FEE BENCHMARKS ADVISORY COMMITTEE REPORT 2023

RECOMMENDATIONS FOR HOSPITAL FEE BENCHMARKS & DOCTORS FEE BENCHMARKS

Table of Contents

EXECUTIVE SUMMARY

This report outlines the approach adopted by the Fee Benchmarks Advisory Committee ("Committee") in recommending the following for the private healthcare sector:

Hospital Fee Benchmarks

- Introduction of fee benchmarks for private hospital charges ("hospital fee benchmarks")

Doctors Fee Benchmarks

- Introduction of new fee benchmarks for private surgeon professional fees ("surgeon fee benchmarks")
- Introduction of new fee benchmarks for private anaesthetist professional fees ("anaesthetist fee benchmarks")
- Updates to the published private doctors' professional fee benchmarks

2 This report also details the principles and parameters adopted for determining the benchmarks, key feedback received from stakeholders and the Committee's recommendations on how the fee benchmarks should be used.

New Hospital Fee Benchmarks

3 MOH has introduced hospital fee benchmarks for 21 common surgical procedures and 8 common medical conditions. Hospital fee benchmarks includes fee components such as hospital room charges, surgical facilities and equipment, implants, consumables, investigations, general nursing services and treatment, and medication. However, hospital fee benchmarks exclude doctors' professional fees (i.e., surgeon, anaesthetist and doctors' inpatient attendance fees), which have separate fee benchmarks.

New Surgeon and Anaesthetist Fee Benchmarks

4 In 2018, MOH introduced surgeon fee benchmarks for 200 common surgical procedures on the Table of Surgical Procedure (TOSP)[1]. In 2020, the benchmarks was extended to include anaesthetist fees and doctors' inpatient attendance fees.

5 To provide a more complete reference for surgeon and anaesthetist professional fees, the Committee has recommended new surgeon fee benchmarks for the remaining 1,900 less common surgical procedures, hence covering all 2,100[2] procedures which can tap on MediSave and MediShield Life. Anaesthetist fee

[1] The Table of Surgical Procedures is an exhaustive list of procedures with table ranking 1A to 7C, for which MediSave and MediShield Life can be claimed.
[2] Excludes procedures predominantly performed by dentists.

benchmarks have also been rolled out for a total of 500 procedures. These benchmarks cover almost all surgical cases in the private sector.

Published Doctors Fee Benchmarks Updated

6 To ensure that the benchmarks remain relevant, MOH has also adjusted all existing surgeon, anaesthetist and doctors' inpatient attendance fee benchmarks to be more reflective of doctors' current operating costs and inflationary pressures. The adjustment was done by applying a growth factor, which has considered key costs, such as manpower, rental and other operating expenses for the past years, onto the published benchmarks.

Stakeholder Engagement

7 More than 10 stakeholder consultation sessions were held between June 2022 and March 2023, with about 600 specialists, administrators from all private hospitals, and insurers. These consultations helped to ensure that the benchmarks reflect a fair range of fees and balance the different stakeholders' interests and perspectives. Key feedback was reviewed in detail by the Committee and taken in where appropriate and relevant. Stakeholders were generally receptive to the new areas of fee benchmarks, and supported efforts to keep the benchmarks updated.

Key Recommendations

8 The Committee recommends that hospitals and doctors make reference to their respective areas of fee benchmarks when providing financial counselling to patients. Hospitals and doctors who charge above the benchmarks should be prepared to justify the higher fees, if queried. Providers should also be transparent about components of the bill that are charged by them. Payers should use the fee benchmarks fairly in determining reasonable charges during claims assessment. Patients are encouraged to use the fee benchmarks as a reference when considering care and treatment options.

MAIN REPORT

1 This report lays out the Committee's recommendations on the new fee benchmarks for the private sector. This includes fee benchmarks for hospital fees, surgeon and anaesthetist professional fees, and updates to the published doctors fee benchmarks. The report details the approach and key principles that were adopted to determine the benchmarks, feedback received from stakeholders, and the Committee's key recommendations.

Background

2 The Ministry of Health (MOH) in January 2018 appointed an independent multi-stakeholder Committee to develop fee benchmarks for high volume surgical and medical conditions. The intent was to guide appropriate charging by healthcare providers and is part of MOH's larger strategy to manage rising healthcare costs. The Committee comprises doctors and representatives from hospitals, consumer advocate groups, insurers and academia, to ensure balanced views. See Annex A for the full composition of the Committee.

3 The fee benchmarks serve as a guideline of what constitutes reasonable fees in the private sector, to allow stakeholders to make more informed healthcare decisions. It aims to keep private healthcare costs affordable and sustainable by increasing fee transparency and reducing information asymmetry among patients, providers, and payers.

4 In Nov 2018, surgeon fee benchmarks were published for about 200 common procedures. As anaesthesia is an integral component of surgery, anaesthetist fee benchmarks were published in 2020 to complement the published surgeon fee benchmarks. Doctors' inpatient attendance fee benchmarks were rolled out in the same year to provide a complete reference for all areas of doctors' professional fees.

5 Since its introduction, close to 90% of doctors have been charging within the recommended surgeon fee benchmarks. This has helped to moderate the growth of surgeon fees – the median private surgeon fee has remained stable, while the 90th percentile private surgeon fee has decreased by about 1.7%, for procedures with fee benchmarks. However, there remained about 1,900 surgical procedures for which there were no fee benchmarks. A fee reference for the remaining components of the hospital bill (other than doctors' professional fees) was also unavailable.

6 To address these gaps, the Committee thus developed hospital fee benchmarks for common medical conditions and surgical procedures, and new surgeon and anaesthetist fee benchmarks for more of the remaining less common procedures.

7 Stakeholders will now have a comprehensive fee reference for the entire private hospitalisation episode for selected common conditions, as well as a more complete reference for professional surgeon and anaesthetist fees. Fee benchmarks for doctors' professional fees that were published have also been updated to stay relevant.

A. Principles and Parameters

8 The following principles were adopted in developing all fee benchmarks, where applicable. The benchmarks should:

a) allow for increases over the years, but excessive growth should be moderated;

b) be a reasonably narrow range;

c) be commensurate with the time and effort needed for the procedure;

d) take into account the complexity of the procedure; and

e) cover a majority of providers' typical and routine cases.

9 The following parameters guide the usage of all fee benchmarks:

a) Fee benchmarks are intended to be a reference for private sector charges only. Doctors and hospital fee benchmarks were set based on data collected from private sector cases submitted to MOH's MediClaim system in recent years, regardless of whether a case was covered by insurance, or managed by insurers' panel providers. Only Singapore Citizen cases are included.

b) Fee benchmarks are intended to be a guide for routine and typical cases only. Cases of exceptional complexity may be charged above the fee benchmarks, and providers should be prepared to justify the reasons for doing so.

c) To minimise disputes on fees, providers should discuss and agree with their patients their estimated fees before admission to the hospital.

B. Setting of Hospital fee benchmarks

Components of hospital fee benchmarks

10 Hospital fee benchmarks inform what a reasonable fee range for items billed by the hospital is. This is a non-exhaustive list that includes fee components such as hospital room charges, surgical facilities and equipment, implants, consumables, investigations, general nursing services and treatment, and medication. Hospital fee benchmarks exclude doctors' professional fees (i.e., surgeon, anaesthetist and doctors' inpatient attendance fees), which have their own separate fee benchmarks, since doctors are usually separate entities from the hospitals, as illustrated below:

Figure 1: Illustration of cost components in a private hospital bill

Hospital Invoice	
Billed by the doctor(s): • Surgeon fees	**Doctors Fee Benchmarks**
• Anaesthetist fees • Doctors' inpatient attendance fees	
Billed by the hospital: *(Some fee components below could also be charged by the doctors)* • Room charges • Surgical facilities and equipment (e.g., use of operating theatre) • Implants • Consumables (e.g., gauze, swab) • Investigations (e.g., radiology tests, laboratory tests) • General nursing services and treatments (e.g., basic monitoring, taking regular blood test, administering drugs and/ or fluids prescribed)	**Hospital Fee Benchmarks**
• Medication	
TOTAL BILL	

11 While the fee components (e.g., hospital room charges, implants) stated above collectively form hospital fee benchmarks, some components could be charged by the treating doctor but billed through the hospital. Such charging practices could vary significantly across hospitals and doctors, even for the same procedure or medical condition. This should be taken into account when doing a fee comparison. Notwithstanding this, the hospital fee benchmarks provides a common reference for the reasonableness of the *total* hospital fee billed by the hospital, regardless of the charging party.

12 The Committee has recommended hospital fee benchmarks for 21 common surgical procedures and 8 common medical conditions managed in the day surgery and/ or inpatient setting (see Annex B for the list of hospital fee benchmarks).

13 Doctors and hospitals are strongly encouraged to be transparent and upfront on the fee components charged by them. They should work together to keep their charges within the hospital fee benchmarks.

Selection of surgical and medical conditions

14 The following key factors were considered in the selection of conditions for the hospital fee benchmarks:

a) High impact conditions. These are conditions that are common and/ or have high bill sizes in the private sector, so that the fee benchmarks would benefit more patients.

b) Conditions with standardised care management. This helps to ensure the fee range could be kept narrow and meaningful for patients.

15 Surgical conditions were set using the TOSP as a basis, consistent with the Surgeon and Anaesthetist Fee Benchmarks. Medical conditions were selected using Diagnosis Related Groups[3] (DRG) stratified by the Clinical Classification System[4] (CCS) to keep the range of conditions covered by the benchmark narrow and meaningful.

Selection of cases for each surgical and medical condition

16 To further ensure that the hospital fee benchmarks are representative of the routine and typical cases, benchmarks were split by care setting and patient type as follows:

a) Care setting. Fee benchmarks were set for the predominant care setting, i.e., inpatient or day surgery, for the condition. Fee benchmarks are applicable to both private hospitals and day surgery centres, since day surgeries are performed in both facilities. Fee benchmarks for inpatient setting includes only cases admitted in single-bedded rooms as such admissions are the most common in the private sector.

b) Patient type. Separate fee benchmarks were set for the adult and paediatric populations if the volume and fees differed significantly. Otherwise, a single fee benchmark was set for all cases, regardless of patient type.

Setting of the fee range

17 To cover majority of the cases, the fee range was set at the 25th to 75th percentile by default, but moderated if the hospital fee growth had been significantly higher than expected:

a) Data. Based on the hospital bills in 2021 and first half of 2022 for private day surgery clinics and private hospital cases (collectively termed as 'private hospital') for Singapore Citizens only. GST is excluded.

b) Range. The hospital fee benchmark was set at the 25th to 75th percentile of the hospital bill by default, consistent with the approach used to develop the doctors' professional fee benchmarks. The fee range would be moderated if:

[3] The DRG is a categorisation of inpatient hospital visits based on severity of illness and cost intensity.

[4] The CCS is a tool for clustering International Classification of Diseases (ICD) codes into a manageable number of clinically meaningful categories (e.g., "Viral infection" and "Influenza"). An ICD code identifies a diagnosis and describes a disease or medical condition.

(i) the average private hospital bill size was growing faster than the average public hospital unsubsidised hospital bill size[5];

(ii) the ratio of private hospital bill size over public hospital unsubsidised bill size was higher than historical average; and

(iii) the average private hospital fee was growing faster than the average private hospital bill size.

c) Sufficient coverage. Finally, the benchmarks were validated to ensure that the fee range could be applied to a sufficient number of cases for each condition and private hospital. See Annex B for the list of hospital fee benchmarks.

C. Setting of New Surgeon Fee Benchmarks

New benchmarks for the lower volume procedures

18 There are about 2,100 surgical procedures in the TOSP, which is an exhaustive list of procedures for which Medisave and MediShield Life can be claimed. In 2018, MOH published fee benchmarks for surgeon professional fees for 200 common surgical procedures, which covered 85% of surgical cases in the private sector.

19 This round, the Committee has recommended another 1,900 surgeon fee benchmarks for less common procedures, which cover 15% of surgical cases in the private sector. Despite being less common, the Committee had received strong feedback from both doctors and payers to develop surgeon fee benchmarks for these procedures to provide a complete set of surgeon fee benchmarks for stakeholders to refer to.

Approach & methodology

20 Surgeon fee benchmarks for the remaining less common 1,900 procedures were developed based on the following processes and considerations:

a) Data. Past transacted fee data was predominantly used as the basis for setting the fee benchmarks. 2017 surgeon fees for episodes involving a single procedure (one TOSP code) were used by default, consistent with the first set of 200 surgeon fee benchmarks published. However, if there were insufficient cases in 2017, data would be pooled from 2016 to the

[5] Refers to Ward A or Day Surgery (Unsubsidised).

first half of 2022 across cases involving single or multiple procedures[6]. All data were based on private surgeon fees, excluding GST, for Singapore Citizens only. Procedures with low volume of cases, even after pooling, were compared to other procedures of similar complexity and adjusted where necessary to ensure reasonableness and consistency in the fee benchmarks across procedures.

b) Range. Fee benchmarks were set at the 25th to 75th percentile of the surgeon fee by default. The fee range would be moderated and adjusted if the fees were found to have grown significantly or were incongruent with the procedure's complexity relative to other procedures, typically under the same specialty. This is consistent with the approach taken for the first set of surgeon fee benchmarks published in 2018.

c) Clinical inputs. Clinical inputs were sought from both the Academy of Medicine, Singapore (AMS) and public sector specialists to ensure that the benchmarks are congruent with the procedure's relative complexity.

d) Adjusted for currency. As the surgeon fee benchmarks were set using 2017 data, a growth factor (see Section E) was applied so that they are more reflective of doctors' current costs and inflationary pressures.

Post-publication monitoring and adjustments

21 In the process of analysing claims data, instances of inappropriate TOSP coding practices (e.g., several codes submitted for procedures used to achieve the same surgical outcome where one code would have sufficed) were observed. In this regard, providers are reminded to abide by the principle that one TOSP code should be utilised where a single TOSP code adequately describes the procedure performed.

22 MOH would continue to monitor the practice and charging patterns of procedures closely. Adjustments to the benchmarks would be made ahead of the regular review cycle of 3 to 5 years, if any anomaly in claims pattern is observed and found to be influenced by the fee benchmarks.

23 See Annex B for the full list of surgeon fee benchmarks.

[6] Involving two or more TOSP codes within one surgical episode.

D. Setting of New Anaesthetist Fee Benchmarks

New benchmarks for moderate volume TOSPs

24 In 2020, the Committee published 200 anaesthetist fee benchmarks, covering 90% of cases requiring anaesthesia support in the private sector. This was also in response to doctors' feedback[7] to fundamentally review the anaesthetist fee structure to better reflect the effort required for managing anaesthetic risks in surgery.

25 This round, the Committee will be publishing an additional 300 anaesthetist fee benchmarks, covering another 5% of cases requiring anaesthesia support in the private sector. In total, there will be anaesthetist fee benchmarks for 500 procedures covering 95% of cases requiring anaesthesia support in the private sector. anaesthetist fee benchmarks, like surgeon fee benchmarks, are also set with TOSP as its basis to facilitate financial counselling, billing and claims for procedures.

26 Beyond these 500 anaesthetist fee benchmarks, the Committee currently has no plans to set fee benchmarks for the remaining 600 procedures, which are rarely performed in the private sector. Furthermore, both private anaesthetists and payers have not indicated a strong need to have fee benchmarks for these procedures. Nonetheless, for procedures without anaesthetist fee benchmarks, stakeholders may take reference from the benchmarks of procedures of similar complexity.

Approach & methodology

27 This new set of 300 anaesthetist fee benchmarks was developed using the same approach as the initial set of 200 published in 2020:

a) Data. The Committee used 2018 private anaesthetist fees for cases involving a single procedure (one TOSP code) for Singapore Citizen cases, excluding GST, as a reference in setting the benchmarks.

b) Anaesthetic risk index. Each procedure was ranked by its procedural anaesthesia complexity and duration using an index. The index considered factors such as the time taken, whether special anaesthesia techniques and/ or changes in position are required, risks of bleeding and complications etc for the baseline case. Thereafter, the Committee determined a "base fee" for each index to form the lower bound of the benchmark. The lower bound of the anaesthetist fee benchmark thus reflects the baseline anaesthetic risk and effort for the procedure.

[7] Doctors had given feedback during 2018 consultation sessions that the common practice in the private sector to set anaesthetist fees as a proportion of surgeon fees might not sufficiently compensate the anaesthetist for the anaesthetic risk and effort undertaken.

c) Patient variabilities affecting anaesthesia. As not all procedures see the same range of patients, different procedures have different fee ranges. A procedure that is typically for patients ranging from the young to old, including the fit to the chronically ill, would have a wider fee range. Conversely, a procedure of similar anaesthetic risk but typically is for only fit and healthy patients (e.g., procedures common for sports injury) would have a narrower fee range.

d) Clinical inputs. The indexes and patient variabilities were advised by the College of Anaesthesiologists, Singapore (CAS) and independently reviewed by public sector anaesthetists.

e) System impact considerations. Given that the anaesthetist fee benchmark was a fundamental change to the anaesthetist fee structure, the Committee had to consider the impact on the overall healthcare system, while ensuring that the fee ranges were commensurate with the effort and risk undertaken by the anaesthetist. The Committee had thus taken in the community's earlier feedback on the remuneration for the minimum level of risk undertaken and balanced it with a narrower fee range and smaller increment between indexes, after taking into account the workload, indexes and variability factors for all 500 procedures.

f) Adjusted for currency. As the anaesthetist fee benchmarks was set using 2018 data, a growth factor (see Section E) was applied so that they are more reflective of today's costs.

28 See Annex B for the full list of anaesthetist fee benchmarks.

E. Published Doctors' Fee Benchmarks Updated

29 To ensure that the existing doctors fee benchmarks (surgeon, anaesthetist and doctors' inpatient attendance fee benchmarks) remain current, the Committee has updated the benchmarks.

Key cost drivers

30 The growth factor considers the key operating costs typically recovered via doctors' professional fees. This includes manpower, clinic rental and other operating expenses. Growth for these areas was proxied using the closest available data reference[8]. Costs that are typically passed on directly to patients as separate billing items such as medication, tests and consumables were excluded.

[8] Manpower cost referenced the wage growth for public healthcare institutions. Rental was based on the rental growth for medical clinics around and within private hospitals. Other operating expenses referenced the core Consumer Price Index.

Period of growth

31 The fee benchmarks were adjusted for growth up to 2022, being the latest full year of data available. The growth factor varies for the different types of fee benchmarks, depending on the period[9] of data used to develop the benchmarks (see Table 1). The Committee recommends that the next review for growth could take place in 3 to 5 years' time in line with the usual fee benchmarks review cycle to keep the benchmarks relevant, or earlier should there be a need to do so.

Table 1: Growth period and rate applied for doctors fee benchmarks

	Growth period	**Growth factor**
Surgeon fee benchmarks	2017 – 2022	12.1% (2.3% per annum)
Anaesthetist fee benchmarks	2018 – 2022	9.9% (2.4% per annum)
Doctors' inpatient attendance fee benchmarks	2020 – 2022	5.7% (2.8% per annum)

32 See Annex B for the list of updated doctors fee benchmarks.

F. Stakeholder Engagement

33 In developing and updating the fee benchmarks, the Committee conducted an extensive consultation exercise which spanned several months and involved the key stakeholder groups[10]. To allow different perspectives to be raised and discussed, private sector surgeons and anaesthetists, private hospital administrators, as well as Integrated Shield Plan (IP) insurers were consulted on a preliminary set of figures. Subsequently, the preliminary fee benchmarks were adjusted as needed, and finalised.

Key feedback received

34 Hospital fee benchmarks. The Committee had initially proposed to set a total bill size fee benchmark which would cover the total bill (i.e., both doctors'

[9] Surgeon fee benchmarks were set using 2017 data; anaesthetist fee benchmarks used 2018 data; while doctors inpatient attendance fee benchmarks used 2020 data.

[10] About 600 specialists from the private sector medical professionals and professional bodies; administrators of all private hospitals with relevant claims; and insurers were consulted over more than 10 sessions held between June 2022 to March 2023.

professional fees and hospital fees combined). The intent was to provide a single, comprehensive fee reference for patients and payers for ease of comparison. However, after reviewing stakeholders' feedback, the Committee decided to separate the hospital's fee components from the doctors' professional fee components. Hospital fee benchmarks would be set instead, in view that:

a) Having a separate benchmark for the hospital bill would increase fee transparency and accountability;

b) The separation of hospital bill and doctors' professional fees is aligned with the current financial counselling and billing process in the private sector; and

c) Having separate hospital fee benchmarks would encourage hospitals to work more closely with doctors in keeping the hospital fee within the benchmarks.

35 Update of published doctors fee benchmarks. Stakeholders did not have any major feedback on the approach. Doctors were supportive of the Committee's effort to keep the benchmarks updated.

36 Surgeon and anaesthetist fee benchmarks. Stakeholders did not have any major feedback on the approach. Both doctors and insurers shared feedback on the fee benchmarks of selected procedures. The Committee reviewed and made adjustments where necessary.

37 Insurers' use of fee benchmarks. Concerns were raised over insurance panel fees being set predominantly at the lower bound of the benchmarks and the increasing administrative challenge from the claims process. The Committee continues to encourage IP insurers to consider the full fee benchmarks range.

G. Key Recommendations

38 The Committee's recommended fee benchmarks for hospital charges and doctors' professional fees, including the general principles and notes accompany each set of benchmarks to guide users on how to interpret and use the fee ranges, can be found in Annex B. To ensure that the benchmarks are effective and helpful to all stakeholders, the Committee would like to recommend that stakeholders use the fee benchmarks in the following manner:

a) Hospitals. Hospitals should use the hospital fee benchmarks when providing financial counselling to patients. Hospitals that charge above the benchmarks should be prepared to inform and justify the higher fees, if queried by the patient or insurer (where applicable). Where certain

items in the hospital bill are charged by doctors, hospitals are advised to work with doctors in managing the total hospital bill.

b) Doctors. Doctors should use the surgeon, anaesthetist and doctors' inpatient attendance fee benchmarks to determine if their charges are within reasonable range and make reference to them when providing financial counselling to patients. Doctors who charge above the benchmarks should be prepared to inform and justify the higher fees, if queried by the patient or insurer (where applicable), including other non-professional fees charged by the doctor. To this end, doctors should satisfy themselves that the fee charged in each case is fair, reasonable and appropriate for the services provided, with due consideration given to the circumstances of each case.

c) Patients. Patients are encouraged to use the fee benchmarks and hospital bill size information found on MOH's website (www.moh.gov.sg/billsandfees) as references when considering care and treatment options. Patients are advised to discuss and clarify charges during the financial counselling process with the hospital and doctor, prior to admission. Patients should also be aware that certain components of the bill (e.g., implants and consumables) could be charged by either the doctor or the hospital. Hence, patients should enquire directly with the doctor if they have questions on the costs of components charged by the doctor. Patients can clarify with their doctor or hospital if in doubt over who the charging party is.

d) Payers. Insurers and Third-Party Administrators (TPA) should use the benchmarks fairly and appropriately in determining reasonable charges during claims assessment or setting of panel fee schedule. If there is a need to depart from the fee benchmarks, they should be prepared to justify to their doctors and patients. For purposes of claim assessment, payers are encouraged to seek clarification from the provider if it is not clear who the charging party is for certain components of the bill.

e) Government. MOH should ensure that the fee benchmarks and related information are made readily accessible and easily understood by the public. The Committee also recommends that the Ministry monitors providers' fees closely following publication of the new and updated fee benchmarks, and make adjustments where necessary to keep the benchmarks updated and ensure cost escalation remains moderated.

H. Acknowledgements

39 The Committee would like to express appreciation towards all individuals and organisations who have contributed their time and expertise towards the development of fee benchmarks in support of a sustainable healthcare system. The Committee wishes to especially thank the following stakeholders, for providing invaluable feedback and inputs and their active participation in the consultation sessions:

a) Individual public and private sector doctors

b) Academy of Medicine, Singapore (AMS)

c) Life Insurance Association Singapore (LIA)

d) All Integrated Shield Plan insurers, including AIA Singapore Private Limited, The Great Eastern Life Assurance Company Limited, HSBC Life (Singapore) Pte. Ltd., Income Insurance Limited, Prudential Assurance Company Singapore (Pte) Limited, Raffles Health Insurance Pte. Ltd. and Singapore Life Limited

e) All private hospitals, including IHH Healthcare Singapore (Gleneagles Hospital, Mount Elizabeth Novena Hospital, Mount Elizabeth Orchard Hospital and Parkway East Hospital), Farrer Park Hospital, Mount Alvernia Hospital, Raffles Hospital and Thomson Medical Centre.

ANNEX A

Composition of the Fee Benchmarks Advisory Committee 2021 - 2023

Name	Designation
Dr Wee Siew Bock *[Chairman]*	Senior Consultant & General Surgeon in private practice
Prof Ang Chong Lye	Senior Advisor, SingHealth; Clinical Professor & Senior Consultant Ophthalmologist, Singapore National Eye Centre
Dr Ho Kok Sun	Assistant Master (Administrative Affairs), Academy of Medicine Singapore; General Surgeon in private practice
Dr James Lam Kian Ming	Chief Executive Officer, Mount Alvernia Hospital
Ms Jasmin Lau	Deputy Secretary (Policy), Ministry of Health
Dr Lim Hui Ling	Honorary Assistant Secretary, College of Family Physicians Singapore; Family Physician in private practice
Ms Nidhi Swarup	Founder & President, Crohn's & Colitis Society of Singapore
Mr Sallim Abdul Kadir	Board Member, Cerebral Palsy Alliance Singapore
Prof Teo Yik Ying	Dean, Saw Swee Hock School of Public Health, National University of Singapore
Dr Toh Choon Lai	Council Member, Singapore Medical Association; Orthopaedic Surgeon in private practice
Dr Yoong Siew Lee	Convenor, Health Insurance Subcommittee, Life Insurance Association; Medical Advisor, Income Insurance Limited
Mr Zainul Abidin Rasheed	Singapore's Ambassador (Non-Resident) to Kuwait, and former Senior Minister of State (Foreign Affairs)

ANNEX B

Annex B – Full list of MOH Fee Benchmarks	*Click here to download the list*