1	
Billing Officer		1	
BD/Receptionist		1	1

Table 3.3: Gender distribution of staff members

Category of Staff members/employees	Male	Female
SUPPORT SERVICE		
Gardener	1	
Security	3	1
Housekeeping	1	1
PATIENT SERVICE		
Patient Care Assistants (PCA)		1
Pharmacist		1
Nurse (OPD)		2
ADMINISTRATION		
Customer Care	1	
Billing Officer	1	
BD/Receptionist	2	

Both men and women work in housekeeping though there is a sharp division in their duties. Male housekeeping staff members change bedsheets, bring the saline stand and provide other services, but female housekeeping staff members clean garbage andwash and clean bathrooms.

Pharmacist female staff members have to also perform the work of customer care such as contacting a doctor, showing the way to the lab for tests and fixing an appointment with a doctor. The salaries of staff members are given in Table 3.4.

One may think that since it is an international corporate hospital, Apollo will be offering much higher salaries at all levels. But its salary levels are modest and are not enough for living in Dhaka. Staff members do not get any other facilities such as medical, medicines or free prescriptions from doctors.

As staff members they are supposed to get a food allowance during their shifts of BDT 80 per day for three meals, but those interviewed said that they did not get this allowance.

Staff members at all levels said that they were being paid less than what they heard the post deserved. For example, a customer care staff member reported that

Table 3.4: Staff salaries

Category of Staff members/employees	<BDT 10,000	BDT 11,000 – 20,000
SUPPORT SERVICE		
Gardener	1	
Security	3	1
Housekeeping		2
PATIENT SERVICE		
Patient Care Assistants (PCA)	1	
Pharmacist		1
Nursing		2
ADMINISTRATION		
Customer Care		1
Billing Officer		1
BD/Receptionist	1	1

he received BDT 15,000, while the authorities reported that he was being paid BDT 20,000.

PCAs reportedly received the least amount of BDT 11,000 to begin with, but a PCA who was interviewed reported that he got BDT 11,000 even after working for six years.

Nurses are supposed to get BDT 20,000 as starting salary. But the nurse interviewed, who had four years of experience in another hospital before she joined Apollo, said she got only BDT 13,000 as starting salary. Moreover, men and women staff members get different salaries for the same job (Table 3.5).

The difference in salary for men and women staff members is usually around BDT 2,000 and there is no particular explanation for such a difference.

The salary level is arbitrarily determined also because there are no hard and fast rules for experience and qualifications. So it is determined by the source from which the staff member is appointed like a relative working in the same hospital

Table 3.5: Salary difference by gender

Category of Staff members/employees	<BDT 10,000 Male	<BDT 10,000 Female	BDT 10,000 – 20,000 Male	BDT 10,000 – 20,000 Female
SUPPORT SERVICE				
Gardener	1			
Security	1	2	1	
Housekeeping	1	1		
PATIENT SERVICE				
Patient Care Assistants (PCA)				1
Pharmacist		1		
Nursing				2
ADMINISTRATION				
Customer Care			1	
Billing Officer			1	
BD/Receptionist	1			

or through known sources. No proper advertising is done although the recruitment is supposed to be through advertising.

Recruited staff members are also supposed to have in-service training of a minimum of 45 days, but the interviewed members reported in-service training for only three days (security assistant) and no training for nurses.

CHAPTER 4

TESTIMONIES OF STAFF MEMBERS

SHAMIMA (25 YEARS)

I am a female security worker. I am posted at the main gate of Apollo Hospital. I have a 4-year-old daughter. My husband is a day labourer. I leave my daughter with my mother-in-law. I live in a female mess near the hospital. I got the job through other staff members in the hospital who are from my district.

I joined Apollo Hospital as a security worker on August 1, 2016. Before this there was no post for female security workers. The number of security workers was increased in Apollo Hospital after the terrorist attack in July 2016.

At the time of joining I was told that my monthly salary would be BDT 12,000. The hospital's management did not issue any appointment letter to me. But I receive only BDT 10,000 per month. I have to accept this because I need the job. I need to save money to bring up my daughter and look after my husband and mother-in-law. My plan is to work for six months and that is why I am scared of raising the salary issue because if they fire me I will lose the job. Even though I want like to ask I do not know where to complain. Fact remains, Apollo is not paying me what it had promised and verbally contracted to me during the interview.

I prefer to have a job inside the hospital. Now, here I am dressed like a man, in front of the hospital among the public. As a girl it is humiliating and deep inside I don't like it. This is not consistent with my culture and beliefs. I feel sad, but I have no choice.

RAMAN (24 YEARS)

I am a security worker in the emergency department. I joined on August 1, 2016. There were no security workers in the emergency department before July 2016. The strength of the security service was increased after the terrorist attack. There

were only 60 security workers in Apollo Hospital before the attack. Now the total strength of security workers is 126. I come from a lower middle class family. I live with my parents. I am unmarried. One of my relatives was working in Apollo Hospital. I was looking for a job so he provided me the present job. I was selected because there was an emergency need for security workers. There was an agreement with me for two years of employment. It is my first job and I have no prior experience. Apollo had mentioned to me that there is no practice of politics in Apollo Hospital. There would be no grouping. I am being paid BDT 12,000 per month.

I work in the outpatient department. There are 54 workers here. I have to work for 12 hours. I have to work standing all the time. There is no place for sitting. Sometimes my legs pain when I bend down. The place of duty changes after every four hours. I am not paid any extra money for overtime.

AFSANA (16 YEARS)

I am a female security associate. I am unmarried. I study in Class X in an open university. My cousin sister works here in the security section. I was introduced by her. I joined on September 8, 2016 after a 2-day training. In the training I learned the art of checking a lady's bag, doing a body search and operating a scanning machine. Security checking has started only recently; it is done before someone enters the main building of Apollo Hospital. This checking was started after the Gulshan incident.

My daily duty is for 12 hours. There is no weekly holiday. I work in shifts. My salary is BDT 10,000. There are no other job benefits. I do my duty at the main gate of the hospital. I cannot go inside the hospital without need. I have not yet had a chance to see the hospital from inside.

My mother, father, sister and brother live in our village. I live with my cousin sister in a women's mess in Dhaka. There is no chance for grouping, politics or a trade union in this hospital.

RAKIBA (26 YEARS)

I am a pharmacist. I am unmarried and come from a lower middle class family. I studied facing great hardships. I have been working for two years. In addition to performing my duties as a pharmacist I have to work on the information desk for outpatients (OPD). I have to perform both the tasks. I work for 12 hours a day.

My salary is BDT 18,000 per month. The person who introduced me to this hospital is a worker in the pathology department. The hospital's management had mentioned to me that there would be no politics.

MONOWARA (28 YEARS)

I work for housekeeping. I am married. We are poor. I have a 5-year-old daughter. My husband works in a hardware shop. We live in a slum area behind Apollo Hospital. There are many people from Barisal working in the hospital. They helped me get this job. I have been working for two years. My salary is BDT 9,000 per month. I did not get an increment this year. I have studied up to Class VIII. The present required qualifications for housekeeping work are a Secondary School Certificate (SSC).

We are not designated as *ayas*. I have to perform night duty for three working days and I get BDT 20 as food allowance per day. We, the workers do not get any medical treatment in this hospital, we have to go elsewhere. We do not dare to request even a prescription from a doctor in this hospital. Housekeeping workers are not entitled to any weekly holiday. We work in shifts for 12 hours a day. We have to attend to our personal work in between shifts. We are not paid any extra money for overtime.

SOLAIMAN (25 YEARS)

I am a housekeeping worker. I have to do three night duties. I work in shifts and there is no provision for being paid for overtime. Previously I worked in a clinic in another district. There I was entitled to medical treatment. But there is no medical facility in this job. Medical treatment has to be managed elsewhere. There are 60 housekeeping workers. The management cautioned us against grouping here.

We keep the entire hospital clean but we do not get any medical treatment. Charges for a doctor's visit are very high and range between BDT 1, 200-1,800. We go to a doctor outside when we fall sick. We buy medicine from a pharmacy. Rich people come here for treatment. More heart patients visit this hospital for treatment.

RAJENDRA (29 YEARS)

I work in the customer care section. I register the names of patients in OPD. I have been working in Apollo Hospital for two years. My monthly salary is BDT

15,000. I had worked for three years in different healthcarecentres before I joined this hospital. Apollo is a big hospital. Everybody thinks that staff salariesmust be very high. In reality there is no future for the workers in this hospital. Staff salariesdo not increase before 10 years of service. There is no sympathy for the workers here. That is why 40 workers resigned and went elsewhere. Now they enjoy freedom of work. Sometimes we have to work for 12 hours a day even though the management says that we work for eight hours a day. The assigned job must be done without any questions. We work here only for survival.

I dropped my bio-data in the box near the main gate of Apollo Hospital with an application for a post in the customer care section. Anybody can drop an application in this box for a job in the hospital.

ALTAF (29 YEARS)

I am a building officer. I have been working here for five years. Initially my monthly salary was BDT 14,000. Now it is BDT 20,000. I work for eight hours a day. But we also have to work for extra time for which there are no extra benefits. However BDT 20 is given in case we work for more than four hours. The monthly salary was mentioned at the time of interview. The salary is not paid based on the hours of duty. This is the system of work and salary here.

The workers in this hospital do not get holidays like government officers. Most of the workers work in shifts. The OPD is closed for two days for Eid.

CHAMELI (25 YEARS)

I am a nurse. I look after OPD patients. I have to work for eight hours a day. My salary is BDT 13,000. I heard that salary in this hospital increases after 10 years.

I joined this hospital three months ago. I did not have any professional training in this hospital. I had to join directly as there was a shortage of nurses. Many doctors have resigned and gone elsewhere. The reason is not known. New doctors have been appointed. Many nurses were sacked during the nurses'movement three months ago. I was appointed at that time.

I had worked in another hospital for four years. I had to do night duty in another hospital. I also had to work in the operation theatre there. Here I do not need to work in the OT and do no night shift in the first year. I was told this when I was hired.

Apollo told me that there is no politics in the hospital. There is no grouping and there is no trade union of workers. But I feel it is better for the workers to have a trade union. I could not tell the management this because if I had they would not have appointed me.

I am unmarried. My mother, father, sister and brother live in our village. I live in a women's hostel in Dhaka.

SUROVI (30 YEARS)

I am a senior nurse. The nurses work in three places: indoor in the hospital, OPD and the emergency department. Some nurses work six hours a day while others have to work for 12 hours a day. Nurses working in OT have to work for 12 hours a day. I work in the OT. We do not have strength to do personal work after working for 12 hours in the hospital.

I will not tell you how much I am paid but will only give you a range of salary that nurses get. Bangladeshi nurses work side by side with nurses from India. Nurses from Delhi and Chennai work here. The salaries of Bangladeshi nurses are lower. The salaries of Bangladeshi nurses in Apollo Hospital start at a minimum of BDT 15,000. The maximum may be BDT 50,000; whereas the salaries for nurses from India start at BDT 50,000 per month. Some of them get BDT 150,000 per month even though the two groups do the same work. They have come from a foreign country so their salaries are higher. Recently Bangladeshi nurses were appointed at a monthly salary of BDT 13,000.

There is no trade union in Apollo Hospital but all the nurses participated in the nursesmovement for realizing their demands. The Bangladeshi nurses in Apollo Hospital also participated in this movement with other nurses. Most of the nurses were sacked because they participated in the movement. Only a few of the senior nurses were retained. The newly recruited nurses are not given any training in Apollo Hospital. According to the hospital's rules the newly recruited nurses are required to attend 1.5 to 3 months of training before joining their duties formally. The training could not be organisedas there was an emergency for nurses in the hospital.

CHAPTER 4

CONCLUSIONS

The quality of treatment, healthcare and services in Apollo Hospital are not consistent with its high costs, glamour and elite posturing as perceived by the patients that we spoke to. Several incidents of wrong treatment and failures were reported by the patients; the media has also highlighted these. In the beginning the high costs were justified with the promise of high standardsin healthcare, which were not available in Bangladesh. Treatment for certain diseases is costly but over the years it has become obvious that the promise to deliver quality healthcare in exchange for money has not worked. There is an inherent contradiction between profiteering and providing healthcare to the needy.

Staff members ranging from those working in the security service to those who provide patient care are an essential part of the services provided by the hospital. But lower ranking staff members are recruited informally; most of thembelong to the lower middle class. The authorities do not pay the salaries that they verbally commit at the time of recruitment, as people from this group require the jobs. In some sections they have to work long hours (12 hours) standing without a break. No overtime is paid for work over eight hours. Newly recruited staff members are also not given weekly holidays. Staff members are not provided any medical services for their illnesses; they have to go elsewhere when they fall sick.

Staff members are warned about not playing ‘politics’in the hospital so that they do not get organised for demanding fair wages, overtime payments and weekly holidays. Staff members work here as they need the jobs, but they do not see any prospectsof working here for a long time.

Nurses are not only overworked but they also face discrimination vis-à-vis nurses recruited from India. Indian nurses are paid twice as much as the Bangladeshi ones and this creates dissatisfaction among the local nurses.

In terms of staff salaries and their working conditions Apollo Hospital does not maintain the standards of an international hospital.

It was very difficult to get information on the working conditions. A lot more time is needed for collecting this information by adjusting to the schedules of the staff members and meeting them during their free time. However, it is not impossible and can be done.

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Public Services International, South Asia
61, I block, Sector 10, Faridabad - 121006, Haryana, India
website: www.world-psi.org