Hospital-Insurer Relations and Competition Law in the Malaysian Private Healthcare Sector

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ABSTRACT

Rising medical costs have become a global healthcare concern and Malaysian private healthcare sector is not immune from this challenge. One area of concern is the relationship between providers and payers in the private healthcare sector. Rising healthcare costs have intensified commercial tensions over reimbursement discounts, provider-panel access and management of insured patients. The recent report of the Malaysian Parliament's Public Accounts Committee recorded concerns that hospitals may face demands for substantial discounts and possible removal from provider panels when those demands are not accepted. At the same time, stakeholders remain uncertain whether collective dispute-resolution and cost-control measures comply with the Competition Act 2010. This article examines how the Competition Act 2010 applies to provider-payer arrangements in Malaysian private healthcare sector. The article combines doctrinal legal research and regulatory gap analysis with documentary evidence from Malaysia and a focused comparative analysis of the Netherlands, Australia and the United Kingdom. Three main findings emerge. The analysis shows that genuine bilateral negotiations and selective contracting are not inherently anti-competitive and may help control healthcare costs. However, closer scrutiny is required where a dominant payer imposes exclusionary or discriminatory terms. In relation to collective agreements, coordination among competing hospitals or insurers may infringe competition law especially where it concerns future prices, common discount levels or shared trading conditions. Apart from that, the allegation of payer pressure requires a proper assessment of market definition, dominance, competitive harm and objective justifications. The analysis also finds that Malaysia lacks a healthcare-specific framework for supervised information exchange and competition-compliant dispute resolution. Accordingly, the article proposes a framework based on a MyCC market review, sector-specific guideline, objective panel and top rules and independent data governance.

Keywords: competition law, private healthcare, hospital-insurer bargaining, de-empanelment, buyer power

INTRODUCTION

The pricing of private healthcare is determined by more than a direct transaction between a patient and a hospital. When the healthcare service is covered by medical insurance or takaful, the cost and availability of healthcare are influenced by the agreements and negotiations between providers and payers of healthcare (Sinaiko, 2026). These agreements govern the relationships between payers and providers of the healthcare services. The agreements normally revolve around panel membership rule, reimbursement rule, claim review procedure, access to cashless admission and grounds for de-empanelment (Gudiksen et al., 2020). It follows that these agreements affect not only reimbursement rate but also insurance premium, hospital choice and continuity of care.

Healthcare pricing agreements require a broader legal analysis because their effects go beyond the commercial interest of the providers and payers. Uncertainty, information asymmetry and the inability of patients to assess treatment quality weaken the assumptions of conventional consumer choice (Arrow, 1963). Furthermore, the

involvement of third-party payers like insurers, third party administrators (TPA) and managed care organizations (MCO), brings the patient out from the equation in the negotiation for the pricing of healthcare services. While it is generally accepted that competition among hospitals and insurers can affect price, quality and access but the concentration on either side of the market may alter the balance of bargaining power between hospitals and insurers (Gaynor et al., 2015; Gaynor & Starc, 2026). Therefore, competition law must tread a fine line between legitimate bargaining that constrains provider market power and conduct that undermines competition through collective coordination or anti-competitive exclusion.

This distinction has become increasingly crucial particularly in the wake of the alarming medical inflation in the Malaysian private healthcare sector. On 24 June 2026, the Public Accounts Committee (PAC) tabled its report on rising medical insurance premiums, private hospital charges and their impact on the provision of healthcare services in Malaysia (Parliament of Malaysia, 2026). The PAC investigated increases in medical insurance premiums and private hospital charges through extensive hearings involving the relevant stakeholders. The findings of the PAC report disclosed a more specific competition concern than the general proposition that private healthcare is expensive. Hospital representatives alleged aggressive discount demands and threats of de-empanelment by insurers (Parliament of Malaysia, 2026). On the other hand, insurers contended that cost containment measures, medical-necessity controls and more selective provider networks were necessary to curb claims inflation (Parliament of Malaysia, 2026). While it is accepted that these allegations may raise competition concerns but they do not, by themselves, constitute conclusive evidence that competition infringement has occurred. The conflicting allegations reveal an entrenched legal uncertainty surrounding the intersection between healthcare-sector regulation and competition law. This article considers how the Competition Act 2010 (CA 2010) should regulate hospital-insurer discount negotiations and coordinated cost-control measures. This article has four objectives. It identifies the competition concerns arising from discounting, panel access, de-empanelment, benchmarking and dispute resolution. It also develops clearer analytical tests for the infringement of anti-competitive agreement and abuse of dominance under CA 2010. In addition, it compares selected healthcare competition frameworks in the Netherlands, Australia and the United Kingdom. Finally, it proposes a competition-compliant framework for Malaysian provider-payer relations.

The article's central argument is that Malaysia currently regulates this relationship through general prohibitions that are legally relevant but operationally incomplete. Bilateral bargaining should remain available because it can reduce cost. At the same time, anti-competitive horizontal agreement on prices or discount levels should remain prohibited. Between those positions lies a third category of supervised collaboration that may generate identifiable efficiency or social benefits but requires strict safeguards governing information exchange, decision-making and patient protection. In this regard, clearer guidelines and an evidence-based market review would reduce unnecessary regulatory uncertainty.

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Healthcare bargaining as a bilateral market process

The economic literature treats insurer-provider prices as the outcome of bargaining rather than as a simple posted-price transaction. Managed care may reduce expenditure through lower utilisation, lower unit prices or both (Cutler et al., 2000). Selective contracting gives an insurer the ability to form a network that excludes some hospitals, while hospitals bargain over the value they contribute to the network. Town and Vistnes (2001) found that a hospital's negotiated price was related to how readily an insurer could construct an acceptable alternative network without the hospital. Sorensen (2003) similarly showed that negotiated discounts differed with the relative bargaining positions of insurers and hospitals.

Later work demonstrates that bargaining power exists on both sides. Hospital concentration can increase negotiated prices while insurer concentration can generate countervailing purchasing power (Moriya et al., 2010). Ho (2009) showed that hospitals that are valued by patients may capture higher mark-ups because their exclusion makes an insurance product less attractive. Gowrisankaran et al. (2015) found that managed-care bargaining can significantly restrain hospital prices and hospital mergers have been shown to be one of countervailing forces that can weaken that restraint. The immediate policy implication is that a lower

reimbursement rate cannot be classified as harmful merely because the hospital dislikes it. The relevant question is whether bargaining remains constrained by competition and whether savings are obtained without suppressing output, quality or access.

The concept of insurer buyer power must therefore be assessed carefully. Buyer concentration may counter monopoly pricing by hospitals. However, it may also develop into monopsony power when the dominant buyers of healthcare services are able to depress reimbursement by reducing output, quality, capacity or investment (Dafny et al., 2012). Evidence from one market cannot be transferred automatically to another. A legal assessment requires information on market definition, provider dependence, alternative purchasers, service quality, investment and downstream effects on patients (Ahamat et al., 2020; Bates & Santerre, 2008).

Provider networks, exclusion and patient choice

Provider networks are simultaneously a cost-control instrument and a potential source of exclusion. Ho and Lee (2017) model the interaction among insurer competition, hospital reimbursement and premiums, showing that increased insurer competition does not mechanically produce lower provider prices because an insurer's size also affects its bargaining position. Ho and Lee (2019) further explain that insurers may have incentives to exclude hospitals when forming networks and that the privately optimal network need not coincide with the network that maximises consumer welfare.

Selective contracting may focus demand on lower-cost providers and reduce expenditure. Empirical evidence associates selective contracting with lower healthcare expenditure in some private insurance plans(van den Broek-Altenburg & Atherly, 2020). Yet network design may also communicate or affect quality. Boone and Schottmüller (2019) show that selective contracting can signal provider quality, but market power may reduce quality and create inefficiency. Accordingly, a broad network is not always procompetitive, and a narrow network is not always harmful. The legal inquiry should examine whether the network is formed through transparent and contestable criteria, whether patients retain meaningful alternatives and whether exclusion protects efficiency or entrenches market power.

Contract clauses can also affect the competitive process. Sinaiko (2026) identifies provisions such as anti-tiering, anti-steering, all-or-nothing, most-favored-nation and gag clauses as possible means by which powerful provider systems protect themselves from competition. Although the Malaysian PAC controversy chiefly concerns payer conduct, these provisions demonstrate that hospital-insurer contracts may restrain competition in either direction. A sound framework should therefore avoid assuming that either hospitals or insurers are invariably the weaker party.

Collaboration, standardisation and regulatory chilling

Healthcare also requires forms of standardisation that cannot be produced entirely through isolated bilateral contracts. Common claims definitions, coding rules, data formats, quality measures and Diagnosis-Related Group (DRG) classifications may reduce transaction costs and improve comparability. DRG payment can alter incentives by replacing item-by-item reimbursement with a case-based payment, but its effects depend on policy design and may include unintended consequences such as up-coding or changes in service intensity (Zou et al., 2020). Development of such a system requires data from multiple competitors and agreement on technical rules.

The competition problem is that standardisation may become a vehicle for fixing commercial terms. A project may begin with legitimate clinical or administrative objectives but drift into discussion of future prices, minimum reimbursement rates, planned discounts or market allocation. Conversely, uncertainty may deter stakeholders from even low-risk cooperation. This article uses the term regulatory chilling to describe the avoidance of potentially beneficial collaboration because participants cannot confidently separate lawful standardisation from prohibited coordination. The appropriate response is not a general healthcare exemption. It is a structured method that identifies the restrictive element, tests necessity and proportionality, and confines access to competitively sensitive information.

METHODOLOGY

This article adopts doctrinal legal research. The doctrinal research examines legal rules, principles and institutions through legislation, regulatory materials, judicial decisions and academic literature (Hutchinson & Duncan, 2012). It aims to identify, interpret and organise the law in a systematic manner (Yaqin, 2007). This approach also connects specific legal rules with the broader principles underlying the legal framework (Theil, 2025). The doctrinal analysis focuses on the CA 2010, relevant MyCC guidelines, the Private Healthcare Facilities and Services Act 1998 (PHFSA 1998), the Private Healthcare Facilities and Services Regulations 2006 (PHFSR 2006), the Financial Services Act 2013 (FSA 2013), the Islamic Financial Services Act 2013(IFSA 2013) and relevant guidelines issued by Bank Negara Malaysia and the Ministry of Health. The article also undertakes a doctrinal analysis of regulatory gaps. It examines whether Malaysian competition law, healthcare and financial-sector laws provide a clear and coordinated response to hospital-insurer negotiations. This is done by comparing the existing legal framework with the regulatory functions needed to address these concerns.

In addition to that, the PAC report is analysed as documentary evidence of concerns within Malaysian private healthcare sector. It provides examples of stakeholder claims relating to discount demands, panel removal, pricing practices and cost-control arrangements. However, the report is not treated as an infringement decision or as conclusive evidence of anti-competitive conduct. The allegations recorded in the report are assessed against the legal requirements of the CA 2010.The article also adopts a comparative legal approach. It examines selected healthcare competition frameworks in the Netherlands, Australia and the United Kingdom. These jurisdictions were selected because they provide developed approaches to provider-payer contracting, collective negotiation, healthcare market investigations and regulatory oversight. The comparison is functional rather than descriptive. It considers how each jurisdiction addresses problems similar to those identified in Malaysia. It then evaluates whether those approaches can be adapted to Malaysia's legal and institutional context.

Malaysian Legal And Regulatory Context

Competition Act 2010

The CA 2010 is a general competition law legislation that is applicable to all sectors in Malaysia. The CA 2010's preamble clearly provides that it aims to protect the competitive process and consumer interests rather than to guarantee any enterprise a preferred price or profit margin. The CA 2010 contains two main prohibitions touching on anti-competitive agreements and abuse of dominance. Until now, the merger control provisions are still not incorporated under the CA 2010. Regarding the anti-competitive agreement, section 4(1) prohibits horizontal or vertical agreements that have the object or effect of significantly preventing, restricting or distorting competition. At the same time, the CA 2010 contains a deeming provision where specified horizontal agreements to fix purchase or selling prices or other trading conditions, share markets or sources of supply, limit market access, or bid rigging are deemed to have object of competition restriction(MyCC, 2012a). The CA 2010 provides broad definition of agreement which includes contracts, arrangements, understandings, association decisions and concerted practices. MyCC's Guidelines on Anti-competitive Agreements require competing enterprises to act independently in determining their prices and commercial terms (MyCC, 2012a).

One of the relevant areas that is addressed under the guidelines is on agreement about information exchange. The guidelines warn the enterprises of the possible competition law infringement if the exchanges involve commercially sensitive information like prices and trading terms (Ahamat & Rahman, 2017). This type of information exchange is condemned under competition law because it neutralizes the rivalry among the enterprises under the market by reducing the uncertainty and facilitating the collusion (Porrini, 2004). Generally, the information exchange will be facilitated by the trade association under the sector. While it is true that trade associations serve the legitimate interest of the enterprises under the sector, they may pose competition concerns when used as a platform for coordinating members' commercial conduct (MyCC, 2012a). It follows that hospitals and insurers must make their pricing and contracting decisions independently. Discussions among competing payers or providers under the private healthcare sector concerning reimbursement rates, discounts or charges may weaken competition by replacing individual decision-making with coordinated conduct. Trade associations are not unlawful in themselves, but they may facilitate collusion when they encourage members to

adopt common commercial terms (MyCC, 2012a). Competition concerns may therefore arise where hospitals agree on minimum reimbursement rates, insurers align their payment ceilings, or an association promotes uniform discounts or charges. MyCC's 2025 warning to private medical associations confirms that an association recommendation concerning new charges may constitute price fixing even before uniform implementation (MyCC, 2025).This warning serves as a clear evidence that collective agreement to directly or indirectly fix the price and trading terms may create legal exposure even without a formal enforceable contract.

When the impugned agreement falls within the prohibition under section 4 of CA 2010, the enterprises concerned may rely on relief of liability provided under section 5 of the CA 2010 (Ramaiah, 2015). However, the relief of liability will only be available if the enterprises are able to prove that all four conditions stipulated under section 5 are cumulatively fulfilled. The onus is on the enterprises to prove that the impugned agreement produces significant identifiable technological, efficiency or social benefits(MyCC, 2012a). Apart from that, such restriction of competition must be proven to be indispensable to the attainment of those benefits (MyCC, 2012a). In addition to that, section 5 also incorporates proportionality condition where it must be proven that the competitive harm arising from the impugned agreement must be proportionate to the benefits achieved(MyCC, 2012a). Lastly, the enterprises are obligated to show that the agreement does not permit complete elimination of competition in a substantial part of the goods or services. Sections 6 and 8 of CA 2010 permit individual and block exemptions respectively. These provisions offer a legal basis for carefully designed healthcare collaboration, but they require a specific assessment rather than an assumption that affordability automatically excuses coordination.

Section 10 of CA 2010 prohibits an enterprise from misusing its dominant market position. In this context, dominance per se is not in itself unlawful. The infringement under section 10 will arise when substantial market power is wielded to restrict competition in the market. The assessment of dominance does not solely depend on the market share even though it may serve as useful proxy for dominance. Rather, the dominance depends on the whether the enterprise faces sufficient competitive pressure to restrain its market conduct (MyCC, 2012b). The prohibited abuse of dominance may include unfair pricing or trading terms, discrimination, refusal to supply, limiting market access, tying and predatory behaviors. Similar to the relief from liability available under section 5 for agreements falling within the Chapter 1 prohibition, section 10(3) of CA 2010 recognizes that conduct by a dominant enterprise may also have a legitimate commercial basis. A questionable conduct that appears restrictive or exclusionary will not necessarily amount to an abuse if it is supported by a reasonable commercial justification. However, section 10(3) is distinct from the efficiency-based relief under section 5 of CA 2010. Rather than requiring proof of technological, efficiency or social benefits, it focuses on whether the dominant enterprise's conduct can be objectively justified as a proportionate and commercially reasonable response to the circumstances. These qualifications are central to issue concerning de-empanelment. The removal from a panel may be a legitimate response to price, quality, fraud or contractual non-compliance. However, it may raise concern where a dominant payer uses exclusion to impose unjustified conditions or foreclose access.

On the other hand, section 11 of CA 2010 empowers MyCC to conduct market review for determining whether features of its structure, business conducts and behaviours or other relevant factors restrict competition. A market review does not require proof of a prior infringement. It is therefore particularly suitable for a sector where the PAC has identified systemic concerns but the necessary market-definition and contractual data have not yet been assembled.

Sectoral regulation

The Malaysian private healthcare sector is regulated through several statutes and regulatory bodies. However, the regulation is fragmented because different stakeholders are governed by different legal regimes. The provider of medical services like private hospitals and clinics are mainly regulated by healthcare legislations. The main legislations governing private healthcare facilities are the PHFSA 1998 and the PHFSR 2006. Within this regulatory framework, the Ministry of Health (MOH) is the main regulator whose power is to exercise oversight over the sector. This framework vests the MOH wide power to oversee issues concerning the establishment, maintenance, licensing and operation of private healthcare facilities and services (Rosnah et al., 2011). This regulation is applicable to various stakeholders under the private health sector which includes the provider of

medical services and facilities, medical practitioners and corporate intermediaries. Being a health sector regulation, the competitive concerns are not the prime focus of this legislation.

While this regulatory framework has been enforced for decades in Malaysia, it is argued that this framework has various practical limits in regulating the private healthcare sector (Onn, 2015). In the same vein, the current regulatory framework faces various challenges involving policy, power, governance, compliance and enforcement capacity (Noriza et al., 2018). This point is important because sectoral healthcare regulation may exercise oversight power over the establishment and operation of private healthcare facilities, but it may not adequately address competition issues such as price coordination, exclusionary contracting, provider-panel restrictions or abuse of bargaining power.

On the other hand, the medical practitioners are regulated through professional regulation. Medical practitioners are regulated separately under the Medical Act 1971(MA 1971) and the Malaysian Medical Council. This framework concerns registration, annual practicing certificates, ethical obligations, professional conduct and disciplinary control (Arvinder-Singh & Harbaksh-Singh, 2022). Being a professional regulation, this framework does not directly regulate the competitive structure of private healthcare markets. Therefore, the competitive concerns are among the blind spot areas which are not adequately addressed by the framework. It goes without saying that, the commercial engagements and market interactions involving the medical practitioners with the other players in the market fall under the regulatory lacunae which is not captured by the professional regulation. This is among the blind spot areas in which the competition law may intervene to ensure smooth running of the competitive process under the market.

On the payer side of medical services, the financiers like insurers and takaful operators are regulated by the FSA 2013, IFSA 2013 and Bank Negara Malaysia's policy framework. This regulatory framework focuses on licensing, prudential soundness, market conduct, consumer protection and the governance of financial products, including medical and health insurance/takaful. Recent policy developments on medical and health insurance/takaful demonstrate that private healthcare financing has become a major regulatory concern (BNM, 2026). Nevertheless, similar concern arises when the financial regulation does not fully address competition issues involving the commercial arrangements between the insurers/takaful operators with other market players in the market.

Competition Concerns in Provider-Payer Arrangement in Malaysian Private Healthcare Sector

As mentioned in the previous part, this article attempts to examine some relevant issues under the PAC report through the lens of competition law. While it is true that the PAC report contains numerous findings touching on various aspects, the discussion in this article will confine to specific findings that have a bearing on competition law and policy. Specifically speaking, the issue revolves around the commercial negotiation between the payer with the provider of healthcare services. In this regard, the PAC report identifies several connected issues. The PAC report recorded that there are prevalent aggressive payer discount requests by the insurers and TPAs in the market. These requests are then accompanied with threat that non-compliant health service providers will be removed from the providers' network. From the payers' perspectives, it was argued that rising healthcare claims should be addressed through stronger cost-containment measures, greater transparency regarding the typical costs of common medical procedures and gradual shift towards DRG-based reimbursement. In their view, these measures could improve price comparability, reduce unexplained variations in hospital charges and promote more predictable reimbursement. In addition to that, the report also noted the absence of an authoritative benchmark for 'reasonable and customary' charges. The absence of this authoritative benchmark has caused the insurers to establish payment limits through their own contractual negotiations with hospitals. It also recorded concerns that a grievance mechanism had been paused pending clarification of collusion risk. The most interesting part of the report is the reference made by the Committee for MyCC guidance on discount negotiations, stronger complaint resolution, DRG implementation and independent governance for private healthcare. These recommendations indicate that competition law may play an important role in addressing the identified concerns. However, competition law should not be treated as the sole solution. Effective reform also requires healthcare regulation to operate alongside competition law in addressing market failures,

regulatory gaps and tensions between providers and payers. These findings are summarised in the following Table 1.

Table 1: PAC issues, competition-law questions and proposed safeguards

PAC issue	Competition-law question	Proposed safeguard
Aggressive discount demands	Legitimate countervailing bargaining or unfair purchase terms by a dominant payer?	Market definition, evidence of dependence and objective cost/quality justification.
Threatened or actual de-empanelment	Efficient selective contracting or exclusion that restricts provider and patient access?	Published criteria, reasons, notice, appeal and continuity-of-care protection.
Collective grievance mechanism	Case-specific mediation or horizontal coordination of future prices and terms?	Regulator-supervised process; no collective rates; bilateral confidential resolution.
Reasonable and customary charges	Useful benchmark or focal point facilitating price alignment?	Independent data trustee; aggregated, historical ranges; transparent methodology.
DRG and claims-data sharing	Indispensable technical collaboration or exchange of sensitive strategic data?	Purpose limitation, anonymisation, aggregation, access controls and section 5 assessment.
Unclear regulatory ownership	Does fragmentation allow harmful conduct or deter efficient cooperation?	Formal MOH-BNM-MyCC protocol and joint market monitoring.

FINDINGS AND DISCUSSION

Bilateral discount negotiation is not inherently anti-competitive

In relation to discount negotiation, it should not be considered as presumptively unlawful from the lens of competition law. A purchaser will naturally seek a lower price and a supplier will seek higher reimbursement. Such differences in commercial interests are part and parcel of the normal bargaining process. The health-economics literature demonstrates that insurer bargaining can discipline provider prices and that the availability of alternative hospitals materially affects negotiated outcomes (Sorensen, 2003). Ultimately, the absence of robust negotiation and market bargaining could increase claims costs and premiums.

In private healthcare market, the relationship between a hospital and an insurer is generally vertical. In other words, both entities operate at different level of supply chain. The hospital provides the healthcare services in exchange of price paid by the insurers on behalf of the policy holders. As mentioned in the previous part, the prohibition under section 4(1) of CA 2010 is also applicable to vertical agreements provided that there must be a significant restrictive object or effect. Nevertheless, paragraph 3.11 of the MyCC's Guidelines on Chapter One Prohibition clearly states that vertical agreements are generally treated as less harmful to competition than the horizontal agreements (MyCC, 2012a). The mere fact that the insurer negotiates for a lower reimbursement rate is not sufficient to establish an anti-competitive effect. Instead the consideration lies on the proof of the anti-competitive contractual terms concerning the exclusion of competitors, exclusivity rules, anti-steering rule, tying and bundling of services, imposition of price-parity clause and most-favoured-nation clause (Sinaiko, 2026). Thus, their legality depends on factors such as market power, the scope and duration of the restriction, barriers to entry, available alternatives and any resulting efficiencies.

Protecting hospitals from all price pressure may wrongly equate hospital interests with patient welfare. Some hospitals may possess strong bargaining power. Similarly, an insurer may depend on a particular hospital to

maintain an attractive provider network. This dependence may arise from the hospital's location, clinical reputation, specialist capacity or brand value (Ho, 2009) . This is not to say that MyCC should totally disregard blatant anti-competitive vertical agreements under the sector. But the analysis of the MyCC's enforcement approach and trend reveals that horizontal agreements, particularly price-fixing, market-sharing and bid-rigging cartels are given greater priority over the vertical agreements (Rahman et al., 2025). Competition law should therefore ensure that negotiations remain fair and competitive, rather than deciding in advance how the financial gains should be divided between hospitals and insurers.

Collective negotiation creates a distinct cartel risk

Unlike bilateral bargaining, the competition analysis changes when the enterprises engage in collective bargaining under the market. Competition concerns will arise where competing hospitals coordinate their reimbursement terms. For example, the hospitals may agree on a common minimum reimbursement rate or a maximum discount. They may also collectively refuse to contract below a rate endorsed by their association or adopt uniform non-price trading terms. These arrangements may fall within the ambit of section 4(2) of the CA 2010. In this regard, strong bargaining power on the part of insurers does not justify collective price fixing by the competing hospitals. Each hospital should negotiate its own terms. The same principle applies to insurers. Each insurer should set its own reimbursement limits and discount requirements. Competing insurers should not coordinate these terms or act together to exclude a hospital group.

This boundary explains the concern recorded in the PAC proceedings. Stakeholders may have valid reasons for seeking a forum to resolve disagreements. However, the forum must be carefully designed and structured. It should not allow competing hospitals or insurers to disclose their current and future rates. Such exchanges could encourage them to align their prices rather than negotiate independently. In this regard, the prohibition of anti-competitive agreement under section 4 is broad enough to capture associations' decision and concerted practice even in the absence de-empanelment agreement among the enterprises. This broad interpretation is reflected in MyCC's stern warning against price fixing decision issued by the association of general medical practitioners in several states in Malaysia (MyCC, 2025).

A competition-compliant grievance mechanism should therefore resolve specific disputes without producing a collective rate. A hospital and an insurer may submit their data confidentially to an independent mediator. Competing hospitals should not attend one another's sessions or receive one another's contractual terms. Any published outcome should identify procedural principles rather than reveal prices, discount percentages or future bargaining positions. The mediator should have power to address continuity of care and procedural fairness. However, such mediator should not be empowered to set a uniform industry price unless Parliament expressly creates a regulated payment system.

Buyer power and threat of de-empanelment under section 10 of CA 2010

Claims that payers exert excessive pressure on hospitals require a proper assessment of buyer power. Such conduct should not automatically be treated as abusive. Dominance must be established in a relevant market. In this regard, the relevant market may be defined in several ways depending on the facts of the case. It could involve the purchase of private inpatient hospital services for insured patients within a particular geographic area. Alternatively, it may also involve the provision of cashless hospital access to a specific group of policyholders or the administration of outpatient benefits for corporate employees. Having said that, the correct market cannot be selected abstractly. The assessment depends on the alternatives available to both hospitals and patients. A hospital may be able to replace the loss of insured patients through contracts with other insurers or employers. It may also attract self-paying patients, public-sector purchasers or medical tourists. On the patient side, the relevant question revolves around whether they can switch insurers or obtain comparable cashless treatment from another hospitals.

Where dominance is established, demands for substantial discounts may be examined under section 10(2)(a) of CA 2010 as potentially unfair purchase prices or trading conditions. However, a low reimbursement rate is not automatically unfair. It may result from legitimate bargaining power that helps control hospital costs. The key question is how that rate was achieved and what effects it produces in the market. On the contrary, it may reflect

the payer's ability to push reimbursement below a level that hospitals can sustain without reducing capacity or quality. Therefore, the assessment should consider the payer's contribution to the hospital's revenue, the hospital's margin on the relevant service and any resulting changes in capacity or quality. It has been cautioned that buyer concentration should not automatically be treated as evidence of monopsony harm (Bates & Santerre, 2008). Thus, the legal assessment should focus on the actual competitive effects of the conduct rather than the label attached to it.

The issue concerning the threat of de-empanelment must also be assessed in its proper context. An insurer may have legitimate reasons for removing a hospital from its provider panel. These reasons may include persistent high charges, concerns about the quality of care, suspected fraud or non-compliance with the contractual requirements. In such circumstances, selective contracting may help the insurer control claims expenditure and maintain appropriate standards within its provider network (van den Broek-Altenburg & Atherly, 2020). It may also encourage hospitals to compete on price, quality and efficiency. This is not to say that de-empanelment will never trigger competition concerns. In fact, competition concerns may arise where de-empanelment is used by a dominant insurer to impose unfair terms, exclude an efficient provider or disrupt patients' access to ongoing treatment without an objective justification.

The effect on patients is particularly important when assessing de-empanelment. A non-panel hospital may still be legally available to the patient, but it may not be a realistic alternative where cashless admission is no longer available. In such cases, the policyholder may be required to pay a substantial hospital bill upfront and seek reimbursement later. This financial burden may prevent some patients from using that hospital altogether. At the same time, the timing of de-empanelment also matters. Removing a hospital from the panel while a patient is undergoing an active course of treatment may interrupt continuity of care. This may occur even where other hospitals are available in the same area. A patient may find it difficult to switch to another hospital because their specialist, medical records, equipment and treatment plan are linked to the current hospital. The competition assessment should therefore consider whether patients continue to have access to comparable and practical alternatives. The this regard, relevant factors to be taken into consideration include the availability of cashless treatment, the distance to alternative hospitals, access to suitable specialists, waiting times and the arrangements made for patients who are already receiving treatment. The number of licensed hospitals alone does not provide an accurate picture of the choices genuinely available to patients.

Discrimination and equivalent transactions

The PAC report highlighted that patients who use guarantee letters may sometimes be charged more than patients who pay in cash or seek reimbursement later. From competition law perspective, the existence of a price difference does not automatically establish unlawful discrimination. Different charges may arise from legitimate differences in payment arrangements which include delayed settlement, claims administration, pre-authorisation requirements, non-payment risk, the scope of negotiated packages and cross-subsidisation between services.

Section 10(2)(d) of the CA 2010 will be applicable when the enterprise is dominant and applies different conditions to transactions that are genuinely equivalent. The difference must also produce the competitive harm required by the provision. It is therefore not enough to compare the final amounts charged to two patients. The comparison must consider whether the transactions involve similar diagnosis, severity of illness, length of stay, hospital facility, physician's fees, medicines, consumables, complications and payment conditions. A difference in any of these factors may provide a legitimate explanation for the variation in price.

The issue recorded in the PAC report demonstrates why standardised billing and independent data collection are essential. Without reliable and comparable information, it is difficult to determine whether a price difference reflects discrimination or it is genuine differences in treatment and payment arrangements. An allegation of discriminatory pricing may therefore be understandable but remain hard to be proven without supporting standardised data on the medical charges. Even where dominance cannot be established under competition law, undisclosed or misleading price differences may still be addressed through transparency requirements and consumer protection rules.

Benchmarking, information exchange and DRG collaboration

The fourth finding concerns the lack of an authoritative benchmark for "reasonable and customary" charges. A reliable benchmark could reduce disputes and help policyholders understand reimbursement limits. However, a benchmark developed by industry participants may also encourage price coordination. The exchanges of current and detailed price information may facilitate price fixing (Rahman et al., 2016). Data collection should therefore be kept separate from commercial decision-making. Hospital and payer data should be collected by an independent public body or an institution subject to statutory oversight. Published information should generally be aggregated, historical and based on a consistent methodology. Hospital-specific data may be required for regulatory purposes, but access should be limited to authorised analysts. The benchmark should remain a reference range unless legislation expressly turns it into a regulated tariff.

DRG development may justify closer cooperation because it requires common clinical classifications, coding standards and payment methods. Even so, a shared DRG system does not require competing hospitals to agree privately on future reimbursement rates. The government may establish the methodology, collect cost data and supervise payment rules, while hospitals continue to compete on quality and other services. Section 5 of CA 2010 provides the appropriate framework for assessing such collaboration. The parties must identify clear benefits, show that any restriction is necessary and proportionate, and ensure that substantial competition remains. General claims about controlling medical inflation are not enough. The arrangement should clearly state what data are needed, who may access them and which decisions must remain independent. MyCC may consider a conditional block exemption for recurring DRG or claims-standardisation arrangements that satisfy these requirements, while more sensitive projects may require an individual exemption.

Regulatory fragmentation and the risk of simultaneous under-and over-deterrence

The fifth finding concerns the lack of coordination between the relevant regulators. As a health sector regulator, the MOH is responsible to oversee matters relating to clinical standards and the duties of private healthcare facilities. This includes questions about patient safety, quality of care, licensing requirements and compliance with facility regulations. On the other hand, BNM is responsible for examining the conduct of insurers and takaful operators. Its role includes oversight of claims management, policy terms, reimbursement practices and the impact of insurer decisions on policyholders. As a general guardian of competitive process in Malaysia, MyCC is responsible for assessing competition concerns under the market. However, there is no clear framework that brings these regulators together. As a result, the same conduct may be viewed differently by each regulator. One regulator may see it as a legitimate cost-control measure. At the same time, the same conduct may be viewed by another regulator as a threat to hospital sustainability. This fragmented regulatory approach creates legal uncertainty as market participants may remain uncertain about the applicable legal requirements.

This fragmented approach can also lead to weak enforcement. Each regulator may assume that the issue falls within another authority's responsibility. It can also discourage legitimate cooperation. Stakeholders may avoid useful joint initiatives because no regulator is willing to confirm whether the proposed process is acceptable. The suspension of the grievance mechanism discussed in the PAC report illustrates this problem. General self-assessment is not enough when the government is promoting reforms that require competitors to share technical information.

The answer to this issue is not to exclude the healthcare sector from competition law. A broad exclusion could permit price coordination and weaken independent negotiation. Instead, healthcare policy should be developed within the competition-law framework. This can be achieved through clear guidance, market reviews, exemptions and proper safeguards. Necessary cooperation should be allowed, but competition over prices, provider networks and service quality should remain wherever regulation has not expressly replaced it.

Comparative Insights From Selected Jurisdictions

A comparative analysis is useful because Malaysia is not the only country facing tension between healthcare cost control and competition law. Other jurisdictions have developed more specific rules for provider–payer contracting, collective negotiation and market oversight. Their experience may therefore offer useful guidance

for Malaysia. This article examines the Netherlands, Australia and the United Kingdom. These jurisdictions were selected because each has adopted a distinct approach to competition in healthcare markets. The comparison does not assume that their models can be transferred directly to Malaysia. Instead, it identifies practical lessons that may be adapted to Malaysia's legal and institutional setting. Particular attention is given to independent contracting, collective negotiation, information exchange, market investigations and regulatory coordination.

Netherlands

The Dutch healthcare system operates through regulated competition. Since the 2006 reforms, health insurers have been expected to purchase healthcare on behalf of their members. In carrying out this role, they may negotiate prices, assess quality and contract selectively with providers (Stolper et al., 2019). The aim is to improve both affordability and quality. However, the model depends on hospitals and insurers making their commercial decisions independently (Schut & Varkevisser, 2017). Against this background, the Authority for Consumers and Markets (ACM) treats individual contracting as the general approach (Authority for Consumers & Market, 2023a). Each provider must decide for itself whether to accept an insurer's offer. Likewise, each insurer must independently choose the providers it wishes to contract with. It must also determine the volume of care it will purchase and the prices it will pay. Although insurers may discuss how healthcare services should be organised, they must not coordinate purchasing prices, volumes or provider selection.

In addition, the ACM's 2023 guidance explains the proper role of healthcare trade associations(Authority for Consumers & Market, 2023b). These associations may provide information on new laws, circulate public materials and conduct general research. However, they must not recommend prices, indexation rates, discount levels, volume increases or other commercial terms. Such recommendations may influence members' negotiations and encourage a common approach to contracting. This concern remains even where the recommendation is presented indirectly or described merely as support for members. At the same time, the Dutch approach does not prohibit all forms of cooperation (Schut & Varkevisser, 2017). Small healthcare providers may negotiate jointly where the purpose is to improve patient care rather than simply obtain higher tariffs (Victoor et al., 2019). In such cases, they must show how the arrangement will improve quality, prevention, capacity or access. Sufficient alternative providers must also remain in the market. Moreover, the proposed outcome should be acceptable to the insurer, the participating providers and patient representatives. A collective refusal to contract is not permitted where the insurer lacks realistic alternatives in the relevant area.

More broadly, this approach reflects the wider purpose of the Dutch system. Selective contracting is intended to help insurers obtain better value from healthcare providers. However, its success depends on effective bargaining, reliable information on quality and patients' willingness to use restricted provider networks (Bes et al., 2017). Furthermore, research shows considerable variation in the prices negotiated between Dutch hospitals and insurers. This suggests that contracting remains decentralised rather than based on a uniform industry tariff (Douven et al., 2020). Overall, the Dutch experience is relevant to Malaysia because it protects independent negotiation while allowing limited cooperation that benefits patients. It also shows how healthcare-specific competition guidance can distinguish legitimate support and technical coordination from collective influence over prices and other commercial terms.

Australia

Australia provides a useful example of how competition law can permit limited collective bargaining without creating a general exemption for the healthcare sector. Competitors may risk breaching the Australian Competition and Consumer Act 2010 when they negotiate and fix prices or trading terms. However, they may seek authorisation from the Australian Competition and Consumer Commission (ACCC). Authorisation may be granted where the proposed conduct is unlikely to substantially lessen competition. It may also be granted where the expected public benefits outweigh the likely public detriments (ACCC, 2022) . Australian scholarship describes this authorisation process as a flexible mechanism for assessing collective conduct according to its likely effects (Hardy & McCrystal, 2020; King, 2013). Nevertheless, the authorisation does not make every form of collective action acceptable. The ACCC assesses collective bargaining and collective boycotts separately. This distinction is important. A boycott adds a coordinated refusal to deal to the negotiation process. It therefore creates a stronger risk of harm to the target business, participating businesses and consumers. Academic analysis

of the Australian system also shows that the ACCC has generally taken a cautious approach to boycott powers and other forms of coercive conduct (Hardy & McCrystal, 2020).

This distinction can be seen in the ACCC's 2025 decision involving Catholic Health Australia (ACCC, 2025). The application covered several forms of cooperation among Catholic healthcare organisations. The ACCC authorised participating hospital operators to negotiate collectively with private health insurers and other funding organisations. It also authorised collective negotiations with suppliers. In addition, the organisations were permitted to exchange revenue, activity, cost and efficiency data for benchmarking purposes. The authorisation was granted until 21 March 2035. However, the ACCC did not authorise the proposed collective boycott of Australia's five largest private health insurers (ACCC, 2025). The proposed boycott would have allowed participating hospitals to refuse to deal individually with those insurers during collective negotiations. The ACCC was not satisfied that the expected public benefits would outweigh the likely public detriments. In particular, it was concerned that the boycott could disrupt access to private hospitals for insured patients. (ACCC, 2025). The decision therefore separated collective negotiation from collective coercion. Hospitals could negotiate together and exchange data for approved purposes. However, they could not jointly withdraw access from the major insurers. This approach is consistent with earlier ACCC decisions. Those decisions recognised that collective bargaining may reduce negotiation costs and improve the information available to participants. However, they also found that collective boycotts could disrupt hospital access and contribute to higher insurance premiums.

The Australian experience offers an important lesson for Malaysia. Collective arrangements should not be classified as entirely lawful or entirely prohibited. Instead, each part of the arrangement should be examined separately. MyCC could assess the parties involved and the matters covered by the negotiations. It could also examine the information exchanged and the duration of the arrangement. Participation should remain voluntary. Any proposed boycott or coordinated removal of access should be subject to a separate and stricter assessment. This model is also relevant to individual and block exemptions under the CA 2010. A Malaysian exemption could permit specific forms of cooperation that produce clear benefits. These may include supervised negotiations, standardised claims processes and independently managed benchmarking. At the same time, the exemption could prohibit collective price floors, coordinated de-empanelment and joint refusals to deal. The Australian approach therefore shows how an exemption may be carefully limited rather than granted to an entire sector.

United Kingdom

The United Kingdom (UK) provides a useful example of a market-wide competition inquiry. Under the UK Enterprise Act 2002, the Competition and Markets Authority (CMA) may examine whether particular features of a market prevent, restrict or distort competition. The inquiry does not need to begin with an allegation against a particular firm. Instead, it may examine the wider structure and operation of the market. In pursuant to the power, a private healthcare investigation was conducted for the purpose of investigating the features of the market that affect competition (CMA, 2014a). This investigation has formed part of the broader UK framework governing competition and patient choice in healthcare (CMA, 2014a; Guy, 2019). In that investigation, the CMA identified serious information problems. The problem lies in the fact that the patients lacked sufficient information about hospital performance, consultant performance and consultant fees. The CMA treated these gaps as market features that harmed competition. Without sufficient information, patients could not easily compare the likely cost and quality of treatment before choosing a hospital or consultant. As a result, patient choice could not place effective competitive pressure on healthcare providers (CMA, 2014a).

To address this problem, the CMA issued the Private Healthcare Market Investigation Order 2014 (Order 2014). The Order 2014 requires private hospital operators to submit information on patient treatment and hospital performance (CMA, 2014b). It also requires consultants to provide current information on their fees. This information is processed and published by an independent information organisation. In this regard, the CMA nominated the Private Healthcare Information Network as the body responsible for this role (CMA, 2014b). The information remedy was designed to make comparison easier. Patients could use a public platform to examine hospitals and consultants before making a decision. The information includes measures relating to treatment

activity, hospital performance and consultant charges. In this way, transparency was treated as part of the competitive process rather than merely as a consumer-protection issue.

Moreover, the CMA did not rely on a single remedy. The Order 2014 also addressed benefits and incentive schemes offered to referring clinicians. It also gave the CMA a role in reviewing certain arrangements between private hospital operators and NHS private patient units. Therefore, the inquiry produced different remedies for different market problems. It did not attempt to treat every concern as an individual infringement case (CMA, 2014b). However, the UK experience also shows that an information remedy requires continuing supervision. The CMA had to monitor whether hospitals and consultants were submitting the required data. It also took enforcement action where providers failed to comply. Full compliance with the transparency provisions was only confirmed in July 2026. This long implementation period shows the need for clear data standards, verification procedures and effective enforcement.

The UK experience offers two useful lessons for Malaysia. First, MyCC should examine the private healthcare market as a whole. The review should cover hospital charges, insurer reimbursement practices, provider panels, de-empanelment and patient access. This would provide a stronger evidential basis for future enforcement or reform. Second, Malaysia should consider establishing an independent body to manage private healthcare data. Hospitals, insurers and takaful operators could be required to submit standardised information. The body could then publish reliable and comparable information on prices, claims and healthcare quality. However, commercially sensitive information should remain protected. Overall, the UK model shows that competition concerns may arise from the design of the market itself. They do not always result from an identifiable unlawful agreement or abuse by one enterprise. A market review may therefore support wider remedies. These remedies may include disclosure duties, data governance and continuing regulatory oversight. The table below compares the approaches adopted in the Netherlands, Australia and the United Kingdom. It also identifies the main lessons that may be adapted to Malaysia. The analysis about international experience on this issue is summarized in the following Table 2:

Table 2: International Experience

Jurisdiction	**Main mechanism**	**Key safeguard**	**Possible Malaysian lesson**
Netherlands	Healthcare-specific ACM guidance on contracting and trade associations.	Individual contracting remains the starting point. Associations may give factual support but should not recommend prices or commercial terms.	MyCC guidelines can classify low-risk, prohibited and conditionally permissible arrangements using healthcare examples.
Australia	ACCC authorisation of collective bargaining where public benefits outweigh detriments.	Authorisation is time-limited and conditional. In 2025, hospital collective negotiation and benchmarking were permitted, but a boycott of the five largest insurers was refused.	Sections 5, 6 and 8 can support narrowly designed exemptions while excluding collective boycotts and price coordination beyond necessity.
United Kingdom	CMA private healthcare market investigation and legally binding information remedies.	Hospitals and consultants must supply information to an independent body for patient comparison. Market-wide remedies were used without treating every concern as a single infringement.	Market review can support independent data governance, transparency duties and targeted structural or behavioural recommendations.

Proposed Competition-Compliant Framework

Market review on private healthcare purchasing and provider networks

MyCC should consider exercising its power under section 11 of CA 2010 to review how private healthcare services are purchased and financed. The review should not focus only on the prices charged by hospitals. It should also examine the wider structure of the market and the relationship between hospitals, insurers, takaful operators, TPAs and MCOs. In addition to that, the review should consider hospital ownership, insurer and takaful market shares, the role of TPAs and MCOs as well as the geographic concentration of providers. It should also examine panel overlap, access to cashless treatment, hospitals' dependence on particular payers, contract duration, reimbursement practices and patterns of de-empanelment. At the same time, both provider power and payer power should be assessed. The review should remain neutral and should not assume in advance which side is responsible for rising healthcare costs.

In this regard, a market review would be more appropriate than moving immediately to infringement action. As discussed in the previous part, the UK experience demonstrates that market review is effective in identifying information and governance remedies for resolution of this problem. Thus, in the Malaysian context, market review would allow MyCC to examine the structure of the sector, the conduct of market participants and the effect of existing regulation before deciding whether enforcement is necessary. The review could lead to several outcomes. MyCC may recommend enforcement action where there is sufficient evidence. Alternatively, MyCC may also propose legislative reform, data-reporting duties or a sector-specific code of conduct. This approach would allow the underlying problems to be addressed without forcing every concern into a single infringement case

Healthcare-specific competition guidelines

In relation to the healthcare-specific competition guidelines, the Dutch experience provides a useful model. As discussed in the previous part, the ACM's guidance on contracting and trade association serves as a relevant reference in translating the competition rules into healthcare contracting without the need for price control by the regulator. Thus, MyCC should issue a clear guideline with input from the MOH and Bank Negara Malaysia (BNM). To provide a practical framework, the guideline should divide common arrangements into three categories. The 'green category' should cover arrangements that generally present a low competition risk. These may include genuine bilateral negotiations, independent decisions on provider networks, quality-based selection of hospitals and the use of aggregated historical benchmarks. By contrast, the 'red category' should cover arrangements that are likely to raise serious competition concerns. These may include collective minimum fees set by providers, common limits on discounts, coordinated de-empanelment and the exchange of intended future prices. In addition, association recommendations on commercial charges should also fall within this category. Between these two categories, the 'yellow category' should cover arrangements that may produce legitimate benefits but still require careful assessment. These may include DRG development, the pooling of claims data, common audit standards and multi-party dispute-resolution mechanisms. Accordingly, such arrangements should be assessed under section 5 of CA 2010 and supported by appropriate safeguards.

To make the guideline easier to apply, it should also include practical examples based on Malaysian contracting arrangements. It should explain how TPAs and MCOs are treated when they act only as agents for a single employer or insurer. It should also distinguish genuine agency arrangements from independent coordination between competitors. Furthermore, the guideline should clarify when commercially sensitive information exchanged through a TPAs or MCOs may be attributed to the competing insurers or employers involved. Finally, the guideline should make clear that it does not determine whether an enterprise is dominant. Nor should it be treated as approval of any particular price, discount or reimbursement rate.

Transparent panel and de-empanelment governance

BNM and MOH should work with MyCC to establish clear rules for the management of provider panels. Major healthcare purchasers should be required to explain how hospitals are selected, reviewed and removed. In addition, the rules should clearly set out the criteria for appointing hospitals and the measures used to assess

their quality and cost. Any conflicts of interest should also be disclosed. Where a hospital is removed from a panel, the payer should provide written notice and clear justification for the removal. At the same time, the removed hospital should be given access to an internal appeal process. For the regulatory oversight, records of panel decisions should also be available to the relevant regulator.

More importantly, the framework should protect patients who are already receiving treatment. For example, where a patient is undergoing surgery, cancer treatment, maternity care or another clinically sensitive course of care, de-empanelment should not immediately end cashless access. However, urgent action is required because of patient safety concerns or suspected fraud. Such protection would not give a hospital permanent panel membership. Rather, its purpose is to prevent a commercial decision from causing unnecessary disruption to ongoing treatment. At the same time, the framework should not require every insurer to include every licensed hospital in its provider network. Such an unrestricted "any willing provider" rule could weaken selective contracting. It may also reduce incentives for hospitals to compete on cost, quality and efficiency. Instead, the better approach is to ensure that panel selection remains open, fair and contestable. Under this approach, hospitals should have a genuine opportunity to meet the required criteria. Insurers should nevertheless retain the freedom to design efficient networks based on objective and transparent grounds.

Regulator-supervised dispute resolution

A hospital-insurer dispute resolution mechanism should be reactivated under a formal protocol. From the outset, the protocol should be designed to comply with competition law. In particular, each bilateral dispute should be handled separately. Competing hospitals or insurers should not be allowed to view one another's submissions. Likewise, discussions about future industry-wide rates should be prohibited. For transparency, the mechanism may publish anonymised procedural lessons, but it should not disclose commercially sensitive information. In addition, mediators should have appropriate legal, financial and clinical expertise. However, they should remain independent. They should not represent competing hospitals or insurers in a way that turns mediation into collective bargaining.

As a priority, the mechanism should deal with disputes involving continuity of care, unexplained de-empanelment, delayed payment, unilateral contractual changes and allegedly discriminatory procedures. Where appropriate, it may recommend that a decision be reconsidered or that temporary access be restored. However, it should not set a common price unless this is authorised by legislation or permitted through an exemption based on a transparent method. Finally, MyCC should be given an observer or advisory role where a proposed settlement may affect competition beyond the parties directly involved.

Independent data governance for benchmarks and DRG

In connection with independent data governance, cost and claims data should be managed by an independent data trustee that is accountable to public authorities. In this regard, the UK experience in connection to provision of information remedy in pursuant to Order 2014 serves as an appropriate reference. To ensure proper governance, the rules should clearly state the purpose of data collection. They should also identify the required data, validation standards, confidentiality safeguards, aggregation thresholds and publication periods. In addition, the rules should specify who may access the data and what penalties apply in cases of misuse. In this connection, it is really important that the hospitals and insurers should receive only the information needed for the stated purpose.

In addition to that, the data should clearly distinguish price from quality and case complexity. This is due to the fact that a lower price does not necessarily indicate greater efficiency where patient outcomes are poor. Conversely, a higher price may be justified by the seriousness of the case or the need for specialist expertise. For this reason, DRG governance should consider cost, utilisation and quality together. Finally, regular audits should be carried out to identify possible responses to changes in payment incentives.

Use of exemptions and formal inter-agency coordination

MyCC should provide a clear and practical process for individual exemption applications involving pilot DRG projects, shared fraud-detection systems, standardised electronic claims and independent medical-necessity audits. To support applicants, MyCC should explain the information required, the assessment process and the safeguards expected. This would allow useful projects to proceed without exposing the parties to unnecessary legal uncertainty. Where experience shows that a recurring category of agreement consistently satisfies section 5 of the CA 2010, MyCC may consider introducing a narrowly framed block exemption. However, the exemption should be subject to strict conditions. In particular, it should prohibit price recommendations and limit access to commercially sensitive data. It should also require independent governance and regular compliance reviews. In addition, MyCC should retain the power to amend or withdraw the exemption where evidence of competitive harm emerges.

Finally, the MOH, BNM and MyCC should adopt a memorandum of understanding or a statutory coordination protocol. The protocol should clearly explain how complaints are referred and how joint investigations or studies are conducted. It should also establish rules for lawful information sharing between the regulators. Under this arrangement, complaints involving clinical safety or healthcare-facility standards should be referred primarily to the MOH. By contrast, concerns about claims handling, insurance practices or the treatment of policyholders should be directed to BNM. Meanwhile, issues involving coordinated pricing, market foreclosure or abuse of dominance should fall within MyCC's responsibility. For cases involving more than one regulatory concern, the agencies should assess the matter jointly. Such cases should not simply be passed from one institution to another. Although the PAC's recommendation for new and independent governance may eventually support wider institutional reform, an inter-agency protocol offers a practical step that can be introduced without waiting for a new commission to be established

CONCLUSION

Hospital-insurer bargaining plays an important role in Malaysia's private healthcare system, but its legal position remains uncertain. On one side, insurers need sufficient freedom to negotiate discounts, design provider networks and control unnecessary expenditure. On the other side, hospitals require protection where a small number of powerful payers control access to a large insured population. At the same time, patients have their own interests. They need affordable premiums, meaningful access to suitable hospitals and continuity of treatment. These interests cannot be protected by assuming that every form of bargaining is abusive. They also cannot be protected by treating every form of cooperation as beneficial.

In principle, the CA 2010 already provides the main legal tools needed to address these concerns. Section 4 of CA 2010 protects independent commercial decision-making and prohibits harmful coordination between enterprises. Section 5 of CA 2010 allows agreements that produce genuine efficiency or social benefits, provided that the restrictions are necessary and proportionate. Section 10 of CA 2010 addresses the misuse of substantial market power. Section 11 of CA 2010 allows MyCC to investigate wider structural and regulatory problems within a market. The main weakness, therefore, is not the absence of legal authority. Rather, it is the lack of healthcare-specific guidance, clear procedures and reliable market evidence.

In this context, the PAC report offers a credible basis for regulatory reform. However, it does not provide sufficient grounds to conclude that any named hospital, insurer or association has infringed competition law. As a first step, MyCC should conduct a market review of the purchase and financing of private healthcare. Following that review, MyCC should issue practical guidance that distinguishes three forms of conduct. These are genuine bilateral negotiations, prohibited coordination between competitors and carefully controlled multi-party cooperation. In addition, reform should include transparent panel-governance rules, regulator-supervised mediation and independent management of cost and claims data. Transitional rules should also protect patients who are already receiving treatment. Where necessary, carefully limited exemptions could support useful collaboration without allowing collective price-setting.

Ultimately, the proposed framework seeks to balance cost control, sustainable healthcare provision and patient access. Competition law should not protect inefficient hospital charges from legitimate negotiation. However, it

should also not allow a powerful purchaser to reduce reimbursement in a way that weakens service quality, restricts supply or disrupts patient care. The proper objective is therefore not to favour hospitals or insurers. Instead, it is to create a bargaining system shaped by genuine competition, greater transparency, objective justification and clear regulatory accountability.

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Ethical Approval

Ethical approval was not required because the study is based exclusively on legislation, public regulatory documents, an official parliamentary report and published literature. It did not involve human participants, animals or the collection of personal data.

Conflict Of Interest

The author declares no conflict of interest.

Data Availability

The materials analysed are legislation, official regulatory publications, the Parliamentary Public Accounts Committee report DR.12/2026 and published academic literature identified in the reference list. No original dataset was created or analysed.

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