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Banyan Tree Syndrome (Corporate Hospitals vs Small Hospitals)

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ABSTRACT

The observation that small plants cannot grow under a banyan tree is a well-known phenomenon, often referred to as the " Banyan tree Syndrome or effect. This phrase is used in corporate contexts to describe a leader, often a founder, who is extremely strong and protective (like a banyan tree) but creates such a dominating, all-encompassing environment that subordinates cannot grow, develop independence, or take initiative. This is similar to corporate hospitals and small hospitals. Big Hospital gets land @Rs1 and relieve taxes. Small Hospitals are giving better care and service to patients, but an increase in rules/laws, less profit, and cut practice are the reasons to shut down. Most of the single doctor-run nursing homes will be shut down, where actually the accountability and liability of the doctor is worth, trustworthy, and fair. Corporate and private hospitals in India have faced numerous allegations of overcharging and exploiting patients. Issues highlighted include exorbitant billing, overcharging for COVID-19 treatment, conducting unnecessary tests, violating regulations regarding package rates and free treatment for the poor, and alleged collusion between doctors and diagnostic centers. Nowadays, doctors are no longer independent and are controlled by corporates, pharma companies, manufacturing medical devices, and private equity finance corporate hospitals. Corporate hospitals excel in complex cases but have higher costs, while smaller hospitals face lower operating costs but struggle with financial sustainability and resources.

Keywords : Corporate hospitals, “cost shifting,”, Affordable Care Act (ACA), Universal Health Coverage (UHC)

INTRODUCTION

Private insurers often pay hospitals more than public insurers, such as Medicare or Medicaid, for the same services (1).

This leads some stakeholders to conclude that hospitals engage in “cost shifting,” the notion that relatively lower public-sector payments cause hospitals to raise private prices to make up for losses (2).

Although simultaneously observing lower public and higher private prices may appear to suggest cost shifting, it does not demonstrate that the cause of the higher private prices is lower payments from public insurers(3).

In addition, although some — often older — academic studies report evidence consistent with the existence of cost shifting, newer empirical studies, often carried out with stronger data and improved study designs, have not found evidence consistent with cost shifting. (4)

A plausible remedy for this problem may reside primarily in reducing healthcare costs, because access and quality are impeded mainly by the unbearably high costs and their opaqueness [5].

Public reporting has been regarded as effective in reducing health care costs by mitigating information asymmetry in the market (6).

Payers have incorporated publicly available information mandates into pay-for-performance programs and value-based purchasing [7, 8].

Empowered by public data profiling, health plans may opt to shift patient volume to health care providers that provide better quality and more cost-efficient care [9].

Hospitals face increasing pressure to provide price transparency. Since the Affordable Care Act (ACA) of 2010, price transparency has been widely promoted across states [10].

The CMS Hospital Price Transparency final rule (84 FR 65,524) mandates that hospitals make all price information publicly available online, including standard charges for items and services for all payers and 300 stoppable services, effective as of January 1, 2021. Accordingly, the CMS is seeking to increase monetary penalties for noncompliance with the final rule [11].

Achieving Sustainable Development Goal target 3.8 of Universal Health Coverage (UHC) by 2030 requires strategic involvement of the private healthcare sector (12).

A resolution to engage the private sector in providing essential health services was adopted in the Sixty-third World Health Assembly in 2010, calling for "Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services" (13,14).

This resolution recognizes the large role of private healthcare providers and acknowledges the range of issues involved in engaging with the private healthcare sector, for which documentation and evidence are weak. (15)

Policy documents also reinforce the need for a strategy and a policy that is inclusive of the different parts of the private sector (private for-profit hospital care, private non-profit care, private diagnostic laboratories, private provision of Indigenous medicine, etc.) to maximize the achievement of UHC (16).

With the prominence of the private sector in many countries, including India, public-private engagement has gained acceptance as an essential element in attaining UHC. (17).

India has one of the most privatised health systems in the world, with private expenditure accounting for 63% of the country's total health expenditure [18].

Additionally, 60% of hospital beds and 70% of healthcare workers, including 80% of physicians, are in the private sector, highlighting the weak state of public health infrastructure and the concentration of resources in the private sector.(19,20)

WHY ARE THE CHARGES HIGHER IN CORPERATE HOSPITAL

Corporate hospitals often charge significantly higher rates for investigations than smaller clinics or public facilities. The causes are diverse, with few acceptable due to high operational overheads, advanced technological investments, and different business models.

The primary reasons for these price discrepancies include:

A) Rational excuses:

High Operational & Infrastructure Overheads:

Corporate hospitals maintain massive physical infrastructures, including 24/7 emergency readiness, specialized backup power, and advanced ventilation systems. These facilities have much higher staff-to-patient ratios and administrative costs than independent diagnostic centers.

Technological Investment:

These hospitals often invest in top-tier medical equipment (like high-Tesla MRI machines or advanced pathology analyzers) to ensure higher accuracy and reliability. The cost of acquiring, maintaining, and upgrading this technology is passed on to the patient.

Accreditation and Compliance:

Corporate entities frequently seek high-level certifications (like NABL or JCI), which require strict compliance with safety and quality standards. Maintaining these standards involves recurring costs for audits, specialized training, and expensive reagents.

Pricing Power and Insurance:

Hospitals often set higher "master" prices to account for delayed reimbursements from insurance companies and government schemes. Additionally, patients with insurance may be less price-sensitive, allowing hospitals to maintain higher tariffs for cashless mediclaim transactions.

Location and Branding:

Hospitals in metropolitan areas or with strong brand recognition command premium pricing. High real estate costs in prime city locations directly influence the final bill.

B) **Irrational excuses**:

1. Profit Maximization Strategies:

Profit Motive and Financing: Unlike public hospitals, corporate facilities are for-profit entities. They must generate returns for investors and cover high capital costs. In some cases, profit targets may lead to "unbundling" services or overutilization of tests to maximize revenue.

Upcoding: This is the practice of billing for a more expensive service than the one actually provided—for example, billing a routine consultation as a "complex" or "emergency" visit.

Unbundling: Instead of a single "package" price for a procedure, hospitals may bill for every individual item used—such as charging for each pair of gloves, a single syringe, or even a cotton swab—at a significant markup.

2. Target-Driven Practices: Doctors and staff are often given "revenue targets." This can subtly (or overtly) pressure them into recommending unnecessary diagnostic tests, longer ICU stays, or surgical interventions when conservative management might have sufficed.

3. Exploitative Pricing (The "Charge master")

Corporate hospitals often use a Charge master—a list of highly inflated prices that serves as a starting point for negotiations.

Price Discrimination:

They may charge different amounts for the same procedure based on whether you have insurance or are paying out-of-pocket.

Pharma Markups:

Medicines and consumables (stents, implants, etc.) are often sold at the Maximum Retail Price (MRP), even though the hospital buys them at a massive bulk discount, pocketing the difference as pure profit.

When you look at the billing practices of corporate hospitals, the high costs are rarely just about the medicine—they are often the result of a business model designed for profit maximization. While these hospitals provide high-end technology and convenience, the "selfish" or profit-driven motives behind their pricing can be categorized into several strategic areas.

4. Forced Dependency

Because public healthcare in many regions is underfunded and overburdened, corporate hospitals operate in a "seller's market."

Lack of Transparency:

Bills are often presented in a complex, jargon-heavy format that makes it difficult for a layperson to audit or question the charges until after the treatment is completed.

Captive Audience:

Since medical care is a "forced expenditure" (you can't choose to have a life-saving surgery), hospitals have the leverage to set prices without fear of losing "customers" to competitors in an emergency.

Why heavy investigation charges:

A) Rational excuses:

1. The "Hospital Overhead" Tax

A standalone lab is basically a small office with some high-tech machines. A corporate hospital is a 24/7 city that never sleeps. Your lab fee isn't just paying for the chemicals and the technician; it's subsidizing:

Emergency Infrastructure:

Maintaining 24/7 trauma care, standby generators, and high-intensity surgical suites.

Real Estate:

Large hospitals are often located in prime urban areas with massive property costs and property taxes.

Administrative Bloat: Billing departments, insurance coordinators, legal compliance, and massive HR teams all add to the "cost per test."

2. Facility Fees vs. Professional Fees

Hospitals often charge a "Facility Fee"—essentially a cover charge for walking through the door and using their sterile environment. Standalone labs rarely have this. They operate on a high-volume, low-margin retail model, whereas hospitals operate on a "comprehensive care" model.

3. Precision & Personnel

While many local labs are excellent, corporate hospitals often (though not always) invest in:

Higher Accreditation:

They frequently maintain international standards (like JCI or CAP) which require expensive, regular audits.

Specialized Staff:

They are more likely to employ full-time MD Pathologists or PhDs to oversee the lab, whereas smaller labs might use part-time consultants.

Faster Turnaround for Critical Care: Their labs are designed to prioritize "STAT" (immediate) results for patients in the ICU, which requires more expensive, high-speed equipment.

B) Irrational excuses:

1. **Inflated Pricing**

Arbitrary Markups: Hospitals often charge 5x to 20x the actual cost of a test to offset losses in other departments like the ER.

Facility Fees: You are billed "cover charges" just for using the hospital's space, even if you never see a doctor.

Unbundled Billing: Some hospitals charge separately for every component of a test that should be a single "package" price.

2. **Unnecessary Testing**

Revenue Targets:

In many corporate setups, doctors face pressure or "targets" from management to prescribe more investigations than clinically necessary.

Bundled Overkill: They may force you into expensive "Executive Health Checks" that include tests you don't need based on your age or symptoms.

3. **Administrative Inefficiency**

Wait Times:

Despite the high cost, you often face long queues due to the high volume of both outpatients and admitted patients using the same lab.

Billing Errors:

Complexity leads to frequent double-billing, incorrect coding, or charging for services that were never actually provided.

Inflexible Policies:

They may refuse to "honor" or look at reports from outside labs, forcing you to pay for the exact same test again under their roof.

4. Poor Patient Experience

Lack of Price Transparency:

You often won't know the final cost until the bill is generated, leading to "sticker shock."

Impersonal Service:

Due to the massive scale, these labs can feel like factories where patients are treated as "case numbers" rather than individuals.

Risk of Hospital-Acquired Infections:

Unlike standalone labs, hospital labs require you to enter a building full of sick patients, increasing your exposure to germs.

5. **Cross-Subsidization (The "Hidden" Cost)**

Hospitals often lose money on certain departments (like the ER or general wards for government-insured patients). To stay profitable, they mark up high-margin services like pharmacy, radiology, and laboratory investigations.

Government gifts to corporate hospitals

As long as corporate hospitals receive land and tax subsidy on health insurance, which is their main source of income, and no adit on actual services provided to BPL patients, and no upper limit on chargesdespite being a PPP model, small hospitals and clinics will continue to sufferand these multinational companies continue to survive. Nowadays, doctors are no longer independent and are controlled by corporates, pharma companies, manufacturing medical devices, and private equity finance corporate hospitals.

Every government is more favorable to corporate hospitals because they get election funds from them.

There is evidence that governments (particularly in India) have historically taken, and continue to take, steps to support the growth of private and corporate hospital sectors. This is often part of a broader strategy to boost private investment in health, promote medical tourism, and manage the, at times, overwhelming patient load in public facilities. Government-sponsored health insurance schemes are increasingly used in private/corporate hospitals, allowing them to gain significant market share. Policies have encouraged corporate hospitals to make India a "health destination" for foreign patients, which often involves focusing resources on specialized, high-cost, and high-tech care.

What are the advantages of a small hospitals than corporate hospitals?

Small hospitals often provide significant advantages over large corporate hospitals, particularly in the areas of personalized patient care, community trust, and patient operational agility. Small hospitals (often 8–50 beds) excel at fostering a warm, familial, and efficient patient experience. Smaller hospitals focus on "time" rather than just "machines," allowing doctors to sit longer with patients, explain treatments better, and reduce anxiety. Patients are more likely to see the same doctor consistently, from consultation to discharge, fostering trust and better health outcomes. Small hospitals can make decisions faster and adapt to patient needs, such as offering same-day appointments or extending hours. Small hospitals often have higher staff-to-patient ratios, allowing for more individualized care and attention. Small hospitals can often provide services at a lower cost to the patient. Charges are typically explained more clearly, with less complicated billing procedures compared to large corporate entities.

1. Why Corporate Hospitals Charge 5–10× More for Investigations

(A)Absence of a Uniform National Price Regulator
India does not have a national medical price regulator comparable to:

• Electricity Regulatory Commissions

• Telecom Regulatory Authority of India (TRAI)

There is no mandatory ceiling on:

• Laboratory tests

• Radiology (CT, MRI)

• Bedside investigations

Result:

A glucose test costing ₹40 in a local lab may be billed at ₹400–₹600 in a corporate hospital.

(B) Insurance Distortion Effect (The Core Problem)

When insurance is involved:

• Hospitals inflate prices because:

• Insurers negotiate later

• Patients are psychologically detached from cost

• This is called “third-party payer moral hazard.”

Corporate Hospitals assume:

“Insurance will pay; the patient will not question.”

Hence:

• Higher MRP for drugs

• Non-standard consumables

• Repeated investigations

• Add-on procedures

C) Cross-Subsidisation Argument (Partially True, Mostly Misused)

Corporate hospitals claim higher prices due to:

• Infrastructure costs

• NABH / JCI accreditation

• 24×7 emergency readiness

However:

• These costs do not justify 8–10× diagnostic inflation

• Many investigations are automated with marginal cost differences

2. Why Medicines Cost More Inside Hospitals

(A)Closed Pharmacy Ecosystem

Most corporate hospitals:

• Force in-house pharmacy purchase

• Restrict outside medicines citing "quality & safety."

Reality:

• Same branded medicine sold 2–3× MRP equivalent

• Generics are often not offered

• Cheaper therapeutic equivalents not disclosed

This violates the spirit (though not always the letter) of:

• National Pharmaceutical Pricing Authority (NPPA) intent

• Ethical medical practice norms

(B) **Insurance- Drug Inflation**

• Prefer higher-priced brands

• Use "insurance-friendly" coding

• Avoid cost-effective alternatives

• Cost escalates without clinical benefit

3. Assistant Doctor Fees & Nursing Charges

Why They Should Be Included in Room Charges (But Aren't)

(A)Global Norm vs Indian Reality

International norm:

• Room charges are all-inclusive

• Nursing

• Resident doctor coverage

• Basic monitoring

Indian corporate model:

• Fragmentation of billing:

• Assistant doctor fee

• Nursing charges per shift

• Monitoring charges

• Service charges

4. Accountability

1. Central Government

• Has not created a National Health Pricing Authority

• Clinical Establishments Act exists but:

• Not uniformly adopted by all states

• Lacks strong penalty mechanisms

2. **State Governments**

• Responsible for:

• Licensing hospitals

• Rate regulation under state Acts

3. **Insurance Companies**

• Complicit through:

• Package-based approvals

• Post-facto negotiation instead of pre-pricing

• Rarely side with patients on overbilling

4. Hospital Accreditation Bodies (NABH)

• Focus on:

• Safety

• Documentation

Medical Councils

• Regulate doctors

• Not hospital economics

• Corporate billing escapes ethical scrutiny

5. Mandatory 20% Free / Poor Patient Care – Reality Check

(A) Policy Background

• Government land at concessional rates

• Tax exemptions

• Infrastructure benefits

(B) Who Should Monitor?

• District Collector

• State Health Department

• Local Health Authorities

6. Why Patients Are Intimidated Into Silence

• Medical jargon complexity

• Fear of retaliation

• Emotional vulnerability during illness

• Lack of accessible grievance systems

7. **Systemic Solutions**

1. National Medical Pricing Authority

• Standard rate bands for:

• Diagnostics

• Procedures

• Room categories

2. Mandatory Transparent Itemisation Rules

• Assistant doctor & nursing included in room charges

• Clear justification for each add-on

3. Insurance Pre-Pricing

• Insurers to approve rates, not just procedures

4. **Public Disclosure**

• Hospitals must publish:

• Diagnostic rates

• Free-care patient numbers

5. **AI-Enabled Billing Audits**

• Standardised AI tools for:

• Duplicate billing detection

• Package violation checks

• Regulatory compliance

This is where AI genuinely empowers patients, not as a gimmick, but as a counterweight to opaque systems.

Conclusion

Corporate hospitals and small (independent) hospitals represent two distinct models of healthcare delivery, differing significantly in scale, cost, technology, and patient experience. Corporate hospitals are characterized by large-scale, high-tech, multi-specialty care backed by private equity, while small hospitals, often run by individual doctors or families, focus on personalized care, community trust, and lower overheads. Corporate hospitals offer state-of-the-art technology, including robotic surgery, advanced diagnostics, and specialized intensive care units (ICUs). Generally, corporate hospitals have much higher costs, though they are preferred partners for insurers, making cashless transactions easier. Whereas a small hospital is known for a more "human touch," personalized care, and stronger patient-doctor relationships. Often deeply embedded in local communities, benefiting from trust, familiarity, and faster decision-making, less bureaucracy, and often lower costs for patients.

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