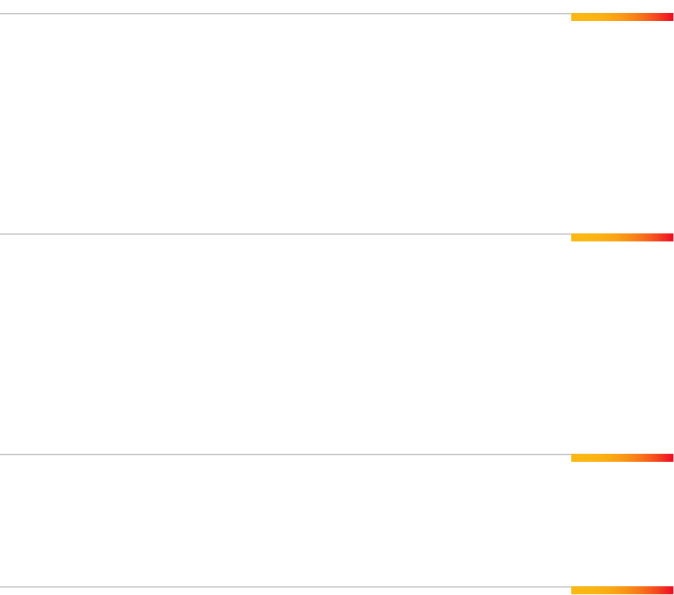
Discovery
Health Medical Scheme

2022 INTEGRATED REPORT

Discovery Health Medical Scheme registration number 1125

In this Report



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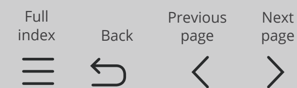


Links to additional content are provided:

In-text links are denoted by underlined text

About DHMS

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a non-profit entity governed by the Medical Schemes Act (the Act)[1] and regulated by the Council for Medical Schemes (CMS). The Scheme belongs to its members, and an independent Board of Trustees (the Trustees or the Board) – of which the majority is member-elected – oversees its activities.

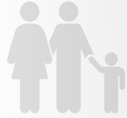
DHMS is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 810 992 beneficiaries at 31 December 2022, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.6%[2].

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd (Discovery Health) through a formal contractual arrangement. In a context characterised by challenging socio-economic conditions and a fragmented and inflationary healthcare system, in partnering with Discovery Health and healthcare providers we work to provide access to high-quality care and ensure good health outcomes for our members by integrating services and achieving the highest possible cost efficiency.

Our aspirations and our goals in the work we do for our members, alongside our partners, are defined in our purpose: to meet our members' healthcare needs in an affordable, equitable and quality, value-based way now and into the future. Our approach to everything we do is rooted in our values-driven culture and our commitment to being an engaged and thoughtful corporate citizen that cares deeply for the wellbeing of our members, our industry and our society.

1 *Medical Schemes Act 131 of 1998, as amended.*

2 *Based on beneficiaries, according to the CMS Annual Report for the year ended December 2021 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/). At the end of 2021, there were 17 open schemes registered with the CMS, with approximately 54% of the total medical schemes market and 55 restricted schemes, with approximately 46% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately two million beneficiaries. Source: Annexures to the CMS Annual Report 2021-2022.*



Why join DHMS?

Quality of care is key to our membership proposition

One of the Scheme's strategic priorities is to drive value-based healthcare, placing our members at the centre of care, an approach that reimburses healthcare providers based on health outcomes and not only the volume of services they deliver. This gives our members access to programmes and providers that are committed to continuous improvement in quality care.

The Scheme strives to ensure that our members have access to the safest, most efficient and effective healthcare available in South Africa. Our partnership with Discovery Health provides our members with many quality of care initiatives and innovations which are closely monitored by the Scheme on an ongoing basis. We also empower our members with information relevant to their needs.

WE EXIST FOR OUR MEMBERS

We provide sustainable access to the best healthcare, connecting our members and their families to an ecosystem that gives them the highest quality of care for the lowest possible cost, at every stage of their lives.

WE'LL BE HERE FOR YOU

Financial strength and sustainability are key factors to consider when selecting a medical scheme. Sound financial control and risk management enable the Scheme to maintain its required solvency reserve levels which ensure its ability to pay claims even when they are unexpectedly high.

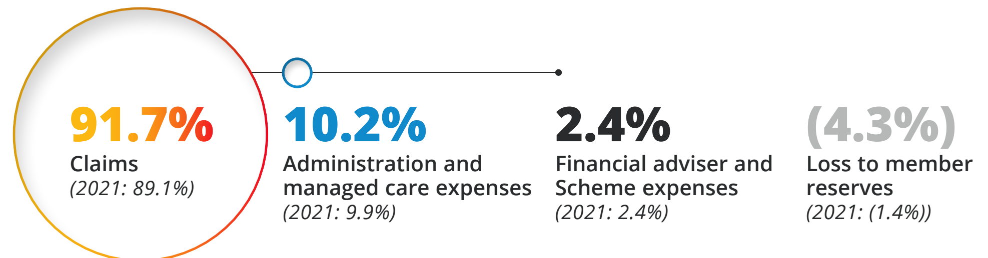
We make sure your investment in membership takes care of you

The Scheme's income is derived only from member contributions and investment returns. The Scheme pools all contributions to fund members' claims, and any surplus funds are transferred to Scheme reserves for the security and benefit of members.

In setting member contributions for each year, the Scheme aims to ensure sufficient contribution income to pay all claims, and to generate a modest surplus to meet regulated solvency requirements and maintain a cushion against unexpected cost increases[1]. This accords with the fundamental operating principles of a non-profit organisation that must meet the claims needs of its members as well as maintain a minimum statutory level of reserves.

A small portion of income (shown below) is used to fund activities that benefit our members and ensure the Scheme's sustainability. These activities include administration, managed care, financial advisers and the daily operations of the Scheme. Apart from the portion allocated to reserves and these activities, the remainder of the Scheme's income is used to fund claims.

2022 Expense breakdown

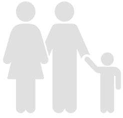


COVID-19 lockdown measures and concerns about infection risks at places of care introduced radical shifts in healthcare seeking behaviour during 2020, resulting in 3.5 million fewer member claims than in 2019 and 76.5% of Scheme income funding claims (versus 87.3% in 2019). Members began to increase their healthcare utilisation again over the course of 2021, resulting in increased numbers of claims (54 556 179 in 2021 compared to 47 675 525 in 2020) and an increased percentage of Scheme income spent on funding claims (2021: 89.1%). In 2022, the number of claims continued to increase to 55 755 192[2], with 91.7% of the Scheme's income funding claims.

The Scheme's ability to defer contribution increases three times to 1 July 2021, 1 October 2022 and 1 April 2023, providing relief to its members and passing on the benefit of excess reserves, has given effective relief of approximately R8.6 billion to our members.

1 *These may relate to various sources of healthcare inflation, and include uncertainty about the timing and severity of the disease burden that is expected to cause increased utilisation post-COVID-19.*

2 *Total claims made in 2022 extracted during February 2023; claims incurred during 2022 but not submitted by the date of extraction are not included.*



WELLTH *fund*

COVID-19 has had an extraordinary impact on the healthcare choices we make, with many deferring their routine, preventative care over the last three years. This results in disease being identified at later and more severe stages, an issue of high concern to the Scheme. To respond to this trend and better support preventative care and the long-term health of our members, we have committed to a significant investment[1] in member health by introducing the WELLTH Fund in 2023.

The WELLTH Fund is an advanced wellness benefit that will give members discretionary access to a range of tailored preventive screenings and other wellness checks. The benefit is activated once all beneficiaries on a policy have completed their health checks from 1 January 2022 onwards, and offers members up to R10 000 per family for a comprehensive set of screening and prevention care services.

We urge members to work with their GPs to identify the best ways to use this benefit, so that it can be tailored to their specific health needs and concerns.

The WELLTH Fund is an advanced wellness benefit that will give members discretionary access to a range of tailored preventive screenings and other wellness checks.

1 *Based on budgeted investment.*

About our report

Our Integrated Report demonstrates the accountability of the Trustees of Discovery Health Medical Scheme (DHMS or the Scheme) to our members in the context of our core service to our members. This constitutes best practice in medical schemes governance and thought leadership in our industry.

This is our primary report to our members, the Council for Medical Schemes (CMS), and other stakeholders of DHMS. It provides a holistic assessment of our governance, business model, strategy, performance and outlook in relation to our material risks and opportunities in the South African private healthcare industry.

Our Report sets out the Scheme's efforts to work in the best interests of our members, while balancing the needs and expectations of our various stakeholders. Achieving this balance underpins the Scheme's financial, operational and relational wellbeing. In turn, as the largest open medical scheme in the country, this supports the overall capacity and viability of the private healthcare industry and the betterment of the national healthcare system.

Board of Trustees responsibilities and approval

The Trustees are committed to providing our members with accurate and reliable information. We recognise our responsibility to assure the integrity of the Integrated Report and are confident that it covers all material matters, complies with the Scheme's responsibility to account for its operations and performance, and serves as a transparent, integrated source of information for all stakeholders.

The Trustees are satisfied that this Report complies with the requirements of the Medical Schemes Act (the Act), as amended, the Scheme Rules, International Financial Reporting Standards, and all additional financial reporting requirements of the CMS. The Trustees are also satisfied that the Scheme has adequate resources to continue with its operations into the foreseeable future. The Scheme's Financial Statements have therefore been prepared on a going concern basis.

Signed on behalf of the trustees on 20 April 2023

John Butler
Chairperson

Johan Human
Trustee

Charlotte Mbewu
Principal Officer

Scope and boundary

This Report covers the benefit year from 1 January 2022 to 31 December 2022, also referred to as the 2022 financial year (the year). In addition, it discusses material developments in early 2023, up to the date of approval of this Report by the Trustees.

The boundary of this Report includes an assessment of our propositions, interactions and outcomes related to key stakeholders, which underpin our ability to create, preserve and limit any erosion of value for our members. This is in line with the Scheme's regulated mandate to act in the best interests of our members, and our business model as a centre of excellence for medical schemes governance.

In line with our Vested® outsourcing model, the Scheme contracts with Discovery Health (Pty) Ltd (Discovery Health) as its administration and managed care provider.

In this Report, the terms the 'Scheme, 'DHMS', 'we' and 'our' refer to Discovery Health Medical Scheme. The terms 'Discovery Health' and 'our administration and managed care provider' refer to Discovery Health (Pty) Ltd.

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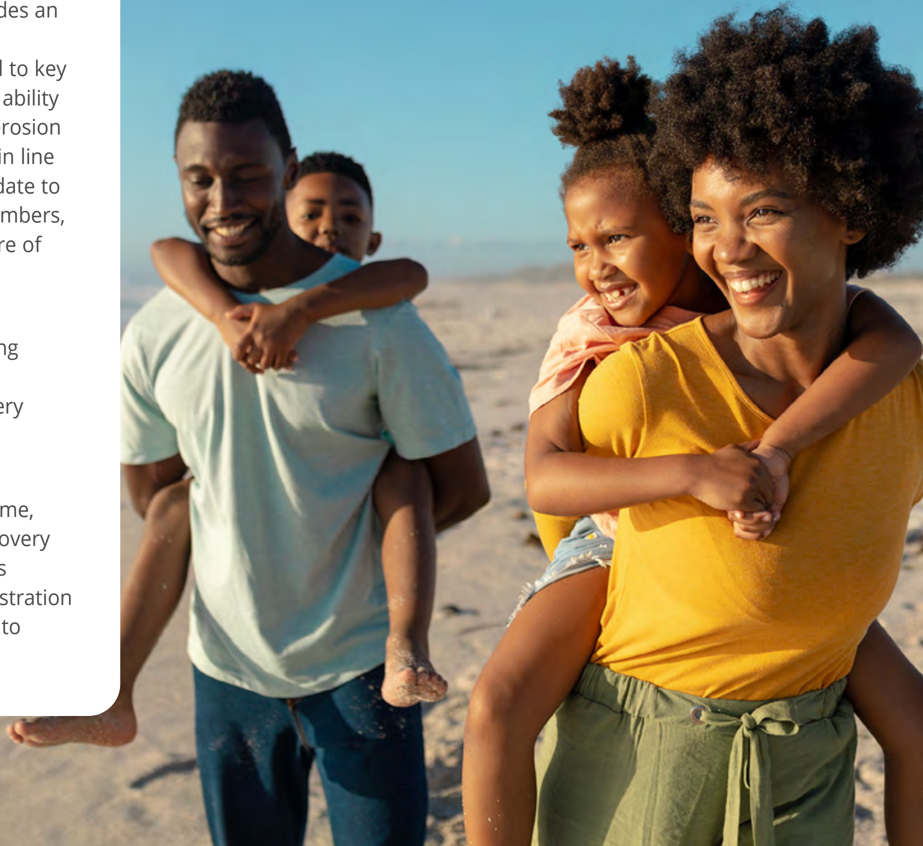


Process disclosures

Reporting frameworks

The Scheme takes guidance from the King IV™ Report on Corporate Governance for South Africa 2016 (King IV), the SAICA[1] Medical Schemes Accounting Guide, and uses the International <IR> Framework (January 2021) of the Value Reporting Foundation[2] as the basis for preparing and improving its reporting. The IIRF is applied insofar as it is relevant and applicable to medical schemes in South Africa.

We consider our 2022 Integrated Report to be as fully aligned to the International <IR> Framework (January 2021) as is possible while still meeting the requirements of our regulatory stakeholders.

Materiality determination

The Trustees are responsible for determining and effectively managing the matters that materially impact the Scheme's ability to create and preserve value, or that may erode value, thus affecting the sustainability of the Scheme over time.

On at least an annual basis, the Scheme's management team engages in workshops on strategy and objectives for the year ahead and beyond, and a strategy workshop is held with the Trustees. These discussions include the broader healthcare, economic, social and political environment as well as specific considerations of product and benefit enhancement opportunities, in concert with risks and opportunities that the Scheme and Discovery Health have identified. The positions of stakeholders are an integral part of these discussions, underpinned by a defined framework and methodology to identify stakeholder groups, assess their needs and interests, and evaluate the impact of these on the Scheme, and vice versa.

The identification of material matters emerges from these discussions and, in addition, the Trustees consider Board and Scheme Office reports, the Scheme's risk register, and formal and informal stakeholder interactions when subsequently considering and approving the material matters for inclusion in this Report.

1 *South African Institute of Chartered Accountants.*
2 *Formerly the International Integrated Reporting Council.*

Auditor independence

PricewaterhouseCoopers Inc. has audited the Scheme's Financial Statements (comprising the statement of financial position at 31 December 2022, the statement of comprehensive income, the statement of changes in funds and reserves and the statement of cashflows) and the notes to the financial statements for the financial year ended 31 December 2022.

Details of fees paid to the external auditors for audit and non-audit services, where applicable, are included in the Financial Statements. The Scheme has a formal policy governing non-audit services and the relevant fees and nature of the work has to be disclosed to, and approved by, the Audit Committee.

Rotation of the designated partner forms part of the independence assessment, and the current audit partner assumed the role for the audit of the financial year ended 31 December 2019. The Audit Committee is satisfied that the auditor remains independent of the Scheme. There were no non-audit services procured from the external auditors for the year ended 31 December 2022.

MANDATORY AUDIT FIRM ROTATION

On 1 June 2017, the Independent Regulatory Board for Auditors (IRBA) issued a rule on mandatory audit firm rotation for auditors of all public interest entities, as defined in section 290.25 to 290.26 of the amended IRBA Code of Professional Conduct for Registered Auditors. This requirement is effective for financial years commencing on or after 1 April 2023. PricewaterhouseCoopers Inc. has been the Scheme's auditor for 22 years; the Scheme is therefore required to appoint a new auditor for the financial period beginning 1 January 2024.

During the year, the Audit Committee embarked on a rigorous process to find a suitable auditor to take over from PricewaterhouseCoopers Inc. A request for information was submitted to various firms accredited by the Council for Medical Schemes to audit medical schemes. Only three audit firms responded to the request and all three firms were requested to submit a proposal. Presentations were made to the Audit Committee on 31 August 2022 and the Audit Committee's recommendation, as approved by the Board, will be tabled at the Scheme's 2023 Annual General Meeting.

Report preparation and approval

Under the direction and oversight of an experienced and expert executive, Scheme management is responsible for the preparation of the Integrated Report.

- The Head: Special Projects and Stakeholder Relations is responsible for gathering, vetting, drafting and co-ordinating reviews and approval of qualitative and quantitative information submitted by relevant content owners.
- Support, in the form of content provision and verification, is provided by specialist internal and Discovery Health functions such as governance, regulatory, clinical, financial, actuarial, risk management and strategy development and implementation.
- Subject matter experts contribute to data validation, interpretation and contextualisation to ensure that the data relating to the Scheme's initiatives is accurately presented in the Integrated Report.
- The reporting project team has unfettered access to the Chairperson of the Board, the Principal Officer, Scheme management and Committee Members, who provide input during report preparation and review and approve relevant sections before these are submitted to the Board for review.
- Following a detailed review by the Audit and Stakeholder Relations and Ethics Committees, the Audit Committee recommends the Integrated Report to the Trustees for approval.
- External auditors provide independent assurance of the Financial Statements.
- Finally, the Trustees approve the report for publication and submission to the CMS.

Combined assurance

The Scheme uses a combined assurance model, which is a risk-based methodology to obtain assurance on the controls across the Scheme's key activities. The internal reporting related to the assurance process provides insight and data that are applied in preparing the Integrated Report.

1st LINE: Scheme management provides the Trustees with assurance that internal control and risk management is integrated into the day-to-day running of the Scheme and that it is monitored on an ongoing basis.

2nd LINE: The outsourced Group Risk Management and Compliance functions assess the effectiveness of the Scheme's internal control and risk management processes.

3rd LINE: Management and the Trustees obtain external assurance on the Scheme's financial performance and internal control frameworks from the Internal Audit function, the external auditors and an independent actuarial firm.

03 Our value story

Our operating context

Medical scheme operating principles

Medical schemes in South Africa are non-profit entities that operate according to social solidarity principles, in a complex but incomplete regulatory environment, specific to medical schemes.

The principles of social solidarity mean that medical schemes must accept all prospective members who wish to join; members are community risk rated so there is no differentiation of pricing based on, for example, the status of an individual's health or age; and members' funds are pooled to provide healthcare funding in an equitable manner thereby providing our members access to healthcare services. Schemes must therefore charge the same contribution rate for a specific benefit plan to all members on that plan.

Medical schemes in South Africa are non-profit entities that operate according to social solidarity principles.

Due to limitations within the regulatory environment in which medical schemes operate, medical schemes are vulnerable to anti-selection, where members may choose to join and leave schemes at times when they have particular healthcare needs. This undermines the ability of schemes to keep contributions lower. It is estimated[1] that should mandatory membership for economically active citizens be implemented, as was originally intended, this would lower contribution rates for all scheme members by approximately 20%.

Economic principles in the healthcare industry differ from most other industries, where pricing is driven by supply and demand. With members paying schemes to insure their healthcare needs and fund these as they arise, they are removed from the pricing of healthcare services as schemes fund these on their behalf. The market therefore does not self-regulate pricing and so the role of schemes in negotiating prices is vital in mitigating healthcare inflation in an environment of mostly unregulated healthcare prices (with the exception of medicines pricing).

Schemes therefore work constantly to negotiate the best pricing from healthcare providers on behalf of their members.

Some of this is done through the creation of designated service provider (DSP) networks, thereby achieving lower prices from the volume of members making use of the DSP network. Schemes may impose a co-payment on members who choose to utilise healthcare providers who are not part of the network, as the lower pricing is dependent on members making use of the network.

1 *It has been estimated that prices in a voluntary environment are some 17%–23% more expensive than they could be under mandatory cover (McLeod & Grobler, 2009). Similarly, it is estimated that open scheme contributions could be lower by 23% in an environment without anti-selection (Childs, 2012)." Source: Anti-selection in voluntary health insurance markets: A focus on medical schemes in South Africa by R Harris and S Besesar, published in the South African Actuarial Journal in 2021.*

Medical scheme governance and regulation

Medical schemes must be registered with the Council for Medical Schemes (CMS) subject to the provisions of the Medical Schemes Act (the Act). The Act established the CMS to regulate registered medical schemes and to protect the interests of scheme members, among other functions.

SECTION 7 OF THE ACT DESCRIBES THE CMS's RESPONSIBILITIES, WHICH INCLUDE:

- Establishing that medical schemes are financially sound, with sufficient contributing members;
- Checking and confirming that medical schemes do not unfairly discriminate against any person on arbitrary grounds;
- Investigating complaints in relation to the affairs of medical schemes;
- Conducting routine monitoring, and regular and specific inspections on schemes regarding appropriate governance and adherence to the Act and Regulations;
- Protecting the interests of beneficiaries at all times; and
- Making recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of the relevant health services provided by medical schemes.

The CMS interacts frequently with the industry and regularly publishes circulars to guide medical schemes on interpreting and implementing the Act. It approves the benefit plans and rules of each scheme, with the latter being binding on the scheme, its members, officers and any person who claims any benefit. The CMS also vets scheme Trustees[1] and principal officers.

The CMS accredits medical scheme administration and managed care providers, as well as the financial advisers who advise the public on private healthcare cover. The Minister of Health annually prescribes the fees paid by medical schemes to financial advisers.

Schemes are governed by independent boards of trustees responsible for overseeing the business of the scheme. In terms of the Act, at least half of the trustees must be elected from among the members.

1 *The Scheme's Nomination Committee provides an additional layer of oversight in approving the vetting of nominees and candidates eligible for election.*

2 *Based on beneficiaries, according to the CMS Annual Report for the year ended December 2021 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/).*

The industry landscape

At the end of 2021, there were 72 medical schemes registered with the CMS, consisting of 17 open schemes and 55 restricted schemes, covering over 8 945 000 beneficiaries (2020: 8 896 000)[2]. These schemes paid out approximately R205 billion in total healthcare benefits[3] in 2021 (2020: R178 billion). The average age of total registered scheme members in 2021 increased by 0.1 years to 33.7 from 33.6 in 2020, and the proportion of pensioners increased to 9.1% from 9.0%[4].

Scheme income and pricing

Schemes derive income only from member contributions and investment returns earned on members' funds. Benefit plans are priced for the following year based on tariff increases and the impact of supply and demand including the utilisation of healthcare services, financial performance, the demographics of the particular scheme, and financial and actuarial forecasts. The pricing of contributions is a function of balancing utilisation, scheme sustainability and affordability for members, with other imperatives. Medical schemes must hold sufficient reserves to weather times of economic difficulty and unexpected claims, providing for variations in utilisation and escalation in the cost of treatment, optimising benefits according to appropriateness, costs and the health needs of scheme membership, and equitable treatment of all scheme members.

As the demographic characteristics of members differ between schemes, for example the percentage of members suffering from chronic conditions, each scheme has unique pricing needs and constraints. An industry risk adjustment mechanism was intended to be implemented[5] to balance the relative risk between schemes, which would contribute greatly to medical scheme financial stability and sustainability. This mechanism would require an equivalent basket of benefits across all schemes to be in place. These mechanisms were recommended by the Health Market Inquiry to "create a market environment conducive to effective competition on pro-consumer metrics".[6]

3 *Total healthcare benefits paid refers to the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members.*

The outlook for medical schemes

In 2022, the demise of Health Squared Medical Scheme (HSMS) was announced. While all the factors contributing to this are not known, HSMS's solvency had reached 2.15% by the end of July 2022 compared to the regulated minimum requirement of 25%, and was projected to be between 0.2% and 2.3% by the end of the year. At the end of 2019, HSMS had the highest average age across all open medical schemes, with almost 26% of beneficiaries older than 65. HSMS reported that COVID-19 claims contributed to its deteriorating financial position.

In contrast, the majority of medical schemes' solvency position improved during the pandemic, driven by reduced utilisation emanating from lower healthcare seeking behaviour by members, and postponement or cancellation of elective surgeries during the national lockdown. Schemes have sought to utilise these excess reserves to the benefit of members in various ways; Discovery Health Medical Scheme (DHMS or the Scheme) has specifically chosen to defer its contribution increases three times to provide financial relief to members.

HSMS serves as an example of how quickly a scheme can deteriorate if its key sustainability metrics become unbalanced. With unprecedented dynamics leading to uncertainty around utilisation and the appropriate level of contribution increases, correct pricing is essential to ensure the long-term sustainability of schemes.

4 *Source: Annexures to the CMS Annual Report 2021–2022. Data includes both open and restricted schemes, but does not include data for 2022 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/).*

5 *The incomplete regulatory framework under which medical schemes operate has a significant negative impact on the sustainability of medical schemes and the scale of contribution increases. The Health Market Inquiry explains: "The Medical Schemes Act No 131 of 1998 (MSA) introduced Prescribed Minimum Benefits (PMBs), along with community rating and open enrolment ... It was envisaged that these policies would be accompanied by further social solidarity principles including mandatory membership and a risk equalisation mechanism ... The Council for Medical Schemes (CMS) continued to work towards a risk equalisation fund (REF) and developed a shadow REF process. This work stalled when the country's focus shifted towards universal health coverage and the National Health Insurance (NHI)." Source: "A discussion of the need for and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition" document (1 December 2017). As reported in the Taylor Committee Report (2002), the NHI Committee (1995) recommended that a risk-equalisation mechanism be introduced as part of a system requiring the mandatory membership of medical schemes.*

6 *Source: Health Market Inquiry Final Findings and Recommendations Report, September 2019.*

Medical Scheme Pricing Dynamics

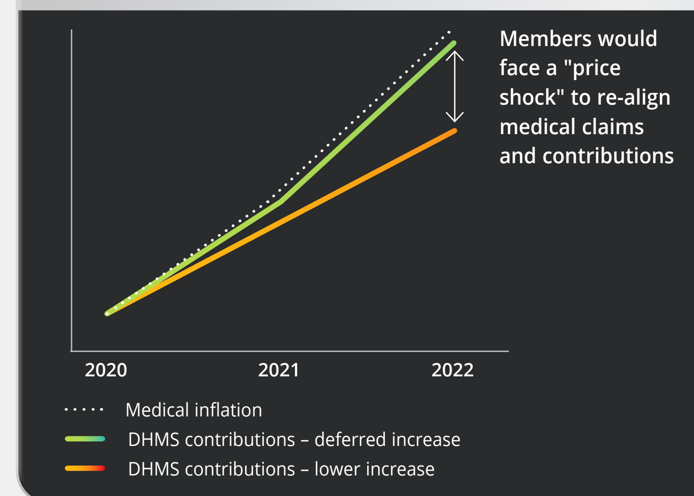
Medical schemes must continually balance affordability, sustainability and enhancement to benefits. Members have short-term affordability expectations, within their financial constraints, but the scheme must be sustainable to take care of members' future healthcare needs.

Schemes price contributions to match expected claims for the forthcoming year (taking into consideration utilisation and healthcare inflation), and for a modest surplus to meet regulated solvency requirements and maintain a cushion against unexpected future events. Prior to COVID-19, DHMS' contributions were matched to claims in this way.

In 2020, utilisation lowered substantially meaning that schemes accumulated excess solvency through unexpected surpluses.

In 2021, DHMS deferred the contribution increase for the first time, ensuring member affordability and returning excess solvency to members. During 2021, utilisation started to increase but remained below expectation, which meant that in 2022 and for 2023, DHMS was able to defer the increase again. At the time of writing this Report, utilisation is almost back to expected levels in relation to long-term healthcare inflation.

This strategy has maintained DHMS' stability and ensured no future corrections will be required to mitigate lower contribution increases. The graph alongside shows the gap that would have occurred if DHMS had followed a strategy of lowering its contribution increases to no longer align with healthcare inflation.



Uncertainty continues into 2023 as utilisation levels are unpredictable, effects of Long COVID unclear, and as COVID-19 variants continue to arise with unpredictable characteristics of transmissibility and severity. Mental health continues to be of increasing concern and is one of the largest contributors to scheme expenditure along with chronic conditions such as cancer, diabetes and metabolic syndrome. The burden of disease in scheme populations is exacerbated by factors that have become increasingly evident, including aging scheme membership and stagnant membership growth. This impacts schemes' risk pool cross-subsidisation as the young and healthy subsidise an older population.

Increasing access to healthcare is a priority for the country and within the medical schemes industry. Many people are unable to access medical scheme membership due to affordability constraints. To fund their healthcare needs, they must either pay out-of-pocket for private care, or pay for public care according to their financial means[1]. This burden would be greatly relieved in the short term by providing a Low-Cost Benefit Option (LCBO), which would provide access to tax credit through SA's tax regulations. Additionally, it would improve access to preventative care and care co-ordination, benefitting the nation's health and productivity, and easing the burden on public healthcare resources. This is consistent with South Africa's pathway to Universal Health Coverage (UHC). The CMS has indicated that the LCBO framework is a priority for 2023, and the industry is working to support and contribute to this work.

The industry is cognisant of the impact of decreasing gross domestic product, high inflation and high unemployment on current and prospective scheme members, resulting in less ability to afford scheme membership. The CMS, together with medical schemes, has a vital part to play in facilitating access and supporting schemes in keeping contribution rates as low as possible. Key drivers for medical schemes include cost containment and improved member health through the use of new technology, screening, implementation of value-based disease prevention and management programmes, and reducing the fragmented nature of care. An increasing focus on quality of care – through better understanding and measurement of process and outcomes and developing industry-wide reporting – provides opportunities to support healthcare providers in achieving better health for members.

It is vital for the industry to partner and collaborate with government, business, labour and civil society stakeholders to optimise the regulatory environment and healthcare system. Opportunities for collaboration will ensure the continued existence of our healthcare system, and equitable access to it, for the benefit of all citizens.

1 *The Department of Health makes use of a means test used to determine who is eligible for free or discounted fees at public facilities. The poorest households are entitled to free healthcare, those on modest incomes are charged subsidised rates and those that earn more than the upper threshold of the means test must pay in full.*

Our material matters

We exist for our members, with their health and wellness at the heart of what is most important for the Scheme.

The Scheme's material matters are the most important factors affecting our ability to create sustainable value for our members, underpinning the financial, operational and relational wellbeing of the Scheme in a complex operating environment. These matters provide the context for ongoing Board discussions and are formally reviewed by the Board of Trustees (the Board or the Trustees) on an annual basis.

Our material matters are derived from an assessment of the emerging events, risks and opportunities in our operating context, and the needs and concerns of our members and other stakeholders. They reflect factors both outside of and within our control. Careful management of the latter presents opportunities for the Scheme to differentiate our product and service offerings, protect our market position and enhance our reputation – all of which contribute to the Scheme's long-term sustainability. As such, they inform our strategic themes and associated objectives, and incorporate our residual risks.

To ensure we can continue to fund the healthcare needs of our members, the financial sustainability of the Scheme and the affordability of contributions must be maintained in a context of challenging economic conditions, healthcare system reform and healthcare inflation, the drivers of which include demand- and supply-side factors and fraud, waste and abuse (FWA) in the industry.

We deliver services to our members through our contractual relationship with Discovery Health. The relationship is governed by the Vested® outsourcing model, a critical factor in our ability to manage these interrelated material matters most effectively.

Our four material matters

CARING FOR OUR MEMBERS

ECONOMIC GROWTH

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

CARING FOR OUR MEMBERS

Healthcare costs increase as our membership average age and burden of chronic non-communicable diseases increases over time; the long-term effects of the pandemic (including Long COVID and less healthcare seeking behaviour) also contribute to increased costs.

Additionally, the rapid development of medical technology, often resulting in high-cost and highly individualised treatments, results in increased costs. The healthcare landscape will continue to change over the short and long term, and factors like the possible long-term effects of COVID-19 and the health impacts of climate change and pollution must be monitored and responded to. Affordability remains a primary concern for our members as unabating healthcare inflation and a struggling economy place consumers under immense financial pressure.

DHMS works to provide members with high-quality, value-based and member-centred healthcare journeys that incorporate leading healthcare technology and treatments, encouraging active participation in their physical and mental health and wellbeing; this is balanced with Scheme sustainability and affordability and equitable treatment of all members.

ECONOMIC GROWTH

Sustained low economic growth, high inflation, escalating interest rates, long-term impacts of the pandemic, global developments such as the Russia-Ukraine war, and domestic infrastructure challenges cause extensive long-term damage to the country. Low economic growth – further impacted by restricted household incomes and affordability constraints – results in low or negative jobs growth, causing muted or negative membership growth for the medical scheme industry. Membership growth is vital for the sustainability of the industry as it brings young healthy lives into the system and enables cross-subsidisation.

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

Our stakeholders give us our regulatory and social licences to operate, and our interdependent relationships with them enable us to care for our members. Partnerships with government, business, healthcare providers and the broader industry offer opportunities to co-create a stronger, more affordable and accessible healthcare system, but barriers include inadequate governance, controls and capacity in the broader business and political environments.

Understanding of and a collaborative approach to benefit design and healthcare funding models with our stakeholders can facilitate equitable access to advanced high-cost health technologies and treatments, and the broader accessibility of population care and wellness. An environment of ethical leadership and social responsibility to society by all sectors, based on a genuine desire to serve the South African population and incorporating best practice governance, is essential to steer our country through these difficult times.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

How both public and private healthcare will look in the future is uncertain, and challenges abound in both sectors, including lack of regulatory reform and incomplete implementation; the prevalence of FWA and corruption; lack of economic growth and healthcare inflation; quality of care; shortage of nurse, doctor and allied professional skills; and affordability and access. If we are to achieve effective levels of care for all South Africans in the spirit of social solidarity, then innovation, competition and collaborative partnerships are essential.

It is essential that we manage the ongoing impact of diseases such as COVID-19 in terms of utilisation, treatments and funding, as well as driving opportunities such as digital health capabilities to optimise access and efficiencies, and offer new platforms for healthcare delivery. What we have learned from the pandemic can become part of our national memory and enable future agility and co-operation.

Our material matters are derived from an assessment of the emerging events, risks and opportunities in our operating context, and the needs and concerns of our members and other stakeholders.

Our strategic themes

Our holistic view of value for members encompasses their health and wellness needs, quality of care and appropriateness of healthcare services, balanced with the cost efficiency and financial sustainability of the Scheme and the affordability needs of members.

Our four strategic themes

Our purpose and our vision guide our strategy which remains adaptive and responsive to our operating context and the evolving needs of our members and other stakeholders. The Trustees and Scheme executives annually review and agree the material matters, which inform the Scheme's strategic objectives for the coming year.

We continually review internal and external factors in line with our business model to identify, mitigate and manage our residual risks, seeking opportunities to optimise value outcomes for our members while ensuring the long-term sustainability of the Scheme. Our strategic themes respond to our material matters with due consideration of broader healthcare trends, while delivering on the related objectives mitigates our residual risks.

Two formal strategy planning sessions are held annually: the first with Scheme executives, and the second with Scheme executives and the Trustees, with input from Independent Committee Members. Both include input from external advisers and a review of Discovery Health's strategy to support the Scheme's objectives.

High-level objectives are broken down into work streams, with key performance indicators set to measure progress and assess associated outcomes. Work streams may continue over several years or longer, depending on the complexity and timeframes of their objectives.

Work streams and related objectives are adjusted in response to changing circumstances, with related policies and planning being reviewed and approved by the Trustees as required. Oversight of the work streams is delegated to relevant Board Committees, according to their terms of reference. In certain instances, the Trustees may resolve to establish an ad hoc committee with delegated oversight of specific objectives. The Scheme Office interfaces with these Committees and the Board, and reports regularly on operational oversight, monitoring, and mitigating emerging risks.

The Scheme's objectives and work streams are closely tied to our performance management methodology, designed to reward excellence and foster a culture of continuous improvement, learning and development for our employees.

Our purpose and our vision guide our strategy which remains adaptive and responsive to our operating context.

PERFORMANCE AGAINST OUR STRATEGIC THEMES IN 2022

1 Caring for our members

Driving value-based care centred on our members informs all strategies to expand existing and implement new care programmes, utilising innovative alternative reimbursement models wherever possible. Our funding policies aim to manage healthcare inflation while expanding appropriate interventions in response to members' needs.

In 2022, we continued to focus on holistic management of prevalent chronic diseases such as diabetes, mental health, and oncology. We also continued to promote our innovative digital capabilities such as the Hospital at Home programme, which offers members with selected conditions the option of being cared for in the comfort of their own homes. In addition, we partnered with MyhealthTeams, giving members access to online patient communities where members affected by certain conditions (currently diabetes, heart disease and COVID-19) can join and receive information and support from other patients, caregivers, doctors, and researchers.

The negative impacts of COVID-19 on mental health continue to be seen across the globe. The pandemic has also resulted in deferrals of screening and preventative care measures, which may result in delayed diagnosis, advanced disease at diagnosis and complications, accompanied by increased treatment costs, reduced quality of life, and increased mortality rates. To mitigate these risks, the Scheme invested in research and development which provided the rationale for enhancing 2023 primary healthcare, selected additional screening investigations and oncology benefits. This research was also the basis for developing innovative ways to expand members' access to care (including virtual healthcare), most of which will be deployed in 2023. Additionally, we actively engaged with patient advocacy groups, doctor societies and other stakeholders to collaborate towards optimal care for our members.

Over 2023, we will continue to develop all available opportunities for members to access affordable and appropriate, high-quality care. Areas of focus for the forthcoming year will include disease prevention and early diagnosis enabled by risk-funded benefits for regular age- and risk-appropriate health checks and the new WELLTH Fund Benefit. In collaboration with members' healthcare providers, we also aim to leverage digital health solutions to enable quality care in members' homes, provide access to virtual urgent care, digital therapeutics for mental health and virtual musculo-skeletal rehabilitation. We believe that, by building customer journeys around our members, we can optimise their healthcare experience and engagement.

Our strategic opportunities inform the determination of our material matters. As such, our strategic themes indicate how we are managing the constraints to our capital inputs, and what actions we are taking to achieve our intended outcomes.

2 Sustainability and membership growth

The Scheme's growth, demographics, financial strength, ability to pay claims, and sustainability over the long term are of critical importance to our members. The Scheme closely monitors and measures its performance on these and other metrics to ensure that critical performance levels are met, and actively searches for opportunities to support membership growth in a stagnant market.

These opportunities may include amalgamations with other schemes, engaging with regulators on policy developments that may affect membership, and ensuring that our plans and benefits appeal to the full range of potential members. This is important to counter anti-selection, where young and healthy people may opt out of medical scheme coverage until they are older and have a higher need for medical funding.

We continue to advocate for the introduction of LCBOs in schemes, as these assist new members to access private healthcare in a highly affordable price range.

In 2022, membership grew by 22 532 principal members (2021: 22 499)[1], even while other industry players are experiencing a decline in membership due to the challenging economic environment. Our focus on retaining members contributes to the stability and sustainability of the Scheme, and member satisfaction and our plans' comprehensive benefits mean that few members have moved from higher to lower plans.

Our investment strategy received close attention in 2022 which will continue over 2023 as we respond to the high level of risk in the economic environment with consideration of responsible investing practices. In 2021 the Trustees adopted an updated Responsible Investing Policy which integrates environmental, social and governance (ESG) factors with our investment strategy, active ownership activities and investment screening. Accordingly, our investment managers continue to embed ESG principles, using the Scheme's assets to have a positive influence on the world while earning excellent returns to safeguard our members' continued access to healthcare.

In 2023, we will continue to ensure the Scheme's strength and sustainability by pursuing further growth and amalgamation opportunities; we have seen that a 1% growth in the Scheme leads to a 0.5% reduction in claims, enhancing our ability to minimise contribution increases. We will also continue to closely manage our investment strategy to align to risk and required solvency levels, and we look forward to the launch of the Dynamic Smart Essential Plan which should attract new members, lead the way in dynamic network capabilities, and optimise efficiencies and care for our members.

Our strategic opportunities inform the determination of our material matters. As such, our strategic themes indicate how we are managing the constraints to our capital inputs, and what actions we are taking to achieve our intended outcomes.

Medical scheme contribution increases must balance long-term sustainability and short-term affordability

When there is uncertainty regarding medical inflation, medical schemes must trade off long-term sustainability against ongoing affordability to determine an optimal contribution increase strategy. Lower increases favour short-term affordability, but compromise the ability of schemes to continue to meet the costs of claims without benefit reductions or larger contribution increases in the future. Higher increases mitigate the risk operating losses, but lead to unaffordable contributions over time. An effective contribution increase strategy must strike the optimal balance between long-term sustainability and short-term affordability for members.

1 Net principal member increase at 31 December 2021 vs 2020 and 2022 vs 2021.

Performance against our strategic themes in 2022 *continued*

3 Regulatory and policy developments

The Scheme continues to monitor the progress of the National Health Insurance (NHI) Bill and conducts extensive and detailed work in responding appropriately to all policy and regulatory changes to promote the best outcomes for members. Industry engagements and broader policy considerations also take place through our industry body, the Health Funders Association (HFA) and Business Unity South Africa's (BUSA's) Health Policy Subcommittee. We are committed to maintaining and enhancing our relationships with regulatory authorities and industry stakeholders as we believe this is key to ensuring beneficial outcomes for all.

In 2022, the Scheme continued to engage with the CMS on several regulatory and policy matters, including an ongoing series of discussions regarding the Scheme's LCBOs. The Scheme also continued to follow up on the publication of the final Section 59 Investigation Panel's report, which has been delayed. The interim report found no evidence of intentional or explicit racial bias in any of the processes or methodologies carried out on our behalf by Discovery Health, and confirmed that our FWA processes are necessary and justifiable given the significant risk and implications of losses to medical scheme members.

In 2023, the Scheme will continue to engage on regulatory developments, working to enhance stakeholder relationships that promote outcomes that support the success and sustainability of the industry, with a focus on promoting wider access through such mechanisms as LCBOs.

Our strategic opportunities inform the determination of our material matters. As such, our strategic themes indicate how we are managing the constraints to our capital inputs, and what actions we are taking to achieve our intended outcomes.

4 Governance excellence

To fulfil their accountability to our members, the Trustees closely monitor the work of the Scheme Office and Discovery Health in their capacity as the Scheme's administration and managed care provider. Our robust governance structures and processes are compliant with the Act and all other applicable legislation. We take guidance from best practice corporate governance principles (as codified in the King IV Report on Corporate Governance for South Africa 2016) and the Scheme proactively makes submissions and provides responses to various regulatory bodies on issues relating to governance and compliance. The outcomes of our approach to governance are detailed in our business model, and in relevant chapters of this Report.

Given the risk of COVID-19 infection and spread, the Trustees resolved to hold a virtual Annual General Meeting (AGM) in 2022. The virtual AGM was a success and incorporated Trustee elections. No special general meeting was convened in 2022.

We plan to hold a physical AGM in 2023 and will be working with a new independent electoral body, due to auditor rotation requirements and to prevent any conflict of interest. We will also focus on implementing our updated innovation framework and Vested roadmap, and strengthening our governance.

Our residual risks

DHMS closely monitors the highly regulated and rapidly-changing healthcare landscape, to identify and mitigate risks, and to optimise value outcomes for our members.

The Scheme continually scans the internal and external environment to assess risks and opportunities associated with our material matters, strategic themes and the core capitals used and affected by the Scheme. A Board-approved enterprise risk management framework, risk appetite framework and statement according to which risks are assessed is in place, and risks are rated according to impact and likelihood on a five-point scale, ranging from low to catastrophic. This process enables us to identify risks to the financial, operational and relational wellbeing of the Scheme and opportunities arising from effectively managing these risks.

This risk assessment covers the Scheme's dependence on the resources and relationships represented by the various forms of capital that pertain directly to our core service to our members and business activities, as well as more broadly. This ensures that emerging risks are included in the scope of assessment, for instance the impact of climate change on disease vectors of climate change. Risk responses and mitigation plans to manage the risks to an appropriate level within the risk appetite framework are developed and monitored by Scheme management, and risks that remain above appetite are given close attention with activities undertaken to lower the risk. Management conducts regular reviews and reports to the Risk Committee, to other Board Committees where relevant, and to the Trustees.

DHMS currently has no catastrophic risks; a description of the Scheme's high and medium-high residual risks and the associated mitigation strategies follow.

The Scheme continually scans the internal and external environment to assess risks and opportunities associated with our material matters, strategic themes and the core capitals used and affected by the Scheme.

Scheme sustainability, affordability of contributions and medical inflation

RISK DESCRIPTION AND IMPACT

Demand-side factors (such as age, gender, chronic status, and anti-selective behaviour) and supply-side factors (such as health technology, pricing and provider-driven increases in utilisation), as well as cost pressures from fraud, waste and abuse are driving above-inflation increases in healthcare costs. This risk is exacerbated by financial and economic pressures as well as a worsening chronic disease profile in the population, and entails a degree of uncertainty due to the potential impact of Long COVID, affecting utilisation which in turn could impact the affordability of our contributions.

MITIGATING ACTIONS

- Each year, the Trustees carefully assess the benefit plans offered by the Scheme to ensure the full spectrum of member needs are met within the confines of affordability and sustainability. Due to the excess build-up of reserves in 2020 and 2021, the Scheme was able to protect existing members and attract new members through its pricing strategy, despite a low-growth environment. The Trustees' decision to defer contribution increases for 2021, 2022 and 2023 to provide relief to members has assisted them to maintain their scheme membership.
- Consideration is given to innovations that may lower healthcare costs while ensuring members have access to quality healthcare through value-based contracting, as well as the development of managed care programmes underpinned by a population health management approach, focused on non-communicable diseases and conditions, to support co-ordinated care and better-quality outcomes.
- The Trustees satisfy themselves that value for money is obtained from Discovery Health, along with other providers and suppliers, and that the Scheme's budget and expenditure is closely monitored and appropriately managed.
- Risk management interventions are implemented by Discovery Health on behalf of DHMS. These are guided by several strategic objectives, to ensure that care is accessed at the most appropriate and optimal level between secondary and primary level care setting, supported by quality health provider networks, and alternative reimbursement models.
- In keeping with the social solidarity principles on which the Scheme operates, active marketing and distribution strategies are developed and implemented to attract and retain members who enable effective cross-subsidisation.
- On behalf of the Scheme, Discovery Health actively monitors and negotiates prices of medicines, treatments and services offered to members. This includes evaluating supply chain dynamics and sourcing alternatives where appropriate. Discovery Health also actively monitors utilisation for the Scheme to enable agile responses to changes.
- Engagement with regulators to address concerns and propose appropriate guardrails in regulatory amendments to help protect the sustainability of the Scheme.
- Active participation in measures to combat FWA, including contributing to the development of industry codes of good practice; mandating Discovery Health to engage in activities to recoup funds incorrectly disbursed; and participating in an industry complaint to the Competition Commission, led by the HFA, regarding overpricing for polymerase chain reaction (PCR) tests during COVID-19 which estimates that medical schemes were overcharged by approximately R1 billion.
- Participating in industry activity towards optimising regulations and guidelines for measures that contain healthcare costs, for example for designated service provider networks, and utilising these to benefit members through new efficiency discount options.

Our risk environment informs the determination of our material matters, and as such indicates the potential constraints to our capital inputs. The intended outcomes we achieve for our stakeholders in turn mitigate our risks.

Policy, regulatory and compliance

RISK DESCRIPTION AND IMPACT

Changes in the regulatory environment and the requirement to manage these changes presents challenges to not only the healthcare industry, but our business model as well. These changes may have operational, compliance, financial and strategic impact on the Scheme. Areas of change include the Medical Schemes Amendment Bill, the National Health Insurance Bill, and changes in financial reporting requirements among others. Reforms currently underway could change the structure and operating requirements of the industry, introducing the risk of being assessed as not or only partially compliant with laws, regulations, rules and self-regulated Scheme standards and codes of conduct, including those related to our values and ethics. This may impact the Scheme's ability to operate effectively and efficiently, and introduces reputational risk. Specific regulatory changes may also negatively impact on our key stakeholders, and so the broader system must be taken into account in considering them.

The possible introduction of LCBOs, depending on the approved framework including a minimum benefit package and underwriting considerations among others, may exacerbate anti-selective behaviour; however, this also provides an opportunity for the Scheme to extend access to a previously uncovered section of the population and offer products currently only available through short-term insurance.

MITIGATING ACTIONS

- Regular, detailed and proactive engagement with relevant regulators at all stages of the regulatory change process, enabling an exchange of information and views, and greater certainty on changes the Scheme must make. This enables the Scheme to develop and implement compliance strategies that are both comprehensive and pre-emptive in anticipation of regulatory changes.
- Proposed amendments are subject to close assessment, including detailed research and analysis regarding potential impacts on the Scheme, our members and other key stakeholders, the healthcare industry, and the regulatory universe as a whole. Where appropriate, collaborative submissions are made with industry partners and/or representatives.
- The Scheme's views and positions are developed with input from independent advisers, industry associations and Discovery Health's extensive policy and regulatory capabilities, and with consideration of affected stakeholders. The Scheme utilises a risk-based approach for all external engagements, taking the rights and requirements of relevant stakeholders into account.
- Participation at public and industry forums, both individually and through industry associations, building of consensus with stakeholders on effective and enabling regulatory and legislative frameworks, detailed review of publications requiring commentary, and submission of considered and well-supported responses to support positive change for the industry.
- Operating in a highly regulated and complex environment requires extensive controls to ensure compliance; the Scheme safeguards compliance in all areas by utilising established and appropriate operational, oversight and assurance processes.
- Regulatory change is monitored closely, and plans are made well in advance of implementation dates to ensure requirements are addressed ahead of time.
- Existing processes are reviewed and improved, with the input of relevant stakeholders where required, to ensure continued compliance and responsiveness to external change, with independent assessments commissioned as necessary.

Our risk environment informs the determination of our material matters, and as such indicates the potential constraints to our capital inputs. The intended outcomes we achieve for our stakeholders in turn mitigate our risks.

Technology and information

RISK DESCRIPTION AND IMPACT

In an environment where the Scheme is heavily reliant on information technology for storage, communication, business processes and management to optimise opportunities it presents for members, security, and proper and ethical management is critical in ensuring we maintain the privacy of our stakeholders. The opportunities presented by technology include the provision of service and benefits, access to healthcare and information. Technology, however, brings with it risks of inadvertent, accidental or maliciously-driven system outages, data breaches, leakage or loss, financial loss and business disruption, all of which can impact the integrity and availability of information assets and the security of personal information. This can also result in regulatory implications.

MITIGATING ACTIONS

- Robust information security measures enable us to ensure the protection of Scheme information, particularly the personal information of our members.
- Cyber and information risk, including global trends of increasing malicious attacks by third parties, is closely monitored by the Scheme's IT Governance Forum, consisting of representatives from the Scheme and Discovery Health.
- Discovery Health, which provides the Scheme's systems infrastructure and applications, reports extensively on the associated risks, controls and compliance with service levels.
- New processes, systems and controls, including infrastructure and security measures, offering improved risk mitigation are continually assessed and implemented where appropriate.

Stakeholder management

RISK DESCRIPTION AND IMPACT

The risk of ineffective stakeholder engagement and management negatively impacting the Scheme's ability to perform optimally, and its reputation in the eyes of members and other stakeholders which may impact the Scheme's sustainability. Equally, effective stakeholder engagement, incorporating appropriate processes and controls where necessary, enables the development of improved understanding, information, achieving consensus where necessary, co-operation where possible, and the development of a stronger and more robust private healthcare industry.

MITIGATING ACTIONS

- The Scheme engages proactively and frequently with all stakeholder groups to understand their needs, engender better understanding of the Scheme and promote alignment with its objectives. Where gaps and opportunities are identified, improvements in processes and governance of stakeholder relationships are instituted.
- In principle, the Scheme's approach to stakeholder engagement and working relationships is to attempt to find solutions beneficial to or at minimum acceptable to all parties.
- The Trustees embrace the Treating Customers Fairly (TCF) principles and framework and receive regular reports on the performance of Discovery Health on key TCF indicators, as well as other stakeholder engagements conducted on behalf of the Scheme.
- The Scheme conducts ongoing environmental scanning, and reviews regular reporting to identify possible risks related to our key stakeholders, which may affect business continuity, and develops or amends specific engagement strategies to deal effectively with these.
- The Scheme proactively shares evidence-based information with stakeholders to support their healthcare access and needs, awareness of quality outcomes, regulatory changes, and the non-profit status of the Scheme.
- The Scheme's use of the Vested contracting model in our engagement and working relationship with Discovery Health prioritises outcomes beneficial to both parties, which cascade into additional value and quality experienced by our members.
- The Scheme and Discovery Health have developed an enhanced procurement governance process enabling the Scheme to assess and mitigate risks associated with contracting with individual vendors. The process is being piloted during the course of 2023.

Our risk environment informs the determination of our material matters, and as such indicates the potential constraints to our capital inputs. The intended outcomes we achieve for our stakeholders in turn mitigate our risks.

Leadership reviews

OUR CHAIRPERSON'S STATEMENT

MR JOHN BUTLER, SC

DHMS has been able to make the once-off WELLTH Fund Benefit available to enable members to better understand their health status and, together with their healthcare providers, to make the best possible decisions to support their health.

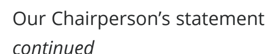
Over the past year macroeconomic volatility has continued to plague our environment, impacting business operations across the globe. The consequent uncertainty – resulting in a rise in interest rates, high unemployment rates and inflation – has required resilience by DHMS. We have taken bold steps to ensure the sustainability of the Scheme, while protecting our members from affordability challenges. From a COVID-19 perspective, for most countries including South Africa, the removal of lockdown restrictions coincided with the positive impact of vaccinations and immunity from infections.

Notwithstanding the economic challenges and utilisation uncertainty, the Board is pleased with the Scheme's performance over the 2022 financial year. Strong solvency of 35.11% and reserves of R28 930 015 at year-end enabled us to cushion members from a contribution increase by deferring the 2022 contribution increase of 7.9% to 1 October 2022. The delayed implementation of the 2022 contribution increase resulted in a 2.0% effective increase for members, based on the annualised December 2021 rates. We have been able to delay our annual contribution increases for a third time in 2023, giving effective relief of approximately R8.6 billion to our members over the three deferments.

Amid economic uncertainty, an aging membership profile and an increasing burden of disease, we are cognisant of the long-term challenges. These include affordability constraints, and increases in chronic conditions, including mental health. Over this period, the Scheme implemented the regional efficiency discounted option (EDO) and the Trustees took a decision to make the WELLTH Fund available to improve access to preventative care, including screening. The use of screening benefits and chronic registrations continues to lag pre-COVID-19 levels[1]. This means that disease may only be discovered in later stages of progression, with worse outcomes for members as a result. We urge our members to take full advantage of these benefits, working with their primary care provider to determine the best options for them based on their individual health and risk status.

DHMS has been able to make the once-off WELLTH Fund Benefit available to enable members to better understand their health status and, together with their healthcare providers, to make the best possible decisions to support their health. This benefit is made possible by the additional reserves the Scheme has accumulated, due to lower healthcare-seeking behaviour during the pandemic and we strongly believe it to be the best possible use of these funds. The WELLTH Fund is made available when all beneficiaries on a membership have had a health check from 1 January 2022 onwards.

1 *Source: Discovery Health Medical Scheme Data Analysis (February 2023).*



Our Chairperson's statement
continued

We continue to emphasise rigorous governance processes in DHMS. To this end, and in addition to a new EDO, succession planning for the Board and Board committees, monitoring services received from Discovery Health, and expanding access to private healthcare, the Board negotiated and approved terms and contracts for the re-appointment of Discovery Health to provide administration and managed healthcare services to the Scheme for the next five years. In reaching this decision the Board appointed Deloitte[1] to conduct an independent review of the landscape using available information. It based its decision on these findings, together with the detailed assessment of the outcomes for the Scheme of the services provided by Discovery Health.

The Trustees also engaged Deloitte to perform an actuarial peer review on a calculation of value received by the Scheme for work done by Discovery Health. This calculation has been performed by Discovery Health and reviewed by Deloitte for the last eight years. We are pleased to report that for 2021, the Scheme received R2.02 in value for every R1.00 paid to Discovery Health[2] (2020: R1.90[3]).

Also of note is that the CMS initiated a routine inspection[4] of DHMS' governance policies, structures, and processes during 2022. We submitted extensive documentation to the CMS to facilitate this and look forward to further engagements on this during 2023. The conducting of routine inspections such as this by a regulator is key to ensuring that the industry is operating in accordance with good governance practice and all applicable legislation, and we fully support the CMS in its endeavours.

We continue to follow the progress of the National Health Insurance Bill closely. We look forward to further robust engagements on the Bill as it is reviewed by the National Assembly before going to the National Council of Provinces for discussion during 2023. We are fully in support of universal health coverage (UHC) in South Africa and believe that with constructive amendments and more clarity in the Bill, especially in areas such as governance requirements and the role of medical schemes, that the path to UHC can be facilitated. We will continue to look for opportunities to collaborate with regulators and other stakeholders to assist in facilitating universal health coverage.

Arising from the Scheme's experience during the height of the pandemic, and a Competition Commission complaint laid by the CMS regarding the pricing of PCR tests by private pathology laboratories, which led to a reduction in pricing, DHMS is participating in an industry initiative led by the Health Funders Association to attempt to recover excessive amounts paid for those tests. We estimate that the amount overpaid during this period amounts to some R1 billion across the industry. Remaining conscious of the importance of the pathology industry to the country and to our members, we nevertheless feel obliged to take this action to fulfil our responsibility to safeguard our members' funds against fraud, waste and abuse as far as we are able.

We bid farewell to three Trustees: Mr David King, Dr Dhesan Moodley and Mr Neil Morrison, and one Independent Committee Member, Mrs Sue Ludolph. Their terms ended in 2022. We commend them for excellent work done during their tenures. We also welcomed three new Trustees elected at the June 2022 Annual General Meeting; Dr Max Price, Mr Marius du Toit and Ms Joan Adams SC. With effect from 1 January 2023, Ms Michelle Norton SC has been appointed to the Board. In addition, Mr Bongani Hlope was appointed to the Remuneration Committee as an Independent Committee Member and as Chairperson of this Committee. I wish our new Trustees and ICM the very best in their work for the Scheme.

Looking ahead, we will continue to engage around the healthcare needs of our members to ensure that our plans and programmes yield appropriate healthcare outcomes at an appropriate cost. Work is underway to develop and deliver strategies to this end, and members can already look forward to the Smart EDO and the launch of new digital solutions.

I thank my fellow Trustees and our Committee Members for their dedication to the best interests of the Scheme and its members, as well as the efforts of the Scheme Office team who ensure the smooth running of the Scheme and support our effective oversight. I commend the Scheme Office on their responsiveness to the Trustees' questions and concerns, especially in making Discovery Health information rapidly available, and making improvements where needed.

MR JOHN BUTLER, SC
Chairperson

Looking ahead, we will continue to engage around the healthcare needs of our members to ensure that our plans and programmes yield appropriate healthcare outcomes at an appropriate cost.

1 *Deloitte Touche Tohmatsu Limited.*
2 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2021, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.02 (2020: R1.90) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*
3 *The 2020 value added has been restated from R1.88 to R1.90 using updated information from the CMS 2020/2021 Annual Report, changes in methodology as well as finalised settlement values for certain components.*
4 *The CMS is mandated to carry out routine inspections by the Medical Schemes Act.*

OUR PRINCIPAL OFFICER'S REVIEW

MS CHARLOTTE MBEWU

Increasing access to healthcare is an ongoing priority for the Scheme. In 2022, we introduced the KeyCare Start Regional Plan. This plan is available in specified areas, where we have been able to negotiate with healthcare providers and create a supportive network, at an excellent contribution rate.

DHMS delivered against its 2022 objectives of caring for our members, managing the implications of COVID-19, ensuring Scheme sustainability and encouraging membership growth; all the while maintaining excellent governance and contributing to relevant policy and regulatory developments – despite a complex operating environment.

To protect our members, the Scheme's responses to the pandemic included funding 752 885 COVID-19 vaccinations and 447 085 COVID-19 tests during 2022. More broadly, we continued to enhance benefits in an effort to ensure that member healthcare needs can be met, and delivered on our mandate to ensure appropriate healthcare outcomes in balance with the financial stability and long-term sustainability of the Scheme.

During 2022, DHMS demonstrated its resilience by maintaining its strong financial position. This enabled us to delay our contribution increases for 2022 to October 2022 and to 1 April 2023 for the 2023 financial period. Further, with the prudent stewardship of our Trustees, this financial strength allowed us to expand our benefits in 2022, specifically to enhance the Assisted Reproductive Therapy Benefit by increasing funding and expanding access to certain treatments.

COVID-19 has had a significant impact on the world, and not least on healthcare. During the pandemic we adopted and adapted to new care delivery mechanisms including telemedicine to ensure continued access to healthcare services, while protecting patients and healthcare providers. We intend to maintain the many benefits of this shift, by facilitating the design of care pathways that optimise delivery mechanisms and ensure an appropriate mix of digital and remote care, and in-person care. To this end, DHMS continues to make Hospital at Home available to members; these home admissions enable the effective management of patients in a familiar environment, with 24-hour monitoring and oversight provided by their admitting doctors. Hospital-level care at home is a rapidly growing global trend. While uptake in South Africa has been slow, we believe there is potential for up to 30% of appropriate admission types to shift from in-hospital to a home-based care setting over time.

Hospital at Home is one example of how we are integrating new technology to enhance access, member experience and quality of care – without replacing the patient-doctor relationship. We are also exploring new opportunities in the mental health space, with some urgency. The prevalence of mental illness increased significantly during the pandemic; in February 2023, the World Health Organisation (WHO) reported a 25% increase in the prevalence of depression and anxiety globally[1]. Digital and self-care tools offer compelling possibilities in increasing access and we are excited to explore these opportunities in partnership with healthcare providers and our members.

Increasing access to healthcare is an ongoing priority for the Scheme. In 2022, we introduced the KeyCare Start Regional Plan. This plan is available in specified areas, where we have been able to negotiate with healthcare providers and create a supportive network, at an excellent contribution rate. Following positive engagements, the CMS approved the plan, demonstrating the significant value of designated provider networks in facilitating access at better cost. At the end of 2022 we also submitted LCBOs to the CMS; unfortunately, these have not been approved as yet, pending the finalisation of the LCBO framework by the CMS and Department of Health. We believe that making such options available to South Africans not in a position to access healthcare is an urgent priority, as the country moves towards universal health coverage, within which LCBOs have a much needed and appropriate place.

For the year ended 31 December 2022, DHMS delivered a planned negative net healthcare result of R3 281 million (2021: planned negative R1 165 million). This result is primarily attributable to the delay of the contribution increase to 1 April 2023; this is the third time the Scheme has been in a

1 Source: https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide.

position to delay the increase, providing relief to members of approximately R8.6 billion over three years. Results are, however, significantly better than expected (likely due to members continuing to defer their healthcare needs during COVID-19 waves in 2022) and the Scheme generated investment income of R2 222 million (2021: R1 772 million), contributing to the net deficit of R1 489 million (2021: R2 044 million surplus) for the year.

We are proud to have grown our membership by 22 532 principal members in 2022, and 22 499 in 2021[1]. This was achieved despite the economic hardship that has seen much of the industry experiencing membership declines. We believe this is due to the extent of cover, the quality and comprehensive nature of our benefits, and the broad range of options tailored to meet our members' needs.

Members' funds decreased to R28.9 billion (2021: R30.4 billion) with a solvency level of 35.11% (2021: 38.01%), exceeding the regulatory requirement of 25%. Despite the challenging and unusual market conditions, DHMS ended 2022 in a strong financial position and we are well placed to meet members' needs, considering the anticipated increases in utilisation as healthcare seeking behaviour returns to normal, and as the postponement of care since 2020, with consequently worsened states of health of our members, impacts the healthcare system.

Our deep concern about the lower screening and healthcare access by members during the pandemic led to us launching the WELLTH Fund in 2023. This innovative, once-off benefit is made possible by our strong reserves, and we believe it to be the most important form of access we can provide to our members facing potentially undetected worsening health stemming from the pandemic. The WELLTH Fund is accessible to all members who have completed a health check from 1 January 2022 onwards.

Aligned with this concern for the health of our member population, in 2023 we are launching a programme to help members at high risk of diabetes or metabolic disease. Early identification and proactive management of these health conditions results in extended and healthier lifespan. The programme offers twelve months of support for these members, with comprehensive clinical management through GP visits and relevant medicine, healthcare coaching and nutritional assistance. At the end of the period, the member may either exit the programme, remain on relevant chronic medicine or register for our Chronic Illness Benefit for ongoing care.

In 2023, we were able to increase the threshold of the oncology benefit on all plans by 25%, to address the increasing costs of treatment. With the prevalence of cancer increasing over time, and the correlated increase in cost of care mainly due to introduction of new oncology treatment protocols, we extended access to a defined list of novel and ultra-high-cost medicines for some cancers on additional plans within the Scheme.

We also look forward to the introduction of our Essential Dynamic Smart plan in 2023. This innovative, information-driven plan assists members to access the most efficient and appropriate facility for their care, depending on their location and condition. The pricing of this plan, again demonstrating the value of efficient designated provider networks, is affordable and supports increased access to healthcare with better health outcomes.

Last year, we reported on the Section 59 investigation into FWA management in the industry. We responded comprehensively to the interim report, which found no fault with the processes and practices operated by Discovery Health on our behalf, and we await the publication of the final report. Discovery Health established a Health Professionals Reference Group (HPRG) to contribute to the review, development and redesign of forensic investigation processes. The HPRG was independently facilitated and has been highly collaborative. Based on the outcomes of the HPRG, Discovery Health has subsequently engaged with a broadly representative group of doctors to collaborate on addressing the outdated coding system for medical procedures currently in use in South Africa. We look forward to the outcomes of this work and its benefit to healthcare providers and our members.

1 *Net principal member increase at 31 December 2021 vs 2020 and 2022 vs 2021.*

The CMS has announced its priorities for 2023, and we look forward to progress in these important areas, and to collaborating with the industry and our regulator in whatever ways we can on these. We appreciate the CMS' lead in the industry code of good practice for FWA management, and look forward to the establishment of a Tribunal to assist with the resolution of these matters. LCBOs, another priority area, is extremely important to extend access to healthcare.

I must thank my team in the Scheme Office for their dedication and hard work in supporting continued access to high-quality care for our members, through a wide benefit offering tailored to meet healthcare needs within individual financial constraints. The guidance and oversight of our Trustees and Independent Committee Members is also invaluable in steering the Scheme through challenging times with careful consideration, in-depth knowledge and in balancing the many difficult trade-offs between competing imperatives. I also thank our members, for whom we exist, and our other key stakeholders without whom we could not fulfil our duty of care as we do: the CMS; healthcare providers and facilities; financial advisers and our administration and managed care provider, Discovery Health.

We remain closely engaged with the development of national health policy and regulatory change, including supporting the move to UHC, for the benefit of all citizens. Despite the considerable challenges we face, we are excited to contribute to a dynamic era of change in healthcare and its regulation, and to build out new opportunities to benefit our members' wellbeing, and that of the South African healthcare system as a whole.

C Mbewu

MS CHARLOTTE MBEWU
Principal Officer

Our business model

Sustaining the Scheme's financial, operational and relational wellbeing serves the primary need of our members: access to healthcare now and in future. Our business model is designed to fulfil this need.

Our members are at the centre of a complex ecosystem of relationships that we oversee and mediate as a centre of excellence in medical schemes governance. Our business model centres on delivering excellence and innovation in our core service to our members, which is governance best practice and thought leadership in our industry.

As a funder that connects our members to the private healthcare value chain, the quality of our relationships with all our stakeholders is essential to realising our vision and creating sustainable value in the interests of our members and a better healthcare system, in line with our purpose.

The Scheme's business model is people led, capability driven and relationship based. This is clearly reflected in the core capital inputs on which we depend, and the value outcomes we generate for our members, employer groups and society.

These outcomes rely on our value propositions to our other key stakeholders, and our material matters reflect both the risks to these capital inputs and the opportunities we have to deliver better outcomes to our members and our other stakeholders.

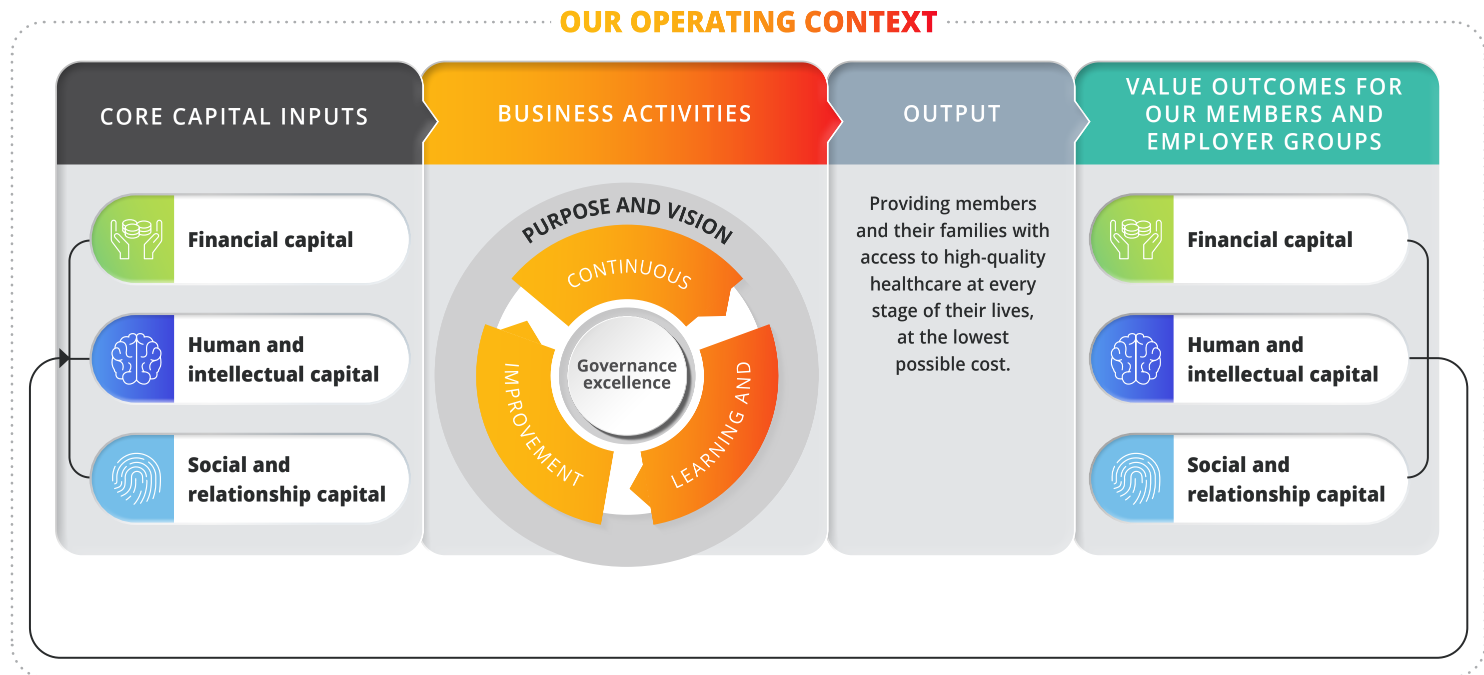
Responding effectively to our material matters is a function of meeting the objectives associated with our strategic themes and mitigating our residual risks. This enables us to secure the financial, operational and relational wellbeing of the Scheme in the best interests of our members and, in turn, to deliver the long-term value outcomes our stakeholders expect.

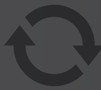
We apply global best practice in how we outsource the administration and provision of managed care. We use the Vested® outsourcing model to govern the working relationship with our accredited administration and managed care provider.

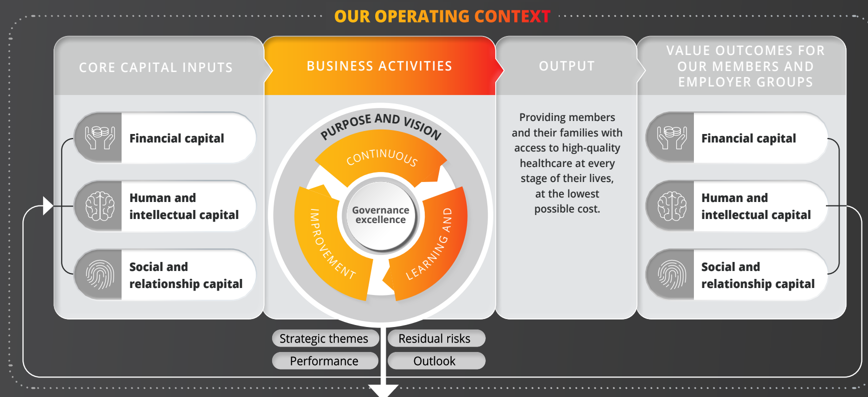
Vested outsourcing applies an outcomes-driven approach characterised by:

- A shared vision and aligned objectives, with both organisations committed to the success of each other;
- Transparency, flexibility and trust;
- Working together to find the best solutions; and
- Fair risk and reward for both parties, leading to fairness, sustainability and best outcomes.

The principles of the model strengthen strategic alignment and encourage a value-driven relationship. In effect, by contracting for results and not activities, both organisations are able to do what they do best, allowing for innovation, improved service, and continuous value creation.







OUR PURPOSE

is to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality, value-based healthcare that meets their needs now and sustainably into the future.

OUR VISION

is to be the best medical scheme in the country. In the interests of our members, we will always pursue excellence, leveraging the Vested outsourcing model to lead healthcare innovation and create value. We will work closely with our regulator, our administration and managed care provider, and the industry to shape an inclusive and complete healthcare system in South Africa.

BUSINESS ACTIVITIES

Discovery Health Medical Scheme (DHMS or the Scheme) undertakes its business activities in line with its operating model, which defines the Scheme as a centre of governance excellence enabled by a culture of continuous learning and improvement and led by a capable, knowledgeable team. This means that the Scheme is focused on:

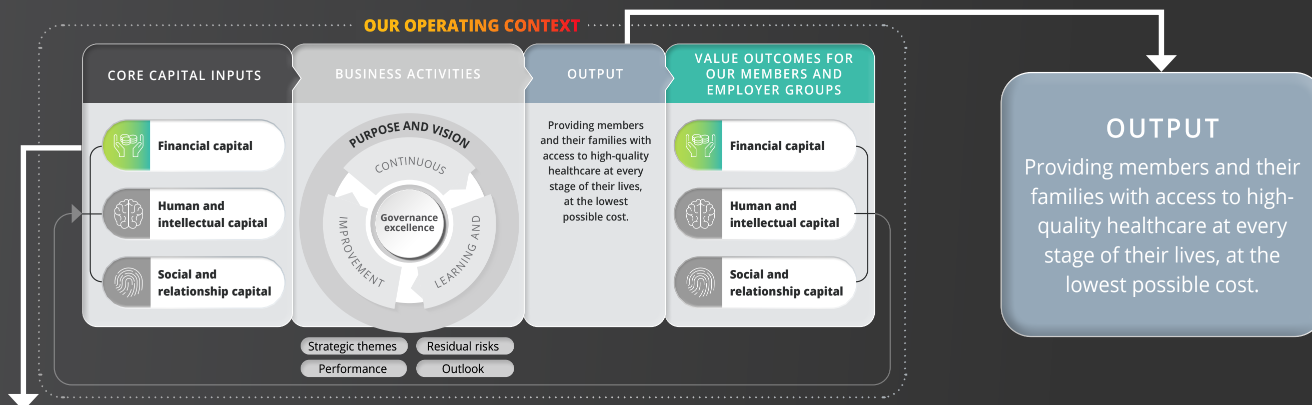
- **Regulatory compliance:** discharging our fiduciary duty and compliance obligations, supported by mature governance systems, ongoing monitoring and adaptation to a complex and dynamic healthcare environment, and managing risk and opportunity effectively.
- **Operational excellence:** guided by social solidarity principles, we work to ensure Scheme sustainability for the benefit of all our members.
- **Responsible corporate citizenship:** we work towards greater quality, efficiency and value in healthcare delivery and healthcare system reform in South Africa.

Business activities follow a cycle of:

- Investment management
- Operations management
- Responsible corporate citizenship
- Stakeholder engagement
- Finance and procurement
- Disputes, legal and contracting
- Regulatory compliance
- Clinical, legal and business risk management
- Planning and reporting
- Talent, culture and leadership management
- Advocating for an improved healthcare system

Key elements of our business model are discussed in:

VALUE SNAPSHOT FOR THE YEAR ENDED 31 DECEMBER 2022



OUTPUT

Providing members and their families with access to high-quality healthcare at every stage of their lives, at the lowest possible cost.

1 *At 31 December 2022.*

2 *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Annual Report for the year ended December 2021 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/). At the end of 2021 there were 17 open schemes registered with the CMS, with approximately 54% of the total medical schemes market and 55 restricted schemes, with approximately 46% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2 million beneficiaries. Source: Annexures to the CMS Annual Report 2021-2022.*

3 *Source for industry information: Annexures to the CMS Annual Report 2021–2022 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annualreport/). Includes open and restricted schemes but does not include data for 2022. The CMS may calculate ratios and average ages at different times and on a different basis to DHMS calculations.*

4 *Based on the CMS Annual Report 2021-2022, as a percentage of gross contribution income.*

CORE CAPITAL INPUTS

Financial capital

- **Member contributions** of R79.5 billion (2021: R75.8 billion).
- **Investment income** of R2.2 billion (2021: R1.8 billion), generated from Scheme assets.

MATERIAL MATTERS RELEVANT TO THE CAPITAL

indicating drivers and constraints of value – with potentially positive, neutral or negative impact on the Scheme.

CARING FOR OUR MEMBERS

- (positive) Affordable access to quality care in the face of compounding healthcare inflation and financial pressure.
- (negative) Impact of burden of disease, climate change and pollution on healthcare landscape.
- (positive) Scheme sustainability and equitable treatment of members.

ECONOMIC GROWTH

- (negative) Low economic growth and affordability constraints causing muted or negative membership growth.
- (positive) Driving membership growth, especially young healthy lives to enable cross-subsidisation.

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- (positive) Partnerships to co-create a stronger, more affordable and accessible healthcare system.
- (positive) Equitable access to high-cost health technologies and treatments, population care and wellness.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- (positive) Social solidarity, innovation, competition and collaborative partnerships to meet healthcare challenges.
- (positive) Driving opportunities such as digital health capabilities to optimise access and efficiencies.

OUTCOMES ACHIEVED IN RELATION TO THE CAPITAL

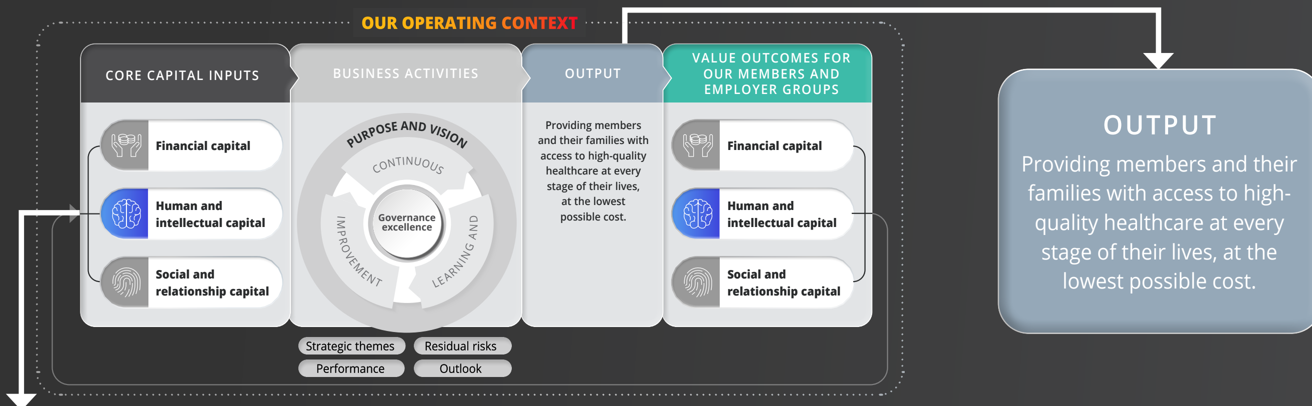
in 2022, demonstrating the Scheme's response to these value drivers and constraints.

Financial capital

- Largest open medical scheme, with 2 810 992 beneficiaries[1] and 57.6%[2] market share.
- DHMS has good demographics when compared to the medical scheme industry, with an average age of 35.3 and a pensioner ratio of 10.4% (versus 35.9 and 11.7% respectively across all other open medical schemes)[3].
- Financial strength, with R28.9 billion in member funds, a 35.11% solvency level, and an AAA credit rating confirming the Scheme's ability to meet large, unexpected claim variations.
- DHMS gross administration expenditure is the fifth lowest[4] out of 17 schemes in the open scheme market.

Other key stakeholder relationships relevant to our financial capital outcomes:

Value snapshot for the year ended 31 December 2022 *continued*



OUTPUT

Providing members and their families with access to high-quality healthcare at every stage of their lives, at the lowest possible cost.

CORE CAPITAL INPUTS

Human and intellectual capital

- **Skilled, knowledgeable, independent Board** accountable for effective oversight and delivery of the Scheme's mandate.
- **Mature governance** frameworks, processes and structures.
- **Effective, efficient and agile business model** with optimised outsourcing.
- **Strong and specialised management team** with appropriate capability and capacity, enabled by continuous learning and improvement initiatives.
- **Values-based culture** that drives the highest ethical standards in the conduct and decisions of the officers of the Scheme.

MATERIAL MATTERS RELEVANT TO THE CAPITAL

indicating drivers and constraints of value – with potentially positive, neutral or negative impact on the Scheme.

CARING FOR OUR MEMBERS

- (positive) Providing high-quality, value-based, member-centred healthcare journeys.
- (positive) Participatory physical and mental healthcare and access to leading healthcare technology and treatments.
- (positive) Scheme sustainability and equitable treatment of members.

ECONOMIC GROWTH

- (positive) Driving membership growth, especially young healthy lives to enable cross-subsidisation.

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- (positive) Equitable access to high-cost health technologies and treatments, population care and wellness.
- (negative) Inadequate governance, controls and capacity in the broader business and political environments.
- (positive) Ethical leadership, best practice governance and social responsibility to society by all sectors.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- (positive) Social solidarity, innovation, competition and collaborative partnerships to meet healthcare challenges.
- (positive) Driving opportunities such as digital health capabilities to optimise access and efficiencies.
- (positive) Offering new platforms for healthcare delivery incorporating pandemic lessons.

OUTCOMES ACHIEVED IN RELATION TO THE CAPITAL

in 2022, demonstrating the Scheme's response to these value drivers and constraints.

Human and intellectual capital

BOARD OF TRUSTEES

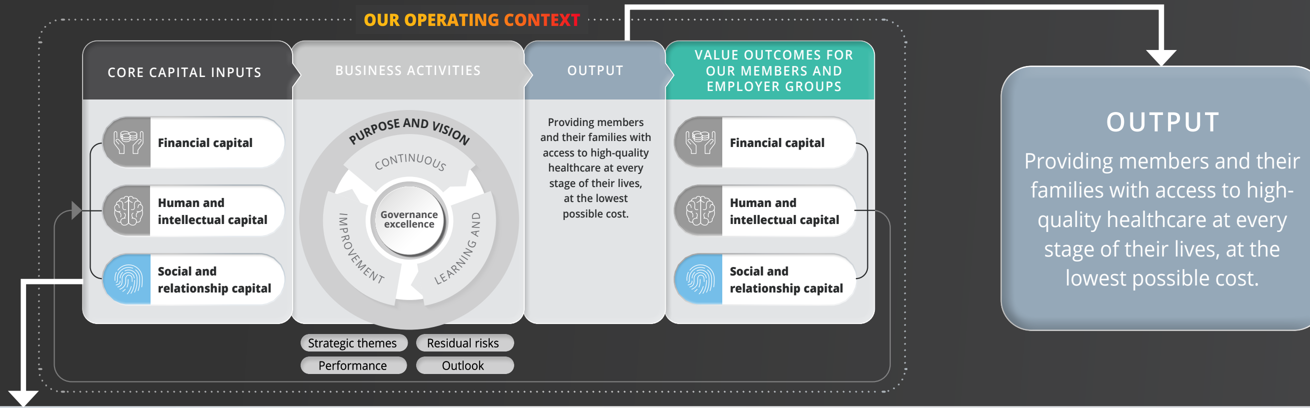
- In 2022, the Institute of Directors in South Africa (IoDSA) evaluated our application of the principles of the King IV Report on Corporate Governance for South Africa 2016, recognised as best governance practice, and rated us excellent at a score of 4.6 out of 5. The next evaluation is due in December 2023.

EMPLOYEES

- The Scheme's value proposition to employees includes protecting their dignity, safety and health, providing decent work, fair remuneration, training and development opportunities, and equitable and ethical treatment. The Scheme is a diverse workplace with a focus on transformation.
- The Scheme Office workplace culture is regularly assessed and informs our people management priorities, including wellbeing strategies.
- Training and development for all employees takes place on a regular basis.
- The Principal Officer and management team's expertise encompasses a broad range of capabilities including medicine, actuarial science, risk management, accounting, business management, strategic development, financial management, investment, governance, law, ethics, compliance and research.

Other key stakeholder relationships relevant to our financial capital outcomes:

Value snapshot for the year ended 31 December 2022 *continued*



OUTPUT

Providing members and their families with access to high-quality healthcare at every stage of their lives, at the lowest possible cost.

CORE CAPITAL INPUTS

Social and relationship capital

- Maintaining our **social licence to operate** in the best interests of our members.
- Attracting and retaining a **substantial membership base** to support cross-subsidies, efficiency and sustainability.
- Maintaining **collaborative partnerships** with all our stakeholders.
- **Balancing constructive relationships and oversight** related to our Vested outsourced partner and other suppliers.
- Reputation for **stability, reliability, accessibility, integrity and thought leadership.**
- Reputation as a **responsible and involved corporate citizen.**
- **Supporting healthcare reform** towards an effective and equitable healthcare system.

MATERIAL MATTERS RELEVANT TO THE CAPITAL

indicating drivers and constraints of value – with potentially ● positive, ● neutral or ● negative impact on the Scheme.

CARING FOR OUR MEMBERS

- ● (negative) Impact on healthcare landscape of burden of disease, climate change and pollution.
- ● (positive) Providing high-quality, value-based, member-centred healthcare journeys.
- ● (positive) Participatory physical and mental healthcare and access to leading healthcare technology and treatments.
- ● (positive) Scheme sustainability and equitable treatment of members.

ECONOMIC GROWTH

- ● (negative) Low economic growth and affordability constraints causing muted or negative membership growth.

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- ● (positive) Partnerships to co-create a stronger, more affordable and accessible healthcare system.
- ● (positive) Equitable access to high-cost health technologies and treatments, population care and wellness.
- ● (negative) Inadequate governance, controls and capacity in the broader business and political environments.
- ● (positive) Ethical leadership, best practice governance and social responsibility to society by all sectors.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- ● (positive) Social solidarity, innovation, competition and collaborative partnerships to meet healthcare challenges.
- ● (negative) Lack of regulatory reform and incomplete implementation.
- ● (positive) Driving opportunities such as digital health capabilities to optimise access and efficiencies.
- ● (positive) Offer new platforms for healthcare delivery incorporating pandemic lessons.

OUTCOMES ACHIEVED IN RELATION TO THE CAPITAL

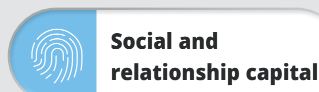
in 2022, demonstrating the Scheme's response to these value drivers and constraints.

Social and relationship capital

RESPONSIVE, HIGH-QUALITY, VALUE-BASED HEALTHCARE

- Driving better health outcomes through value-based partnerships with healthcare providers, focused on efficiency and quality of care, the ongoing development of managed care programmes, innovation and integration.
- Due to the exceptional utilisation patterns caused by the COVID-19 pandemic, and to assist members to deal with economic pressures, the Scheme has been able to defer contribution increases three times, giving effective relief of approximately R8.6 billion to our members.

OUTCOMES ACHIEVED IN RELATION TO THE CAPITAL *continued*



VALUE OF BENEFITS[1]

- Members receive substantial value in terms of their healthcare benefits when they need to claim. The largest hospital claim made during 2022 would require 228 years of contributions by the member to cover that particular claim, based on the plan that the member is on; put another way, it would take 306 years of contributions based on the average risk contribution of R1 930 per month per beneficiary.
- For an average risk contribution of R1 930 per month, R72 billion was paid out for claims in 2022. This includes:
  - R5 233 per beneficiary with a chronic condition for out of hospital costs (773 148 beneficiaries);
  - R59 969 per admission (618 114 hospital admissions);
  - R111 338 per beneficiary undergoing oncology treatment (44 422 beneficiaries).
- 16.3% of beneficiaries claimed more than their contributions.

PLAN CHOICE

- Our full spectrum of 24 plan options offers our members sufficient choice to meet their medical and financial needs.
- Low movements between plans reflect member satisfaction and appropriate benefits and pricing. For the periods December-January 2022, September-October 2022 and December-January 2023, 96.53%, 98.68% and 97.15% of members respectively did not change their plans.

AFFORDABILITY[2]

- Average contributions for our members in 2023 are 12.2% lower than the next seven largest open medical schemes (2022: 14.6%)[3].

The Scheme is more affordable than the next seven largest open schemes across all plan categories in 2023 (income capitated: -0.9%; hospital: -2.5%; limited day-to-day: -13.6%; extensive day-to-day: -20.2%).

VALUE FOR MONEY

- The Trustees conduct a formal evaluation of the value for money Discovery Health provides to the Scheme every year. In 2021, DHMS received R2.02 of value added by Discovery Health for each rand paid to it[4].

DIGITAL CAPABILITIES AND INNOVATION[5]

- The member app gives our members easy access to their health plan information and other convenient functionality to assist them in managing their healthcare needs.
- An average of 2 469 doctors regularly used HealthID in treating our members during 2022, with 3.05 million individuals having consented to their doctors accessing their records on HealthID[6], creating a single view of the patient's health records. This supports care co-ordination and pathways, and potentially reduces fragmentation of care, improving quality of care and clinical outcomes. Benefits for the provider include administrative efficiency.
- 15 700 virtual consultations were conducted during 2022, facilitating ease of access for members and convenience for providers, and enabling consultations under circumstances where patients are unable to attend a physical consultation.
- Facilitated the shift to alternative care settings including through Connected Care, an ecosystem of benefits, services and digital capabilities to help members manage their health and wellness at home.
- Access to patient communities where members affected by certain conditions (currently diabetes, heart disease and COVID-19) can share information and support with other patients, caregivers, doctors, and researchers[7].

MEMBER SATISFACTION

- Member perception score of 8.87 out of 10.
- The Discovery Health contact centre was recognised as the "Best Domestic Contact Centre" for customer service facilities in South Africa[8].
- Awarded product of the year in the medical aid category[9].
- Discovery Health received the Global Innovator Award and the Gold Product and Service Innovation Award for our Discovery Hospital at Home offering[10].

SOCIETY

- Private healthcare funding benefits society by giving individuals access to quality healthcare and protecting them, organisations and the economy from the adverse effects of ill health. It also reduces the burden on the public healthcare system. The Scheme seeks to amplify these benefits by working towards an improved healthcare system.

Other key stakeholder relationships relevant to our social and relationship capital outcomes:

1 *All figures for the period October 2021 to September 2022, with the exception of the number of Scheme members with a chronic condition and number of DHMS members undergoing oncology treatment, where the figures are as at September 2022.*

2 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*

3 *The methodology for calculating the contribution differentials has been amended to reclassify a competitor plan and to correct a calculation error. The differential reported for 2022 was 14.9%, which has now been amended to 14.6%.*

4 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2021, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.02 (2020: R1:90) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year. A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged Deloitte to perform an actuarial review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2020 to 2021 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed.*

5 *For members of all schemes administered by Discovery Health.*

6 *HealthID, the only comprehensive funder electronic health record in South Africa, allows members to consent to the sharing of health records with their doctors, improving quality of care and reducing administration for doctors.*

7 *See https://www.discovery.co.za/medical-aid/online-patient-communities for more information.*

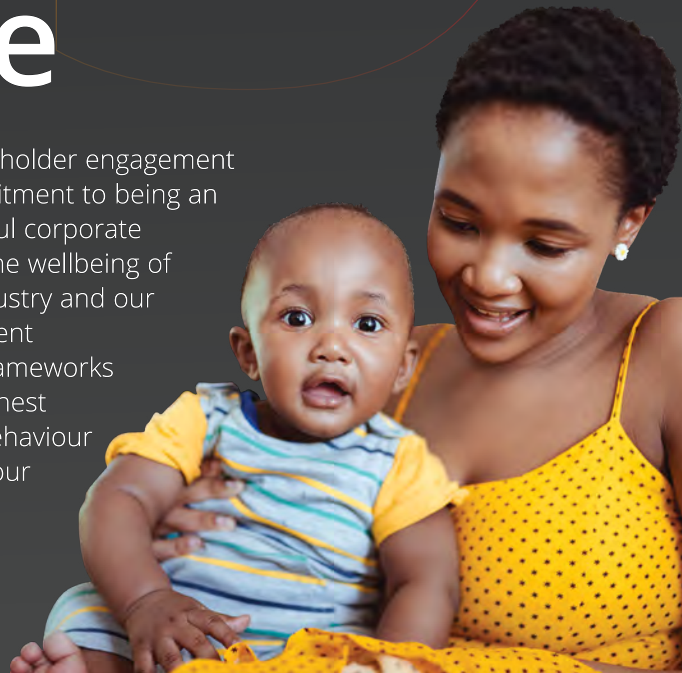
8 *Awarded by the Contact Centre Management Group, this professional body represents over 2 000 contact centres, 22 500 top and middle managers and 10 000 agents nationally.*

9 *Results of a survey by BabyYumYum.*

10 *At the 2022 EfmaAccenture Innovation in Insurance Awards.*

05 Creating stakeholder value

Our approach to stakeholder engagement is rooted in our commitment to being an engaged and thoughtful corporate citizen that cares for the wellbeing of our members, our industry and our society. This commitment is reflected in policy frameworks that bind us to the highest standards of ethical behaviour and enacted through our values-driven culture.



Responsible corporate citizenship

Discovery Health Medical Scheme (DHMS or the Scheme) engages continuously and extensively with our stakeholders. Our active engagement with our stakeholders and our responses to their needs fall within our strategic, long-term approach to responsible corporate citizenship. Our responsible corporate citizenship framework guides us in aligning all our relationships to our core intention of protecting our members while also contributing to positive reform and developments in society.

In line with the requirements of the King IV Report on Corporate Governance for South Africa 2016 (King IV), the Stakeholder Relations and Ethics Committee is mandated to oversee all aspects of the Scheme's responsibility as a corporate citizen. To help it fulfil its mandate, the Committee adopted a responsible corporate citizenship framework which defines and delineates the principles, parameters, operating requirements, and environmental factors pertinent to the Scheme's responsible corporate citizenship approach. The framework serves as a guide for the Trustees, Board Committees and Scheme Office management. It includes relevant legislation and governance requirements, Scheme governance and management, ethics, stakeholder engagement, the Scheme's impact on society and vice versa, sustainability, and associated measuring and reporting requirements. While the Scheme's non-profit status and governing regulations constrain our ability to invest in specific social responsibility activities, we work with relevant stakeholders to improve the effectiveness of the healthcare system in South Africa. The Committee receives regular reports, recommendations and presentations on areas covered by the framework, enabling it to monitor progress and provide input on related activities.

The Scheme's support of Discovery Health's shared value model – which engages stakeholders in working together towards better healthcare access, quality and affordability, and beneficial regulatory reform – extends the Scheme's influence to drive positive change in our industry. This includes the Scheme's contribution to broader environmental, social and governance (ESG) imperatives. In a shared value system, all stakeholders benefit when the system improves.

During 2022, the Investment Committee oversaw the application of the Responsible Investing Policy which integrates ESG factors with the investment strategy, active ownership activities and investment screening. Our investment managers are mandated to earn excellent returns and to use the Scheme's assets to create broader, positive external impacts.

Our ethics, values and culture

We aim to operate according to the highest ethical standards with relevant policies that are binding on the Trustees, Independent Committee Members and employees of the Scheme. Where appropriate, we also include ethics clauses in our contracts with third parties.

Policies set the standard of behaviour expected of our Trustees, Independent Committee Members and employees in areas such as legal compliance, protecting personal information, human rights, employee rights and sound business practices.

The effectiveness of the Scheme's Board and Board Committees are assessed regularly, as is the management and oversight of ethics, with reference to King IV as governance best practice. The Scheme Office has an ongoing focus on ethics, supported by an experienced executive who is a certified ethics officer[1], and whose portfolio includes legal and ethics matters.

The Scheme and all its stakeholders have access to an independently operated facility for reporting fraud or unethical behaviour. Employees also have access to internal ethics and fraud reporting facilities. Anonymous reporting is supported on both platforms.

1 *As per the Ethics Officer Certification Programme run by The Ethics Institute.*

Policies set the standard of behaviour expected of our Trustees, Independent Committee Members and employees in areas such as legal compliance, protecting personal information, human rights, employee rights and sound business practices.

As part of our focus on continuous improvement and governance excellence, we appointed The Ethics Institute in 2023 to conduct an ethical culture maturity assessment for the Scheme. We expect this will provide insights into any areas of weakness and input into our ethics management plan.

Moral duties and ethical values

The Scheme's standards of behaviour take guidance from King IV, which requires that the governing body should lead ethically and effectively, achieving four governance outcomes of an ethical culture: good performance, effective control and legitimacy. King IV recommends that Trustees cultivate integrity, competence, responsibility, accountability, fairness and transparency in order to achieve these outcomes, and that they exhibit these in their conduct.

The Scheme also aligns with the expectations of the Council for Medical Schemes (CMS):

Moral duties

Conscience, stakeholder engagement and inclusivity, competence, commitment, and courage.

Ethical values for governance, management, and operations

Discipline, transparency, independence, accountability, fairness, and responsibility.

Our values guide our behaviours and interactions

INTEGRITY	MUTUAL RESPECT	ADAPTABILITY AND AGILITY	TEAMWORK, SUPPORT AND CARE	PURSUIT OF EXCELLENCE	RESILIENCE	SOCIAL RESPONSIBILITY
We will do the right thing. We will take personal accountability for our actions and, in our actions and decisions, hold true to our promise that we care.	We will be courteous and treat others as we would want to be treated ourselves. We will listen to what people say and ask for and value other people's inputs.	We will be sensitive to the external environment and to the needs of others, while remaining responsive to changing needs and adapting to the pace of change.	We will support and care for ourselves and others. When working together, we will share the load and work interdependently.	We will focus on continuous improvement, development and quality with learning core to how we work.	We will remain resilient and persevere, with the ability to bounce back when required.	We will act responsibly and in the best interest of our members and society.

Treating Customers Fairly

The Treating Customers Fairly (TCF) outcomes are founded on sound business principles and best governance practice. The Scheme embraces these outcomes, recognising their relevance to the quality of service we provide to our members.

As a registered Financial Service Provider in terms of the Financial Advisory and Intermediary Services Act 37 of 2002, our administration provider, Discovery Health, has implemented a framework to support the following TCF desired outcomes:

Culture and governance

Customers are confident that they are dealing with financial institutions in which the fair treatment of customers is central to their culture.

Product design

Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.

Clear communication

Customers are given clear information and are kept appropriately informed before, during and after they sign on the dotted line.

Suitable advice

Customers are given advice that is suitable and takes account of their circumstances.

Performance and standards

Customers are provided with products that perform as financial institutions have led them to believe, and the services associated with those products are of an acceptable standard and in agreement with what they have been led to expect.

Claims, complaints and changes

Customers do not find themselves faced with unreasonable post-contract barriers to change the product, switch provider or register a complaint.

TO ASSESS ITS TCF PERFORMANCE, DISCOVERY HEALTH MONITORS:

- Plan movements;
- Opportunities for process improvement;
- Communication and completion of interactions with members;
- Consistency of decisions and delivery;
- Correction of errors made;
- Embedding of TCF culture;
- The total number and content of complaints received;
- Fair treatment of customers relating to privacy of information; and
- The perception scores of members, financial advisers, healthcare providers and employer groups.

The Stakeholder Relations and Ethics Committee reviews and considers regular reports on Discovery Health's performance relative to the objectives of TCF. In addition, the Dispute Committee is able to seek an advisory opinion from a specially convened TCF Committee when it believes that matters regarding the fair treatment of members may influence its deliberations in pending dispute hearings.

Engaging with our stakeholders

The Scheme strives to balance the needs and expectations of all our stakeholders in the South African healthcare system so that we achieve the best possible outcomes for our members.

The Stakeholder Relations and Ethics Committee oversees all stakeholder engagement activities and reports to the Trustees on these matters. The Committee uses a defined framework and methodology to identify stakeholder groups, assess their needs and interests, and evaluate the impact of these on the Scheme, and vice versa. According to the degree of impact and alignment, stakeholders are then prioritised for more detailed assessments regarding key concerns, degree of mutual trust, related risks and engagement plans.

The inclusion of a trust rating is in line with key principles of the Vested® outsourcing model that is formally applied in our contractual arrangement with Discovery Health and informs our interaction with our other stakeholders. The results of the assessment are reported to the Committee, informing its priorities and the formulation and management of engagement plans. In addition, ad hoc matters are reported to the Committee as they arise for it to assess and recommend further engagement if required. The Committee monitors the effectiveness of these plans and attends closely to the resolution of specific incidents and stakeholder concerns.

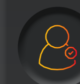
As the Scheme's administration and managed care provider, Discovery Health conducts certain stakeholder engagement work on behalf of the Scheme in accordance with the contractual agreements governing our relationship. Discovery Health reports to the Scheme on all these interactions and, where necessary, escalates items to the Scheme Office for direct involvement. This assessment process ensures the Committee and the Scheme Office fulfil their oversight and governance accountabilities in this regard, and Scheme Office representatives attend Discovery Health forums where matters affecting stakeholders are discussed. The Committee receives regular reports from Discovery Health on stakeholder engagement and perceptions, supplemented by presentations and discussions on matters of concern to the Scheme.

Discovery Health has extensive stakeholder engagement capacity and experience; specialised teams either respond to requests and queries received or engage proactively according to the Scheme's initiatives and industry activity. Material items are presented to executive-level forums on a weekly basis or escalated to the appropriate executives, including the Chief Executive Officer of Discovery Health. These are also addressed by the Scheme Office and the Principal Officer as needed.

The Stakeholder Relations and Ethics Committee oversees all stakeholder engagement activities and reports to the Trustees on these matters.

SOME ACTIVITIES CONDUCTED ON BEHALF OF THE SCHEME INCLUDE:

Responding to member queries via call centres, chat platforms, the member app and website;


Engaging with employer groups regarding their needs and concerns;

Proactively contacting identified member groups regarding healthcare concerns or opportunities;

Engaging at healthcare provider events to engage on Scheme initiatives and support healthcare providers in addressing their challenges and concerns, and at thought leadership events on topics that are relevant to the sustainability of the industry;

Developing and implementing innovative managed care programmes with healthcare providers and their societies to increase quality of care, decrease fragmentation and control costs for our members and the Scheme;

Supporting the Scheme's regulatory and policy engagement through gathering information and working with stakeholders; and

Providing training and support to financial advisers on the Scheme's products.

OUR MEMBERS

We exist for our members, who entrust us with their healthcare funding needs and with facilitating their access to beneficial programmes and treatments. Keeping this top-of-mind, the Scheme aims to manage contribution affordability in a challenging economic context characterised by high healthcare inflation, in an uncertain environment impacted by the pandemic and other external factors. This is critical to ensuring our members have continued access to the highest possible quality of care. Building and maintaining strong relationships with our other stakeholders is fundamental to our ability to achieve these objectives.

One of the Scheme's key strategic priorities is driving value-based healthcare that places members at the centre of care. In this delivery model, health results are prioritised over the volume of services delivered by reimbursing healthcare providers on health outcomes rather than inputs, which facilitates the access of our members to facilities, programmes and professionals that are committed to continuous improvement in quality healthcare. This approach also encourages healthcare providers to collaborate in providing holistic, high-quality patient care to our members.

DHMS engages with patient advocacy groups to develop mutual understanding of needs and constraints, and to work in alignment with each other towards improved access to healthcare and clinical outcomes. This aligns to the Scheme's obligation to treat all members equitably. Outcomes of these engagements can result in successful collaborations that enhance Scheme benefits for our members. Examples include facilitating access to innovative health technologies such as continuous glucose monitoring devices, and the introduction of the Assisted Reproductive Therapy Benefit on selected benefit plans.

Through Discovery Health, the Scheme is engaged in many quality of care initiatives that are closely monitored to ensure our members have access to the safest, most effective and efficient healthcare available in South Africa, at the lowest possible cost. We empower our members with information that is relevant to their needs, when they need it. A recent addition for members affected by certain conditions (currently diabetes, heart disease and COVID-19) is online patient communities, which members can join to share information with and support other patients, caregivers, doctors, and researchers.

Discovery Health's infrastructure and member support systems provide a range of engagement options for our members. This includes comprehensive information on the website, which also has virtual agent capability using artificial intelligence to respond to member questions. Members can also make contact via the call centre, a chat platform, or the member app. On admission, members have access to benefit specialists in many hospitals throughout the country who facilitate their healthcare journeys and support and advise them on their plan entitlements. Additionally, members can contact the Principal Officer directly if required.

These support mechanisms provide members with easy access to accurate information about their benefits, claims and other plan information. The Scheme ensures that our members are consistently informed of changes in benefits and contributions, and have access to formularies and the Scheme Rules governing their health plans. This enables our members to make informed decisions about the benefit options best suited to their healthcare and affordability needs, even as they change.

Various customer satisfaction and operational metrics are monitored to assess whether our members' service expectations are being met. Dissatisfied members can access a complaints and disputes process and, in the case of escalation, these members can elect to have a hearing before an independent Dispute Committee in terms of Scheme Rule 27. Alternatively, or if dissatisfied with the outcome of the dispute process, members may choose to take a complaint to the CMS in terms of Section 47 of the Medical Schemes Act (the Act).

MEASURING MEMBER SATISFACTION

The Scheme maintained a high average member perception score in 2022: 8.87 out of 10 (2021: 8.76). We track members' perceptions of service received at multiple points and locations, including after-claims processes and the call centre. Follow-up surveys are also frequently conducted with members after their interactions with us.

For our members

Care at home

Need more support and information with your COVID-19, diabetes or heart disease condition? Join our patient communities

WELLTH Fund

Information on some specific conditions, benefits and programmes

DIABETES

MENTAL HEALTH

ONCOLOGY

THE DISEASE PREVENTION PROGRAMME FOR MEMBERS AT RISK FOR DIABETES OR CARDIOVASCULAR DISEASE

Support for our members who are at risk for diabetes or cardiovascular disease: if you meet the eligibility criteria for 12 months you have access to dedicated clinical care, coaching support and additional Scheme benefits to improve your health.

HEAR FROM SOME OF OUR MEMBERS

MEMBER APP

The member app enables easy access to features enabling members to manage their health plans and healthcare needs, for example:

- Submitting and tracking claims, including a summary of hospital claims, and searching past claims (12 months).
- Viewing and tracking health plan benefits and Personal Medical Savings Account balances (where applicable).
- Viewing approved chronic conditions and related benefit usage.
- Finding a suitable healthcare provider or facility, and viewing personal health records.
- Ordering and tracking medicine, and comparing prices with generic alternatives.
- Getting instant help through Emergency Assist.
- Finding and downloading important documents.

EMPLOYER GROUPS

Many employers offer their employees the opportunity to join a medical scheme as part of their benefit package and employers can fund membership through a specified subsidy or a structured salary package. Information published by Global Credit Ratings in 2018[1] indicated that DHMS was the most popular open medical scheme among employers, with more than 70% of individuals that belong to an open medical scheme through their employers being DHMS members. The Scheme had over 7 000 employer groups belonging to the Scheme in 2022 and remains secure in its position as an industry leader for employers.

In 2022, COVID-19 cases declined and the number of employees returning to the workplace increased. Employers have since elevated their focus on employee wellness, corporate social responsibility, and providing a safe and supportive environment for their workforce.

Perception surveys were conducted to establish how satisfied employers are with Discovery Health as an administration provider. The 2022 independent survey results consolidated by PMR.africa[2] placed Discovery Health, as administration provider, first amongst employer groups with a mean score of 8.57 out of 10.

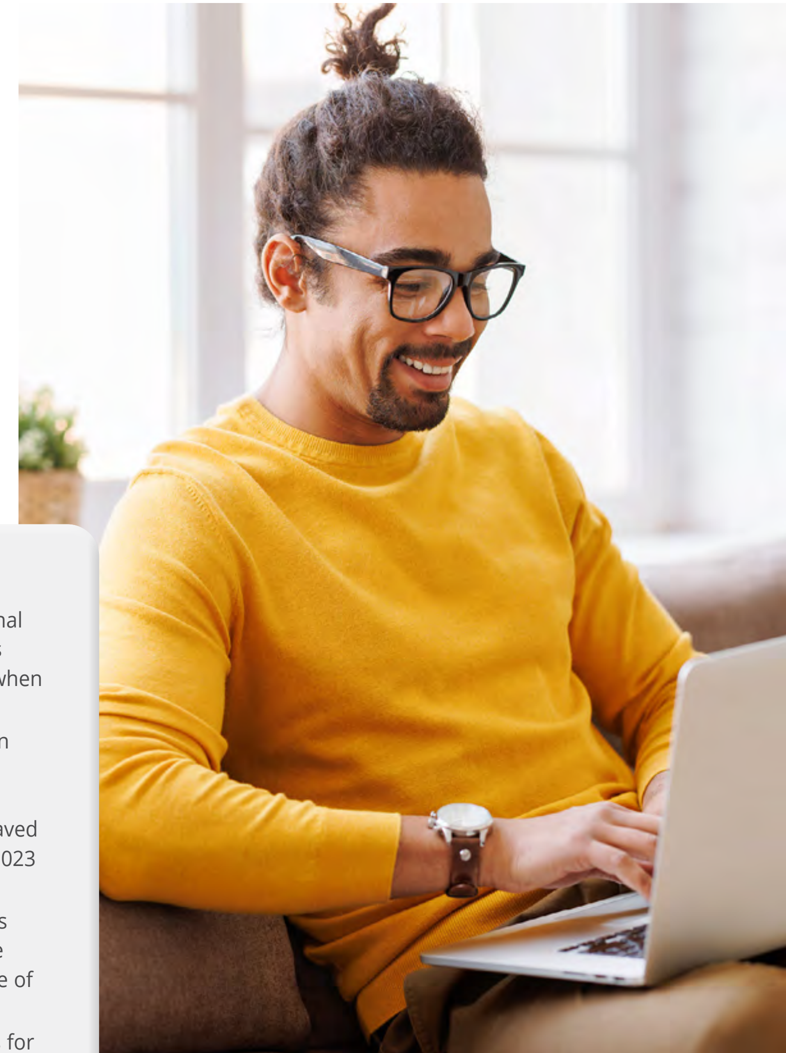
PROVIDING EMPLOYER GROUPS WITH AN INTEGRATED HEALTH AND WELLNESS SOLUTION

During 2022, Discovery Health offered DHMS employer groups and their employee members a fully integrated corporate health and wellness solution. This included:

- Digital and physical solutions for wellness screening for various health metrics, allowing wellness specialists to identify members at risk and refer them for appropriate care;
- An enhanced employee intelligence dashboard (EID) that offers employers integrated servicing and reporting for all Discovery Health-administered employer products, including for DHMS, for improved service experience;
- Discovery Healthy Company, a proactive, digitally enabled employee assistance programme; and
- COVID-19 Business Support, which was wound up in March 2022 due to indications of fewer and less severe COVID-19 outbreaks; however employee COVID-19 statistics remain accessible to employers via EID or report requests.

In addition, DHMS offered employers:

- Extended financial support for 2022 through an additional contribution freeze until October 2022. DHMS members experienced an effective increase of under 2% in 2022 when compared to their December 2021 rates;
- Affordability for members has been further supported in 2023 through an additional deferral of the contribution increase until 1 April 2023. DHMS members – or their employers where contributions are subsidised – have saved a total of R8.6 billion in contributions over the 2021 to 2023 period through the contribution increase deferrals;
- Thought leadership and guidance about pertinent issues faced by employers, including post-COVID-19 healthcare trends, the digitisation of healthcare and the importance of improving screening and prevention behaviour; and
- National training on product and benefit enhancements for 2023 for key decision makers, supported by comprehensive employee training sessions.



1 Based on annual Global Credit Ratings reports for the six largest medical schemes that subscribed in 2018.

2 Source: PMR.africa National Survey on Accredited Medical Scheme Administrators 2022 (www.pmrafrica.com).

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES

COLLABORATIVELY SHAPING A POSITIVE FUTURE FOR SOUTH AFRICAN HEALTHCARE

After a series of turbulent years, we are hopefully emerging from the acute phase of the COVID-19 pandemic. Recognising the devastating human and economic impact of the pandemic, we are proud of and humbled by the skill and dedication of our country's healthcare providers through this very challenging period.

Taking heart from this, DHMS and Discovery Health remain fully committed to continued investment in South Africa's healthcare system, working alongside health professionals who continue to shape the future of healthcare. Discovery Health is mandated by the Scheme to engage in a variety of stakeholder engagement activities on its behalf, including with healthcare providers.

In recent months, we engaged in a series of forums to listen to healthcare providers, an initiative that has taken us around the country to hear health professionals' ideals and aspirations. These sessions revealed valuable learnings and inspiring examples of resilience and ingenuity; we have committed to ongoing dialogue to ensure that we understand health professionals' lived experiences and are aligned with their strategic objectives.

At the height of the pandemic, we implemented a range of unique funding models, digital services and other supportive initiatives to help healthcare providers and their patients navigate clinical and economic challenges. As we jointly confront the ongoing impact of the pandemic, particularly delayed screening, preventative interventions, and the effects of Long COVID (which may contribute to the prevalence of non-communicable diseases) we will be introducing a new set of innovative solutions to support patients' access to appropriate preventative care.

As we moved to virtual engagements during the pandemic, we continued to establish and maintain deep relationships with health professional groups across the care spectrum including specialists, family doctors, dentists, and allied and therapeutic professions. We are excited to return to in-person engagement platforms and will be participating in many congresses and healthcare provider meetings during 2023.

We hosted two milestone events in the second half of 2022:

- ***The Hospital at Home event:*** showcasing the home as a safe new setting of care for general ward level admissions. This event was attended by 328 professionals both online and in person.
- ***WELLTH Fund event:*** launching the WELLTH Fund Benefit to healthcare providers and explaining the care journey from an initial health check to accessing appropriate interventions individually tailored to the Scheme member. This event was attended by 706 healthcare providers, both online and in person, 578 of whom completed an application to perform health checks that enable the WELLTH Fund benefits.

In 2022, Discovery Health participated in 36 conferences, where engagement took place on a number of Scheme initiatives including:

-
- In-room procedures
- Various doctor society governance programme collaborations
- Electronic engagement opportunities
- Care co-ordination programmes

Relevant Discovery Health value-added products and services were also promoted to health professionals:

Discovery Health leaders were invited to address 18 conferences. These included keynote addresses on the future of healthcare in South Africa as well as more focused talks on a growing list of shared value initiatives.

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES *continued*

LOOKING BACK AT 2022

Throughout the COVID-19 pandemic, the Scheme implemented several measures to reduce the economic impact on members and health professionals, ensuring ongoing access to medical cover and minimising financial hardship wherever possible.

In partnership with Discovery Health, the Scheme made major strides towards enhancing quality, cost efficiency and ongoing sustainable healthcare by implementing innovative shared value initiatives. We have been recognised for implementing funding that improves care outcomes that are important to patients, as detailed below.

CONTRIBUTING TO THE GLOBAL IMPLEMENTATION OF VALUE-BASED CARE (VBC)

Globally, value-based healthcare is positively transforming the healthcare system by ensuring that patients receive the best possible healthcare outcomes at the lowest possible cost, while aligning healthcare professional incentives to promote the provision of clinical best practice.

Discovery Health and DHMS are at the forefront of this global transformation as showcased in the World Economic Forum Insight report[1] and the International Federation of Health Plans White Paper[2]. Case studies of the successful implementation of VBC projects were highlighted:

The Arthroplasty VBC programme successes since inception

- The Arthroplasty Network remunerates services under a global fee for the hospital, surgeon, anaesthetist, physiotherapist, and prosthesis, with all other costs billed on a fee for service basis.

Continuous learning and iteration in the primary care environment

- We implemented a value-based payments structure with additional tools to support the primary care environment. This allows general practitioners (GPs) to be remunerated based on their participation on digital platforms, facilitates an enhancement in quality health outcomes and promotes cost efficiency within the environment.

HOSPITAL AT HOME – PARTICIPANT IN THE HARVARD COLLABORATION

Hospital at Home, introduced in 2022, provides hospital-level care at home as an alternative for patients requiring admission to a general ward in an acute hospital. The Scheme has contracted two service providers, Discovery Health (in partnership with ER Specialist Governance Incorporated (ERSGI) and Quro Medical) to provide Hospital at Home services to members.

Discovery Health has collaborated with the Harvard School of Public Health and Brigham & Women's Hospital in the "Home Hospital Early Adopters Accelerator Program" to further develop and enhance the Hospital at Home clinical entry criteria, pathways and overall service. This has produced a clinically robust solution that will enable the best possible clinical standards and patient experience.

Since launching in January 2022, the Hospital at Home programme has received widespread interest and acclaim. In June 2022, Discovery Health won Gold in the Product and Service Innovation category for Hospital at Home at the EFMA-Accenture Innovation in Insurance Awards[3]. Discovery Health has also received widespread acclaim from various international partners through its membership with the Hospital at Home Users Group, a dynamic collaborative of Hospital at Home programmes and health system leaders in the US and Canada[4].

Once a treating specialist identifies that one of our members has an illness that can be treated at home, they can refer the patient to be admitted into hospital at home and access 24/7 monitoring of their patient's condition through a secure dashboard, until they are ready to discharge the patient.

AFRICA TELEHEALTH COLLABORATION (ATC)

Since the onset of the COVID-19 pandemic, global healthcare systems have repositioned themselves for efficiency and sustainability. Aligned with this has been the rise of virtual health and telehealth solutions, driving appropriate use of remote care. Globally, adoption has been favoured more among patients than clinicians. The same trend has manifested locally which, until the advent of the pandemic, was influenced by a restrictive telehealth regulatory environment.

To contribute to a constructive discourse on telemedicine regulations to the benefit of the Scheme's members, and the broader healthcare system, Discovery Health has participated in the Africa Telehealth Collaboration, a voluntary association developed in collaboration with leading industry stakeholders, to facilitate a broad-based approach to shaping a unique South African and African healthcare telehealth ecosystem. The ATC focuses on appropriately using telehealth to enhance access, cost-effectiveness and quality of care, particularly in resource-poor and underserved communities.

The ATC's work to date encompasses:

- Broad-based and targeted engagements with key stakeholders (including the Health Professions Council of South Africa (HPCSA), National Department of Health, National Treasury, College of Medicine SA, Council for Health Services Accreditation of Southern Africa, the South African Medico-Legal Association, various Non-Government Organisations (NGOs), healthcare providers, leaders and academics, CareConnnect, leading corporates and schools of health sciences and business schools).
- Publications in journals such as the South African Medical Journal to galvanise research.
- A website to facilitate collaboration and act as a repository for best practice guidelines and relevant research publications.
- Developing user engagement surveys, with an initial focus on healthcare providers.

The collaboration has demonstrated exceptional leadership and was pleased to note the release of the revised booklet 10 of the HPCSA guideline, which creates a more enabling environment to take telehealth forward in the South African healthcare landscape. In 2023, the ATC intends to scale its efforts by contributing to academic research and implementing projects on adopting telehealth in the South African context. An exciting inaugural Smart Health Conference is being planned for June 2023.

1 *The Moment of Truth for Healthcare Spending: How Payment Models can Transform Healthcare Systems. Insight Report, January 2023. World Economic Forum.*

2 *Unravelling Value Based Health Care: What health funds can learn from 15+ years of experience implementing Value-Based Health Care within international health markets. Author: Denisa Widyaputri, MD. Date: September 2022. Copyright iFHP (https://ifhp.com/).*

3 *https://www.mynewsdesk.com/za/discovery-holdings-ltd/pressreleases/triple-win-for-discovery-at-the-efma-accenture-innovation-in-insurance-awards-2022-3189672.*

4 *https://www.hahusersgroup.org/sites/.*

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES *continued*

HEALTH PROFESSIONAL REFERENCE GROUP (HPRG) TO ADDRESS FRAUD, WASTE AND ABUSE (FWA)

On behalf of the Scheme, Discovery Health's forensic auditing and analytics units employ a host of sophisticated tools and analytical methods for the ongoing detection of reimbursement irregularities, ensuring that medical scheme funding is paid in strict alignment with medical scheme and industry rules. The auditing processes and advanced data science techniques enable proactive and efficient detection of healthcare FWA that could otherwise threaten the sustainability of medical schemes and their ability to fund healthcare access.

On identifying a potential irregularity, the unit engages with relevant parties to verify their initial findings and most irregularities are easily explained though constructive interaction. In cases where undue reimbursement is confirmed, the losses of the Scheme are recovered and restored to the Scheme members' shared risk pool, once again available to cover their medical costs.

The process to detect and address FWA is regularly reviewed to ensure that it is fair and effective. This is done through the HPRG, an established collaborative forum where key healthcare professional stakeholders are invited to contribute to Discovery Health's forensic processes. The HPRG forum has endorsed a detailed revision of the engagement process with healthcare providers and will continue to contribute to a well-managed healthcare industry, facilitating access to quality healthcare and the long-term sustainability of medical schemes.

PROFESSIONAL CODING REFERENCE GROUP

Based on the success of the HPRG process, Discovery Health was approached by a broadly representative group of healthcare providers to collaborate on addressing the procedural coding system used in South Africa. This outdated system compromises the cost-effective adoption of new technologies into our private healthcare system. This highly functional engagement is making good progress in this regard and is also laying the foundation for the adoption of value-based healthcare. We will continue with this collaborative forum into 2023.

SHOWCASING DIABETES CARE

As members with diabetes use more healthcare than others, diabetes places an increased burden on the healthcare system. Since 2010, the prevalence of diabetes within DHMS has increased at a compound annual growth rate of 8.5%. As of 2022, the prevalence of diabetes within DHMS was 4.9% with these members accounting for 16.4% of DHMS' risk costs. The average cost for a member with diabetes (at R5,736 per month) is also 3.35 times greater than the average Scheme member.

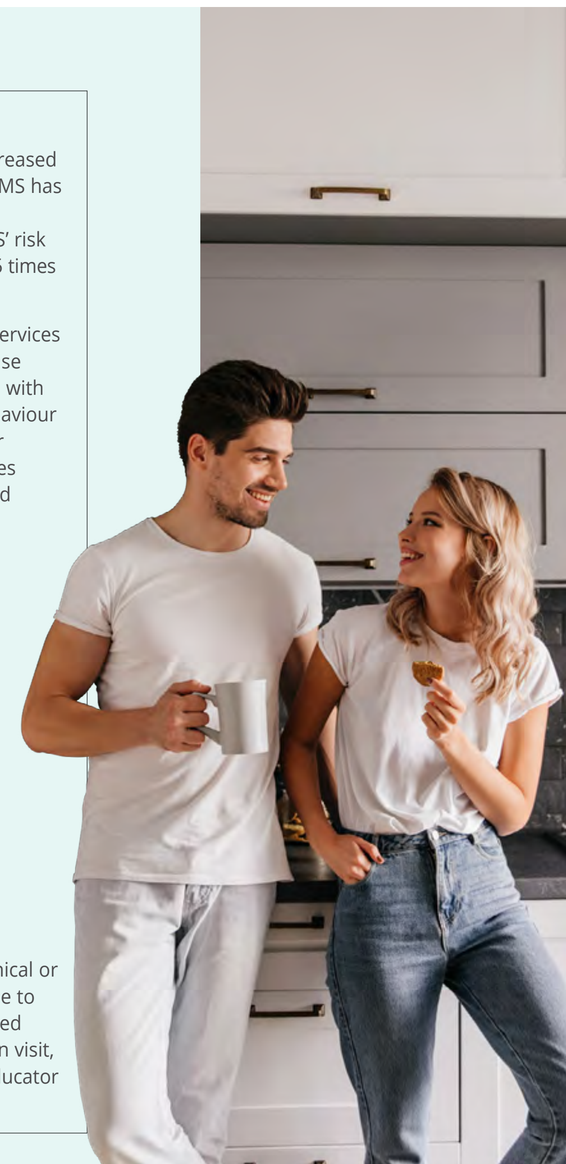
To significantly improve clinical outcomes, drive the appropriate utilisation of care services and reduce overall costs associated with diabetes, a population based chronic disease management programme, known as Diabetes Care, was implemented for members with diabetes. Driving innovation in care delivery, supporting positive health-seeking behaviour by members, and actively assisting healthcare providers to proactively manage their diabetes population are the cornerstones of this programme. Alignment of incentives through a shared value arrangement provided DHMS with the opportunity to reward quality of care outcomes and value derived from good clinical management.

The model has proved to be very successful, with enrolments on the programme increasing rapidly and tangible quality improvements being achieved.

In 2022	Members on Diabetes Care	Members not on a programme
At least one out of hospital consultation	90%	73%
HbA1C test completed	68%	46%
Kidney function test completed	44%	37%
Lipogram test completed	60%	40%
Microalbuminuria test completed	17%	8%

The success of the programme is demonstrated most significantly with a 11% lower admission and 21% lower re-admission rate for members on the Diabetes Care programme compared to those on no programme.

Members are encouraged to join the Diabetes Care programme, and there is no clinical or financial reason a member with diabetes should not be registered on it. We continue to enhance this programme with additional benefits which are additive to the prescribed minimum benefit treatment basket (e.g. additional glucose strips, additional dietitian visit, cover for a biokineticist) and other support such as coaching by a diabetes nurse educator or health coach, subject to meeting clinical entry criteria.



LOOKING FORWARD TO 2023

WELLTH *fund*

THE WELLTH FUND

COVID-19 has had an extraordinary impact on the healthcare choices we make, with many people deferring their routine, preventative care during the past few years. This is of great concern to the Scheme as it increases the probability of diseases being identified at later and more severe stages. In response, we are making the biggest single investment in the long-term health of our members by introducing the WELLTH Fund in 2023.

The WELLTH Fund is an advanced wellness benefit that will give members discretionary access to a range of tailored preventive screenings and other wellness checks. The benefit is activated once all beneficiaries on a policy have completed their health checks; checks that have taken place from 1 January 2022 are valid for this activation. The benefit offers members up to R10,000 per family for a comprehensive set of screening and prevention care services.

DOCTORS PLAY A CRUCIAL ROLE IN PROMOTING HEALTH AND PREVENTING DISEASE

The WELLTH Fund provides healthcare providers with a powerful set of additional tools and funding to support patients' access to care for early disease detection and management as well as missed screening and other preventive interventions that should have taken place during the first three years of the COVID-19 pandemic.

Under the guidance of their GP, patients can take ownership of their personal health journey once their health check assessments are complete. We urge healthcare providers to work closely with their patients to identify the best ways to use this benefit so that it is tailored to their specific health needs and concerns.

VIRTUAL HEALTH CHECK IN A DOCTOR'S ROOMS

Providers can offer a health check in their rooms by registering to participate in the Vitality Wellness Network.

The WELLTH Fund is an advanced wellness benefit that will give members discretionary access to a range of tailored preventive screenings and other wellness checks.

CARDIOMETABOLIC PROGRAM

People living with cardiometabolic syndrome have a significantly elevated risk of progressing to chronic disease, with a potentially substantial negative impact on life expectancy and quality of life.

We have developed a sophisticated model to identify Scheme members at the highest risk of being diagnosed with cardiometabolic disease in the short to medium term, allowing for early detection, intervention and potential reversal of disease progression. We are partnering with doctors to make the cardiometabolic programme available to patients who may be at risk of being diagnosed with cardiometabolic disease.

In 2023, DHMS members identified as at risk of developing cardiometabolic disease will be notified and prompted to consult with a Premier Plus GP[1] for further examination and investigation. If the risk is confirmed, members will be invited to enrol in a specially designed cardiometabolic management programme under the guidance of their Premier Plus GP, gaining access to a range of benefits funded by the Scheme.

If a cardiometabolic disease diagnosis is received while on the programme, members can be registered for Chronic Illness Benefits (CIB) and enrolled in the appropriate care programme (e.g. Diabetes Care, Cardio Care, or both). Those members that achieve appropriate risk reduction and disease reversal will exit the programme, with continued monitoring for any subsequent increase in risk.

1 *A Premier Plus GP is a network GP who has contracted with us to provide members with co-ordinated care and enrolment on one of our care programmes for defined chronic conditions, for example diabetes and hypertension.*

FINANCIAL ADVISERS (BROKERS)

The private healthcare industry in South Africa is complex, encompassing different types of healthcare providers, facilities, funding structures and mechanisms, as well as individual patient needs. Financial advisers play a critical role in helping existing and prospective members navigate this complexity by providing comprehensive and independent advice about the healthcare cover best suited to their specific health and affordability needs.

Financial advisers introduce individual consumers and employers to the full spectrum of medical schemes in the industry, helping them to compare the benefits, pricing, strengths and weaknesses, and service levels of competing medical schemes. Consumers can then match their needs with the most appropriate medical scheme and plan offering. Once consumers have joined a scheme, financial advisers provide ongoing information through annual reviews and update members and employers on product and service changes.

Financial advisers are reimbursed by the Scheme for their services according to legislated fees and their contractual arrangements with the Scheme – members do not pay them directly. Financial advisers must be registered with, and are regulated by, the Financial Sector Conduct Authority and must comply with the Financial Advisory and Intermediary Services Act. They must also be accredited by the CMS to provide advice on private healthcare cover.

Discovery Health engages extensively with financial advisers on the Scheme's behalf. In-depth training and assessment sessions are supplemented by annual product launches, webinars and in-person engagements to ensure advisers are supported with the most recent product information and industry knowledge. The Scheme ensures that our health plan information and marketing material is easily understood and accessible for the benefit of both members and advisers.

Perception surveys were conducted to establish how satisfied financial advisers are with Discovery Health's medical aid administration and product marketing. The overall perception score by advisers of Discovery Health for the year was 9.17 out of 10, up from 8.99 for 2021.

ENGAGEMENTS IN 2022

The annual update on the Scheme's product and benefit enhancements for 2023 was provided in a national rollout to over 200 business consultants and agents. It was also presented and broadcast to more than 8 200 financial advisers from the annual product launch event. Following the product update, several virtual sessions and approximately 30 in-person sessions were held with business consultants and financial advisers across the country to explain the contribution and benefit updates. Broker consultants also received training and were assessed on their knowledge of the Scheme's products, the private healthcare industry, and sales and presentation skills.

Discovery Health met with the Financial Intermediaries Association (FIA) to discuss the interpretation of CMS Circular 26 and 35 of 2022 and to share our independent response to these Circulars.

All financial advisers had access to year-end marketing material, including training videos, brochures, articles, FAQs and thought leadership insights informing financial advisers and their clients of updates and benefit changes for 2023.

THOUGHT LEADERSHIP

In addition to the annual product launch, two national webinars were held for corporate brokerages during the year to provide insights on the Scheme's strategies, industry position, financial results, and risk management initiatives.

Financial advisers can also access competitor industry analysis, topical white papers and documents to support the Scheme's differentiated offerings.

The COVID-19 information hub is updated regularly to provide advisers with access to the latest clinical insights, vaccine rollout and related information.

SERVICE ENHANCEMENTS

Significant investment has been directed into creating digital tools and platforms to better support financial advisers and improve the ease of doing business. Recent enhancements include:

- The Health New Business Digital Innovations Hub, located on the Financial Advisor Zone, which offers financial advisers the tools and content to enable growth and drive digital engagement;
- The New Business Online Journey, which has created efficiencies for financial advisers writing new business; and
- New servicing channels, such as virtual agents and WhatsApp for financial advisers.

DISCOVERY HEALTH (PTY) LTD

Discovery Health is a leader in healthcare administration and managed care with a proven track record of excellent service and innovation. Providing services to 3.5 million medical scheme members, Discovery Health provides administration and managed care services to DHMS, as well as 18 other restricted schemes. Our relationship with Discovery Health has enabled the Scheme to become the largest open medical scheme in South Africa.

The Scheme and Discovery Health have an arm's length contractual relationship that governs all activities outsourced by the Scheme to Discovery Health. Our working relationship is governed by the outcomes-based Vested model, which is characterised by a shared vision and aligned objectives to ensure the partnership works in the best interests of our members.

Discovery Health is appointed by the Scheme's Board and reports extensively to the Trustees, the Board Committees and the Scheme Office on a regular basis. The Trustees are responsible for ensuring that Discovery Health meets agreed strategic and operational requirements.

The managed care and administration agreements with Discovery Health were renewed in 2022. In addition, a Vested Compatibility and Trust (CaT) assessment was carried out, as well as a workshop to discuss the outcomes of the CaT assessment and the related qualitative feedback. The CaT assessment rates outcomes on a scale of unhealthy; developing relationship; healthy relationship; and Vested. The state of the DHMS-Discovery Health relationship scored as "very healthy", with three of the five dimensions falling in the Vested range, and with no material problems affecting the relationship identified.

The operational Vestedness of the relationship between the Scheme Office and various Discovery Health business units has been assessed from 2021 onwards, both for monitoring purposes as well as to guide improvement in specific areas. Again, the Vestedness of these relationships between the Scheme and these operational teams is very healthy overall.

The Trustees monitor and measure Discovery Health's performance against extensive service level requirements contained in the agreement between the Scheme and Discovery Health. Engagement between the organisations is frequent and focuses on:

- Scheme performance and risk management;
- Implementation of the Scheme's strategy;
- Product design and implementation of Scheme benefits;
- Fraud and forensics management;
- Marketing and sales;
- Member and other key stakeholder communication;
- Regulatory and industry matters;
- Internal audit compliance and combined assurance; and
- Stakeholder engagement on behalf of the Scheme, including escalation to the Scheme Office for direct involvement when required.

Two management committees, the Relationship Management and Innovation Committees, support enhanced governance and relational dynamics relating to the Vested relationship between DHMS and Discovery Health and provide scope for continued innovation. These management committees meet on a regular basis according to their terms of reference and function as effective mechanisms to enhance the working relationship and maintain a joint focus on innovation for the benefit of our members. The Relationship Management and Innovation Committees report on a regular basis to the Stakeholder Relations and Ethics Committee, and the Risk Committee respectively.

OUR EMPLOYEES

The Scheme is committed to protecting the dignity, safety and health of our employees and providing a decent work environment, fair remuneration, and opportunities for training and development. In line with our responsible corporate citizenship framework and good employer practices, we are committed to treating our employees in a fair and equitable manner. Our values inform all employee interactions and we have adopted a set of managerial leadership practices designed to enhance transparent communication and engagement towards best efforts in alignment with the Scheme's strategic objectives.

The Scheme's human resource policies are reviewed by the Remuneration Committee and approved by either the Remuneration Committee or the Board, according to the requirements of the delegation of authority, and embedded in the Scheme's human resources lifecycle. The Principal Officer is accountable for all employee-related matters and employees have access to all human resource policies.

The Scheme's small and specialised team must be agile in responding to industry developments and strategic and operational initiatives, including daily oversight of services performed by Discovery Health on behalf of the Scheme, to ensure the Scheme's effective operation and sustainability. Accordingly, the team's work and remuneration must be aligned to the Scheme's vision, purpose and objectives.

Training and development opportunities are regularly identified, and a development plan is in place for all employees, who attend training relevant to their work and their potential within the Scheme.

As a small team offers limited scope for promotion, the Scheme's value proposition for employees is assessed periodically to enable interventions that promote staff satisfaction and retention. Additionally, regular performance discussions help employees maintain focus on the Scheme's strategic objectives, their role objectives and career development.

The Scheme appointed independent expert consultants to conduct a role grading exercise during 2022 to ensure that all DHMS roles are appropriately positioned. This is being followed by a benchmarking exercise in 2023 to ensure that the roles are fairly and appropriately remunerated.

All employees and their dependants[1] have access to Healthy Company, a comprehensive employee assistance programme, incorporating physical, emotional and financial wellbeing, and legal support. As 2022 was a particularly busy year for the Scheme, workshops on stress, burnout and self-care were conducted to support employees in managing their health and wellbeing. We conducted a culture survey, similar to the survey conducted in 2020, to track changes and identify opportunities for improvement. The survey results will be interrogated closely in 2023, with appropriate interventions developed if needed. The Scheme also continues to monitor the implementation and outcomes of its hybrid workplace model, implemented in 2022, and will continue to adjust this to achieve an optimum balance of operational requirements, employee engagement, maintaining Scheme Office culture, fostering relationships with key stakeholders, and offering a suitable degree of flexibility to employees.

1 *Dependants are spouses, children, parents, or anyone living in the same household as the main member who are financially dependent on the main member. An employee's dependants can access advice and assistance with episode management, including telephonic support and counselling with a Discovery Healthy Company coach, legal adviser, debt or trauma counsellor, or through face-to-face consultations with registered psychologists or social workers.*

REGULATORY BODIES

The Scheme and Discovery Health are required to adhere to strict legislation, with the Scheme primarily governed by the Act. We work co-operatively with our regulatory bodies and relevant stakeholders, advocating for effective regulatory reform to drive positive change in the healthcare industry, including contributing towards health policymaking and amendments to legislation.

Maintaining constructive relationships with our industry regulators is critical to the Scheme's ability to create value. We work hard to build and maintain a collaborative working approach and to keep lines of communication open with the relevant authorities.

The Scheme and Discovery Health continue to engage the National Department of Health and the CMS on matters affecting the sustainability of the broader industry, including advocating for broad-based access to private healthcare, access to more affordable health technology, managing fraud, waste and abuse, and in promoting positive regulatory change. The Scheme also engages on industry-related matters with regulators through our industry representative body, the Health Funders Association (HFA), and through the Health Policy Subcommittee of Business Unity South Africa (BUSA). We may engage with the Information Regulator, Competition Commission, and other regulators as required.

COUNCIL FOR MEDICAL SCHEMES

The CMS regulates all medical schemes in South Africa. Its role includes:

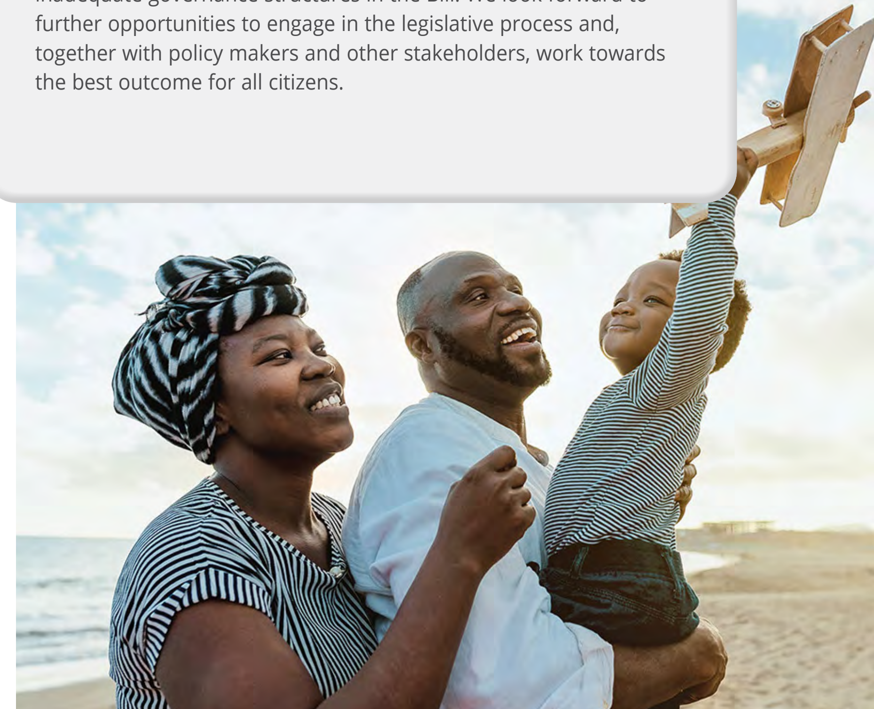
- Protecting and educating the public regarding their medical scheme cover;
- Assessing and registering schemes' rules and benefits;
- Handling complaints and disputes between the public and medical schemes;
- Ensuring that schemes comply with the Act and maintain high standards of governance and management; and
- Working with the Department of Health regarding regulatory and policy interventions.

The Scheme engages actively with the CMS on matters of health policy, application and interpretation of rules, benefit design, Scheme finances and resolution of disputes with members. In 2022, the CMS published 71 circulars and the Scheme submitted responses to these where required, as well as to other ad hoc and formal enquiries from the CMS. The Scheme also seeks required approvals from the CMS for annual Scheme Rules, benefits updates and new plans. The CMS publishes regular reports covering activity across the private healthcare funding industry.

THE NATIONAL DEPARTMENT OF HEALTH AND THE PARLIAMENTARY COMMITTEE ON HEALTH

The Scheme interacts with the National Department of Health whenever required, either directly or through the HFA. DHMS supports the objectives of universal health coverage as well as the need for the healthcare industry to respond to the needs of its patients within our social, economic and demographic context.

We closely monitor the progress of the National Health Insurance Bill and have raised various shared concerns including possible Constitutional challenges to the Bill, the potential impact on the right of access to healthcare, alternative funding models, and inadequate governance structures in the Bill. We look forward to further opportunities to engage in the legislative process and, together with policy makers and other stakeholders, work towards the best outcome for all citizens.



06

Governance and leadership

How we are governed

The industry in which we operate is highly complex, making best practice governance both central to our business model (which guides our strategy, approach to risk and daily operations) and our continued ability to operate.

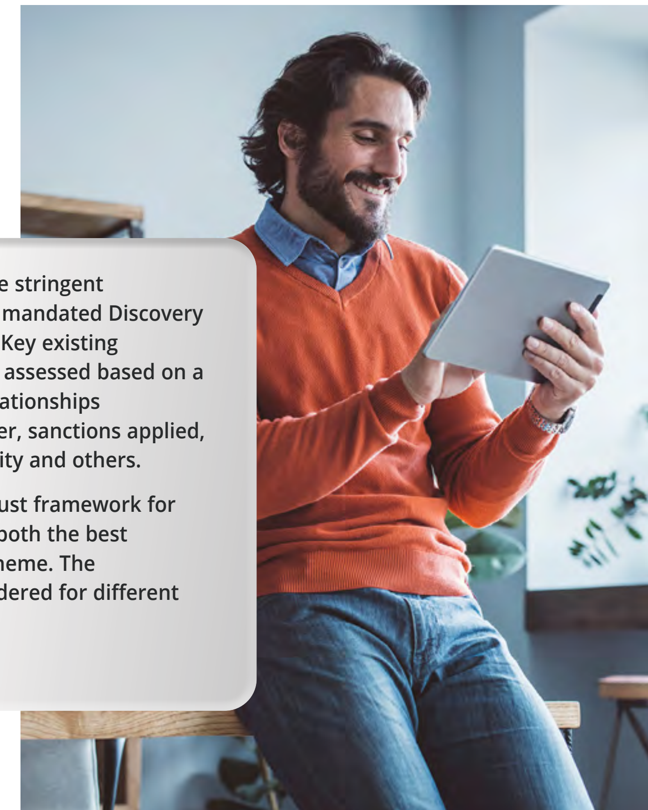
Meeting the needs and expectations of our members and providing them sustainable access to affordable and equitable healthcare means that we must go beyond compliance and maintain our thought leadership in this arena to ensure that we can create and protect value for these and other key stakeholders, while limiting value erosion.

All medical schemes in South Africa are governed by the Medical Schemes Act (the Act). Discovery Health Medical Scheme (DHMS or the Scheme) Rules are developed in accordance with the Act and registered annually by the Council for Medical Schemes (CMS).

Additional governance guidance is taken from the King IV Report on Corporate Governance for South Africa 2016 (King IV) which sets the standard for good corporate governance in South Africa and is internationally recognised as best practice. King IV defines corporate governance as the exercise of ethical and effective leadership by boards to achieve:

- EFFECTIVE CONTROL
- GOOD PERFORMANCE
- AN ETHICAL CULTURE
- LEGITIMACY

The Board of Trustees (the Trustees or the Board) embrace the principles of King IV in achieving optimal governance outcomes for the Scheme and within the Scheme environment. According to the Scheme Rules, the Scheme's affairs must be managed by a fit and proper board. Trustees are entrusted to lead ethically and effectively, both individually and as part of the board, and must conduct themselves with requisite competence, integrity, accountability and transparency.



In 2022, the Scheme developed a framework for a more stringent procurement governance process for the Scheme, and mandated Discovery Health to operate the process on the Scheme's behalf. Key existing suppliers, as well as all potential new suppliers, will be assessed based on a range of criteria including investigations underway, relationships potentially influencing the relationship with the supplier, sanctions applied, undesirable associations, licence and registration validity and others.

The Scheme engaged advisers in also developing a robust framework for engagement with related parties[1], designed to ensure both the best outcomes for its members and sustainability of the Scheme. The framework sets out various factors that must be considered for different types of contracting arrangements.

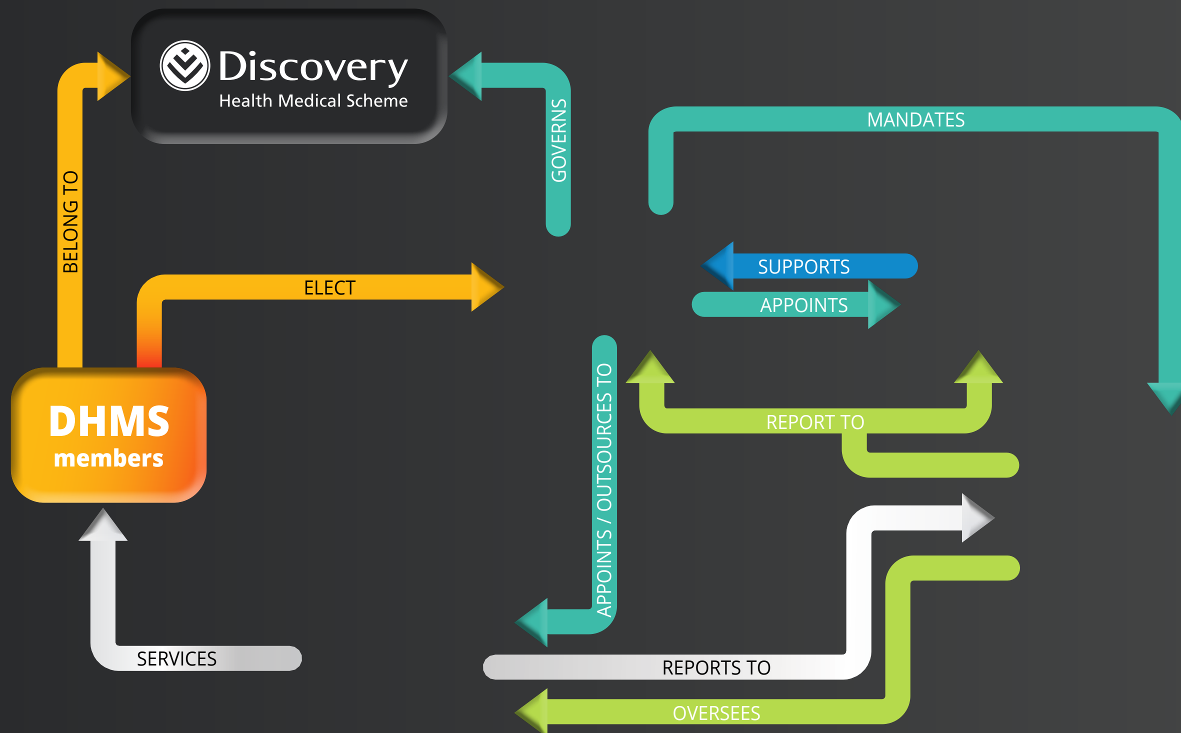
Both frameworks are being piloted in early 2023.

1 The International Accounting Standards (IAS) define a related party as a person or entity that is related to the entity that is preparing its financial statements (referred to as the 'reporting entity') [IAS 24.9].

The Board of Trustees

DHMS is governed by an independent Board, responsible for overseeing the business of the Scheme. The Trustees hold decision-making power and are ultimately responsible for overseeing the Scheme's material matters, developing and implementing the Scheme's strategy and responsibly managing its business and policies.

Our governance structures



Trustees are accountable to the Scheme's members and their overriding objective is to ensure that the best interests of Scheme members are served equitably, while safeguarding the sustainability of the Scheme.

The Board comprises independent, highly skilled professionals with a diverse range of specialisms, experience and professional backgrounds, bringing multiple perspectives to bear in discussion and debate, ensuring robust oversight and strategic decision-making. Our Trustees' expertise extends across various fields including legal, actuarial, accounting, economics, governance, medical, mental health, financial, financial reporting, and investment. The Trustees seek to dedicate themselves to the discharge of their fiduciary duties. This extends beyond attendance at meetings, to ensure effective leadership and stewardship.

Composition and functioning

The affairs of the Scheme are managed by a Board of a minimum of five and a maximum of eight persons. At any given time, at least half of the Trustees must be elected by Scheme members, with the balance either elected by Scheme members or appointed by the Trustees, provided that the number of appointed Trustees shall at any given time, not exceed three.

The Scheme has no influence over the election of member-elected Trustees and the resulting Board composition. Due to its limited succession planning ability in this regard, the Board may appoint additional Trustees to fill knowledge, experience and skills gaps where required, and may re-appoint such Trustees (subject to the requirement that all Trustees may only serve two consecutive terms of not more than three years each). Trustees have access to professional advice, both within and outside of the Scheme, to inform the proper execution of their duties. They may also obtain such external or other independent professional advice as they consider necessary.

The role of the Trustees

The Trustees are responsible for strategic oversight and sound management of the Scheme. In this regard they:

- Evaluate, direct and monitor the Scheme's strategy, ensuring alignment with the purpose and value drivers of the Scheme, alongside the legitimate interests and expectations of stakeholders;
- Review the sustainability of the Scheme and evaluate whether the services offered by the administration and managed care provider (Discovery Health) meet the needs of and offer value for money to the Scheme and its members;
- Monitor innovation and oversee the functioning of the Scheme Office, and the improvement of the Scheme's operations at all levels;
- Monitor adherence to Scheme Rules and the provisions of the Act in the day-to-day running of the Scheme's affairs; and
- Consider stakeholder perceptions and their impact on the Scheme's reputation.

At all times, the Trustees must act with due care, diligence, skill and good faith in the best interests of the Scheme and its members. Measures are in place to assess any conflicts of interest that may arise, and the Trustees manage these in accordance with best practice governance and any relevant legal requirements.

The duties of the Trustees, set out in the Act and the Scheme Rules

- Take all reasonable steps to ensure that the interests of beneficiaries, in terms of the Scheme Rules and the provisions of the Act, are protected at all times while acting with impartiality in respect of all beneficiaries;
- Ensure the proper and sound management of the Scheme by applying sound business principles to ensure its financial position is sound;
- Take all reasonable steps to protect the confidentiality of medical records concerning the state of health of the Scheme's members, and ensure that the Scheme Rules, operations and administration comply with the provisions of the Act and all other applicable laws;
- Oversee and direct the management of the Scheme's outsourced activities performed by the administration and managed care provider;
- Appoint, evaluate and delegate oversight functions to the Principal Officer;
- Ensure that proper control systems and record keeping are employed by and on behalf of the Scheme; and
- Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Scheme Rules.

Board activities

As required by its annual calendar and the operational and strategic requirements for 2022, the Trustees met 13 times during the year.

At each meeting, the Board reviews a range of materials and topics including those raised by Committee Chairpersons, standard operational reports and specific strategic reports; they also have access to all Committee minutes.

The Board's key activities for the 2022 financial year are listed alongside.

OPERATING CONTEXT

- Considered and discussed key factors in the operating environment likely to impact the healthcare industry and the Scheme. These included:
  - Our competitive landscape, particularly as this relates to findings from the 2022 CMS Annual Report indicating that a number of medical schemes may have been underpricing contributions and may not keep pace with medical inflation;
  - Sector-related change, innovation and disruption;
  - Our current regulatory landscape and any forthcoming regulatory changes; and
  - The continuing and projected impacts of COVID-19 on health, healthcare and medical schemes.
- Discussed the potential impact of Health Squared Medical Scheme's liquidation on the market and DHMS.

STRATEGY AND PERFORMANCE

- Reviewed DHMS' performance against the 2021 strategy, and approved the 2022 strategy.
- Considered Scheme growth for 2021 and reviewed and discussed the 2022/2023 product strategy.
- Discussed benefit enhancements for 2022/2023, including enhancements to the oncology benefit.
- Deliberated the revised actuarial valuation report and approved a 7.9% contribution increase (effective 1 October 2022), amending Scheme Rules where required.
- Considered and approved the 2022 actuarial valuation report, 2023 benefit and rule changes and a deferred contribution increase for 2023.
- Approved a new efficiency discounted option for the Essential Plan; this was submitted to the CMS for registration.
- Deliberated and resolved to re-submit a Low-Cost Benefit Option (LCBO) business plan to the CMS for registration.

VESTED® OUTSOURCING

- Considered and discussed recommendations from the Services Renewal Committee on fee negotiations for our outsourced administration and managed care functions.
- Discussed the Administration fee proposal and mandated the Scheme Office to negotiate fees and innovation spend terms with Discovery Health.
- Considered Discovery Health's operations strategy for 2022.
- Reviewed and evaluated the value delivered by Discovery Health in 2022.
- Reviewed a strategy presentation by Discovery Connect regarding their progress delivering membership growth on behalf of the Scheme.
- Reviewed and discussed Discovery Health deliverables for 2021 and 2022, ensuring these remain aligned with Scheme requirements.
- Deliberated and approved the accredited administration services, other administration services and managed healthcare agreements, mandating the Principal Officer to execute these agreements with Discovery Health.

GOVERNANCE

- Debated and deliberated Board and Board Committee succession planning requirements, identifying any vacancies that needed to be filled.
- Approved appointing an additional Trustee[1] and discussed Board and Committee reconstitution in light of the election of three new Trustees at the 2022 Annual General Meeting (AGM)[2].
- Confirmed the re-appointment of Dr Alewyn Burger and Mr Eric Mackeown.
- Discussed the recruitment process for the Nomination Committee and the proxy process at the AGM.
- Discussed and considered governance aspects of related party contracting and conflicts of interest and decided that a framework be considered and put in place.
- Reviewed and approved the 2023 Board charter and all Committees' terms of reference.
- Discussed and approved the updated delegation of authority framework.

1 Ms Michelle Norton's term commenced 1 January 2023.

2 Ms Joan Adams, Mr Marius Du Toit and Dr Max Price.

REMUNERATION

- Reviewed feedback from the Remuneration Committee's discussions and approved salary increases and short-term incentives for employees.
- Discussed Trustee remuneration and considered and approved long-term incentives for the executive team.

REPORTING AND ASSURANCE

- Approved the Audit Committee's recommendation to appoint PricewaterhouseCoopers Inc. (PwC) as the Scheme's independent auditor for the 2022 financial year.
- Deliberated the mandatory audit firm rotation processes and approved the Audit Committee's recommendation for tabling at the Scheme's 2023 AGM.
- Contemplated and approved the material matters for the 2021 Integrated Report.
- Considered and approved the Scheme's 2021 annual Financial Statements and Integrated Report.

Trustee remuneration

Trustees are remunerated for their services in terms of the Scheme's Remuneration Policy. The benchmarked professional fees of Trustee and Board Committee Members are discounted in recognition of the Scheme's non-profit status.

Board evaluations

As of 2022 the Board is assessed annually, either by external independent parties or through self-appraisals. The last Board evaluation was conducted by the Institute of Directors in South Africa (IoDSA) in December 2022 via self-evaluation questionnaires and virtual consultations with each Trustee, resulting in an overall evaluation score of 4.6 out of 5 (rated as excellent by the IoDSA). As part of the evaluation, the IoDSA reviewed responses against King IV corporate governance best practice to develop a plan and recommend actions for the Board. The report will be assessed by the Board and an implementation plan put in place to address relevant gaps identified. The next evaluation will be conducted in December 2023.

The Board is satisfied that the diverse skills and experience of the Trustees enable it to competently execute its duties and fulfil its responsibility to the Scheme's members. In addition, the Board is satisfied that it has fulfilled its mandate in accordance with its charter and the Act, having carried out its duties in an ethical, responsible and equitable manner throughout the year.

Trustee terms

Trustee	Designation	Appointed/Elected	Start of Term	End of Term
Mr David King	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	23 Jun 19	22 Jun 22
Dr Dhesan Moodley	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Mr Neil Morrison	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Ms Joan Adams SC[1]	Trustee	Elected	22 Jun 17	30 Aug 21
	Trustee	Elected	23 Jun 22	22 Jun 25
Mr Johan Human	Independent Co-opted Member	Appointed	05 Sep 16	13 Aug 17
	Trustee	Appointed	14 Aug 17	13 Aug 20
	Trustee	Re-appointed	14 Aug 20	14 Aug 23
Mr John Butler SC[1]	Independent Co-opted Member	Appointed	05 Sep 16	13 Jun 17
	Trustee	Appointed	14 Jun 17	13 Jun 20
	Trustee	Re-appointed	14 Jun 20	13 Jun 23
Dr Susette Brynard[2]	Trustee	Elected	22 Jun 17	30 Aug 21
	Trustee	Elected	01 Sep 21	31 Aug 24
Mrs Lalita Harie	Trustee	Elected	01 Sep 21	31 Aug 24
Dr Max Price	Trustee	Elected	23 Jun 22	22 Jun 25
Mr Marius du Toit	Trustee	Elected	23 Jun 22	22 Jun 25
Ms Michelle Norton SC[2]	Trustee	Appointed	01 Jan 23	31 Dec 25

1 The terms of Ms Adams and Dr Brynard were to have ended on 21 June 2020, but due to COVID-19 restrictions on gatherings, the Scheme sought and received the necessary exemption and approval from the CMS to extend their terms until such time that the joint 2020/2021 AGM was held on 30 August 2021.

2 Ms Norton was appointed during 2022. Her term began with effect from 1 January 2023.

The Board is satisfied that the diverse skills and experience of the Trustees enable it to competently execute its duties and fulfil its responsibility to the Scheme's members.

2022 Meeting Attendance Record

Board Meetings attendance in 2022		23 Feb	24 Feb	28 Feb[A]	13 Apr	10 Jun	22 Jun[A]	15 Jul	01 Aug[A]	30 Aug[A]	08 Sep	22 Sep[A]	21 Oct[A]	24 Nov
Trustees	Mr John Butler SC %	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Dave King *	✓	✓	✓	✓	✓	✓	–	–	–	–	–	–	–
	Dr Dhesan Moodley *	✓	✓	✓	✓	✓	✓	–	–	–	–	–	–	–
	Ms Joan Adams SC ◊	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓	✓
	Mr Johan Human	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ms Lalita (Gita) Harie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Marius du Toit ◊	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓	✓
	Dr Max Price ◊	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓	✓
	Mr Neil Morrison *	✓	✓	✓	✓	✓	✓	–	–	–	–	–	–	–
	Dr Susette Brynard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairperson: Audit Committee	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Independent Members	Dr Alewyn Burger #	✓	–	–	–	–	–	–	✓	–	–	–	–	–
	Ms Henda van Deventer #	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Prof Laurel Baldwin-Ragaven #	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Ms Melanie Bosman #	✓	–	–	–	–	–	–	✓	–	–	–	–	–
	Mr Ndumiso Luthuli #	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Dr Nonkululeko Mlaba #	✓	–	–	–	–	–	–	–	–	–	–	–	–

A - Ad hoc meetings:

Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee Members are remunerated according to the preparation and duration of such meetings.

- *A meeting was convened on 28 February 2022 to discuss the appointment of an Acting Principal Officer for the duration of the Principal Officer's leave.*
- *A meeting was convened on 22 June 2022 to discuss the services renewal agreements with Discovery Health.*
- *A joint Board, Audit and Product Committee meeting was convened on 1 August 2022 to discuss the revised DHMS Actuarial Valuation Report in preparation for the 2022 contribution increase.*
- *A meeting was convened on 30 August 2022 to discuss the updated LCBO business plan and the Essential Smart efficiency discount option plan.*
- *A meeting was convened on 22 September 2022 to discuss various matters including succession planning, recruitment and service level agreements, and to discuss and close out outstanding matters emanating from the 2022 annual general meeting.*
- *A meeting was convened on 21 October 2022 to discuss the services renewal agreements with Discovery Health.*

% *Mr Butler was appointed as Chairperson of the Board of Trustees effective 1 January 2022.*
* *Term ended on 22 June 2022.*
◊ *Elected as a Trustee effective 23 June 2022.*
\# *Invited to attend the Board of Trustees Strategy Session on 23 February 2022.*
– *Not required to attend.*

Our Trustees[1]

MR JOHN BUTLER SC

CHAIRPERSON (from 1 January 2022)

BCom LLB; MA (Senior Counsel, member of the Cape Bar)

Mr Butler SC is a practising advocate and was appointed Senior Counsel in 2008. He specialises in commercial practice, including insolvency, company, insurance, finance and banking, and competition law. He has served as an acting judge of the High Court of South Africa, and as an arbitrator in commercial disputes. He is a former chairperson of the Cape Bar Council.

Mr Butler was appointed as a Trustee on 14 June 2017 and serves on the Stakeholder Relations and Ethics and Remuneration Committees. He was elected Chairperson of the Board effective 1 January 2022.

1 *All ages are at 31 December 2022.*

MS JOAN ADAMS SC

Bluris LLB; MInstD

Ms Adams SC has been an advocate for 35 years. She was previously a Senior State Advocate and Senior Family Advocate and served for five years on two presidentially elected Commissions of Inquiry addressing fraud and corruption. She was appointed Senior Counsel in early 2018. She is an experienced commercial forensic practitioner and a member of the Legal Practice Council, the Gauteng Society of Advocates and the Institute of Directors of Southern Africa. Ms Adams SC has considerable experience in medical law and ethics, has chaired numerous professional conduct inquiries, and has presented various ethics seminars.

She was elected as a Trustee in 2017 and served on the Clinical Governance, Risk, Audit and Stakeholder Relations and Ethics Committees until her term ended in June 2020. She was re-elected in June 2022, and serves on the Investment, Remuneration, Risk and Stakeholder Relations and Ethics Committees.

DR SUSETTE BRYNARD

BSc (Sciences); PhD (Education); Trustee Development Programme

Dr Brynard was a lecturer and research fellow at the University of the Free State, specialising in education management. She was formerly part of the management team of the Bloemfontein College of Education, and is currently a director of SAMBA, a co-operative buy-aid. She also serves on the National Executive Council of Down Syndrome South Africa. She attained her postgraduate degrees cum laude and is doing ground-breaking work on the education and development of learners with Down syndrome internationally, and currently assists the London Down Syndrome Consortium in their research on Alzheimer's disease. She also serves as vice chair of the National Executive Council of Down Syndrome South Africa.

Dr Brynard was elected as a Trustee in 2017, currently chairs the Stakeholder Relations and Ethics Committee, and serves on the Remuneration and Product Committees.

MRS LALITA (GITA) HARIE

BA (Social Work); BA (Hons) Social Science (Psychology); Certified Director (IoDSA)

Mrs Harie has more than 40 years' experience in the mental health field, 19 years of which was as executive director of one of the largest mental health non-governmental organisations (NGOs) in the country. She is currently serving as a non-executive director on the boards and standing committees of the Health and Welfare Sector Education and Training Authority, Health Systems Trust and Professional Board for Psychology of the Health Professions Council of South Africa. Mrs Harie has also been appointed by the Legal Services Ombud onto the Database of Lay Persons to serve on the disciplinary committees of the Legal Practice Council and its Appeal Tribunal.

She has received numerous awards in recognition of her leadership, governance, and innovative services and was selected on two occasions for the International Visitors Leadership Programme (IVLP) by the United States Department of State to visit the USA for mental health programmes, the second visit being as an IVLP Gold Star Alumni participant.

Mrs Harie was elected as a Trustee on 31 August 2021, chairs the Risk Committee and also serves on the Clinical Governance and Stakeholder Relations and Ethics Committees.

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MR JOHAN HUMAN

BBusSc; FIA[1]; FASSA[2]

Mr Human has more than 25 years' experience in actuarial and healthcare consulting to large corporate organisations and medical schemes. He is currently a director and co-founder of LifeHouse Finance (Pty) Ltd, with interests in private equity, infrastructure fund management and structured finance.

Mr Human was appointed to the Board on 14 August 2017 after being co-opted as an Independent Co-opted Member on 5 September 2016, and was re-appointed for a second term in August 2020. He currently chairs the Investment and Product Committees and serves on the Audit Committee.

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MR DAVID KING[3]

BSc (Hons); MBA; Health Risk Management and Managed Care Certificate

Mr King is a seasoned business executive with over 25 years' multinational experience. He spent 12 years as Human Resources Director of Brandhouse Beverages and was instrumental in their becoming a formidable competitor in the South African drinks industry. He previously chaired the board of Oxygen Medical Scheme and is an expert in executive leadership and employee engagement.

Mr King was elected as a Trustee in 2016, chaired the Remuneration and Risk Committees, and served on the Stakeholder Relations and Ethics Committee.

60

DR DHESAN MOODLEY[4]

Masters in Metabolic, Functional and Anti-aging Medicine; MMed (Sports Science); MBChB; MBA; EDP Economics

Dr Moodley is currently in private practice in Functional and Anti-aging Medicine. He is a non-executive director of the Smile Foundation, an NGO that conducts corrective surgery for children with conditions such as cleft palate or burns. Previously, he was president of Alexander Proudfoot North America and Africa, CEO of Bluepeter Consulting, partner of Ethos Private Equity Technology Fund, associate partner at Accenture, and principal at Gemini Consulting. He has deep expertise in health insurance and healthcare. His past and present affiliations include the Health Professionals Council of South Africa, South African Medical Association, American Academy of Anti-aging Medicine, Young Presidents' Organisation, World Presidents' Organisation, Black Management Forum of South Africa, and American Chamber of Commerce.

Dr Moodley served the Scheme as Chairperson and a Trustee between 2001 and 2011. In 2016, he was re-elected as a Trustee, chaired the Clinical Governance and Investment Committees, and served on the Product and Stakeholder Relations and Ethics Committees.

66

MR NEIL MORRISON[5]

BSc (Hons) Physics; MA (Economics)

Mr Morrison was an external consultant to McKinsey and Company until 2015. Before this, he was Special Adviser to the Minister of Public Enterprises and until 2004, CEO of Deutsche Bank, Johannesburg Branch as well as head of its Global Markets division.

Mr Morrison was elected as a Trustee in 2016. He served on the Audit, Investment and Remuneration Committees, having previously served on the Stakeholder Relations and Ethics Committee. He was elected Chairperson of the Board on 14 August 2017 and served until 31 December 2021, when he resigned as Chairperson to allow for a handover period and succession planning for the position.

1 Fellow of the Institute of Actuaries UK.
2 Fellow of the Actuarial Society of South Africa.
3 Term ended on 22 June 2022.
4 Term ended on 22 June 2022.
5 Term ended on 22 June 2022.

MS MICHELLE NORTON SC

BA LLB; D Phil

Ms Norton SC is a practising advocate and a member of the Cape Bar and the Johannesburg Bar. She was appointed Senior Counsel in 2015. She specialises in public law, competition law, and general commercial law. She has served as an acting judge of the Western Cape High Court and acted as an arbitrator. She has served on the Cape Bar Council, chaired the Cape Bar's Pro Bono Committee and Transformation Committee, and is a trustee of the Equal Education Law Centre.

Ms Norton was appointed as a Trustee effective from 1 January 2023. She serves on the Stakeholder Relations, Remuneration and Product Committees.

DR MAX PRICE

MBBCh; BA; MSc; Postgraduate Diploma in Occupational Health

Dr Max Price is qualified in medicine and public health. Most recently he was vice chancellor of University of Cape Town for ten years, before which he was dean of the Wits Faculty of Health Sciences for ten years. His earlier academic work was in health economics and policy and he was instrumental in the creation of the Wits Donald Gordon Private Academic Hospital. He is currently an independent consultant in leadership and higher education. He also serves, or has served, on the boards of several public benefit organisations and has previously served as a trustee of another medical aid scheme.

Dr Price was elected as a Trustee in 2022, currently chairs the Clinical Governance Committee and serves on the Stakeholder Relations and Ethics Committee, the Product Committee and the Service Renewal Committee.

MR MARIUS DU TOIT

BCom (Mathematics); FASSA[1]

Mr du Toit has extensive experience as a professional actuary, as well as long range strategic planning and policy decision making, revision and creation of legislation, actuarial governance and compliance. He has advised funds on various aspects including funding requirements, investment strategy, benefit structures and reinsurance requirements. His roles have included that of divisional executive of the FSCA[2], and Acting Chief Financial Officer and Chief Actuary of the FSB[3].

Mr du Toit has served on various committees of the International Association of Actuaries and the Actuarial Society of South Africa and he has served as a trustee of two pension funds.

He was elected a Trustee in June 2022, and serves on the Audit, Investment and Product Committees.

1 *Fellow of the Actuarial Society of South Africa.*
2 *Financial Sector Conduct Authority.*
3 *Financial Services Board (now the Financial Sector Conduct Authority).*

Board Committees

In compliance with the Act and in line with best practice governance principles, the Board has established appropriate governance structures to navigate and manage the complex operating environment, risks and strategic objectives of the Scheme.

The Board is supported by nine Board Committees constituted and structured according to the needs of the Scheme, to assist the Board to effectively fulfil its fiduciary and oversight duties. Board Committee Members comprise both Trustees and Independent Members according to each Committee's requirements. Independent Committee Members serve three-year terms and are eligible for subsequent re-appointment for a further term but may not serve more than two consecutive terms. Committee Members are remunerated for their services in terms of the Scheme's Remuneration Policy.

The Committees each have terms of reference and clear procedures for reporting, and report to the Board regularly. The terms of reference set out each Committee's role and responsibilities and are reviewed annually to ensure continued relevance to the business of the Scheme. The Committees make recommendations to the Board for approval of decisions to be taken, and for any changes required to their terms of reference.

Board Committee evaluations

Board Committee evaluations contribute to the effectiveness of the Committees and the Board as a whole, form part of their accountability duties, and allow a greater granularity of governance scrutiny within the Scheme.

On 10 October 2022, DHMS appointed the IoDSA to independently facilitate the Board Committee evaluation. Self-evaluations were conducted by individual Committee Members to assess the performance of the specific DHMS Committees they serve on. Each Committee received an overall score tallied from the individual self-evaluations of its members. These results indicate that our Committees are operating exceptionally well (rated as excellent by the IoDSA):

All Committees deliberated on the feedback received from the IoDSA and the findings were reported to the Board, together with recommendations for how to enhance performance where necessary.

The Nomination and Dispute Committees were not evaluated as they are independent and exclude Trustee representation to maintain impartiality and independence in fulfilling their duties.

OUR COMMITTEES' MANDATES, ACTIVITIES, ATTENDANCE AND FUTURE FOCUS

AUDIT COMMITTEE

The Audit Committee is a statutory committee established in line with the requirements of Sections 36 (10) to (13) of the Act. Chaired by an Independent Committee Member, it comprises at least five highly skilled and experienced members with extensive financial, actuarial, governance, legal, and IT governance expertise and knowledge. At least two members of the Committee are Trustees and the majority are Independent Committee Members. The Committee assists the Board in discharging its responsibilities relating to safeguarding assets, operating adequate and effective internal control systems, and preparing fairly presented financial statements in compliance with all applicable legal and regulatory requirements and accounting standards.

The responsibilities of the Committee include:

- Providing oversight for and ensuring the integrity of the Scheme's Integrated Report, Financial Statements and related procedures;
- Considering the impact of any financial, fraud, information technology, regulatory and other risks on the integrity of the Scheme's financial results;
- Reviewing the basis on which the Scheme has been determined to be a going concern;
- Reviewing the statutory solvency requirements of the Scheme;
- Reporting to the Board on the acceptability of the Scheme's accounting policies;
- Considering and recommending the appointment and/or termination of the external auditor, including their audit fee, independence and objectivity, and determining the nature and extent of any non-audit services;
- Overseeing external and internal auditors;
- Evaluating the expertise and experience of the Internal Audit and outsourced finance functions;
- Evaluating the independence and objectivity of the Internal Audit function;
- Evaluating the performance of the Chief Financial Officer;
- Monitoring the effectiveness and appropriateness of the combined assurance model;
- Monitoring matters relating to the sustainability of the Scheme to the extent that these impact the financial results; and
- Considering and recommending annual contribution increases for approval by the Board.

COMBINED ASSURANCE

The Scheme's combined assurance model, which was approved by the Committee during the year, is based on three lines of defence:

FIRST LINE	Scheme management (Principal Officer and executives);
SECOND LINE	Risk, Compliance, Quality Assurance and Forensics functions; and
THIRD LINE	Internal Audit, appointed external auditors, appointed independent actuaries and other independent assurance providers.

The combined assurance assessment showed that adequate assurance was provided and received in respect of all significant risks for the 2022 benefit year. The Trustees are satisfied with the level and type of assurance the Scheme obtains.

ACTIVITIES DURING 2022

The Committee considered the results of the 2021 committee effectiveness review, making changes where required, and continued to support the Trustees in fulfilling their governance and oversight responsibilities during the year. The Committee is satisfied that its activities, reporting and recommendations to the Board during 2022 have fulfilled its responsibilities in accordance with its terms of reference.

During 2022, the Audit Committee and the Mandatory Audit Firm Rotation (MAFR) Committee, began the process to find a suitable audit firm to succeed PwC for the financial period beginning 1 January 2024. This is in compliance with the MAFR requirement from the Independent Regulatory Board for Auditors (IRBA) that takes effect on 1 April 2023.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Audit Committee comprised two Trustees and three Independent Committee Members, one of whom chaired the Committee.

In accordance with its annual work plan, the Committee met four times and held additional ad hoc meetings. The Audit and Product Committees jointly considered the preliminary actuarial valuation and contribution increases for the 2023 benefit year; PwC and Insight Actuaries & Consultants, the Scheme's external auditors and independent actuaries, were invited to attend. The external and internal auditors met regularly with the Committee without the administration and managed care provider and Scheme management present.

The external auditor, internal auditor, Scheme management and heads of the outsourced administration functions attend all Committee meetings by invitation, to provide information and insight into their areas of responsibility. They also have unrestricted access to the Chairperson of the Audit Committee.

The Committee may consult any expert or specialist to assist in performing its duties. The Independent Actuarial function is regularly invited to Committee meetings to provide information and assurance in accordance with the applicable agreements in place.

Audit Committee attendance in 2022		24 Mar	26 May[A]	01 Aug[A]	11 Aug	25 Aug	31 Aug[A]	20 Oct
Independent Member/ Chairperson	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	✓	✓	✓	✓
	Mr Neil Morrison (Trustee) *	✓	✓	–	–	–	–	–
	Mr Marius du Toit (Trustee) ◊	–	–	✓	✓	×	✓	✓
	Dr Alewyn Burger (Independent Member)	✓	✓	✓	✓	✓	✓	✓
	Ms Melanie Bosman (Independent Member) □	✓	✓	✓	✓	✓	✓	✓

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee Members are remunerated according to the preparation and duration of such meetings.
- *A Joint Audit, Clinical Governance and Product Committee meeting was convened on 26 May 2022 to discuss the Oncology Benefit Proposal.*
- *A joint Board, Audit and Product Committee meeting was convened on 1 August 2022 to discuss the Revised DHMS Actuarial Valuation Report.*
- *A joint Audit and MAFR Committee meeting was convened on 31 August 2022 to interview Audit Firms for MAFR and review and discuss the presentations.*

* *Term ended on 22 June 2022.*
◊ *Appointed as a Committee Member effective 15 July 2022.*
□ *Appointed as a Committee Member effective 1 January 2022.*
– *Not required to attend.*
× *Apology tendered.*

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. This includes continuous careful consideration of how the Scheme should balance its solvency requirements against the provision of future Scheme benefits, managing higher utilisation and keeping contributions affordable.

With 2023/24 being a transitional period for the Scheme's external auditors, the Committee will also focus on ensuring a smooth transition between the outgoing and incoming external audit firms to ensure that the level of assurance obtained from external auditors is not compromised.

MANDATORY AUDIT FIRM ROTATION COMMITTEE

In June 2017, the IRBA issued a rule prescribing that auditors of public interest entities in South Africa must comply with MAFR with effect from 1 April 2023. Being a public interest entity, DHMS established the MAFR Committee during 2022. This ad hoc committee is responsible for overseeing the audit firm recruitment process and for supporting the Audit Committee in finding a suitable audit firm accredited by the CMS to succeed PwC for the financial year beginning 1 January 2024.

The MAFR Committee was established in line with the Scheme's Procurement Policy, which requires governance oversight and evaluation of tenders by at least two members of the DHMS executive team. It comprised representatives from the Audit Committee, including the independent Chairperson of the Audit Committee, and Scheme executives.

ACTIVITIES DURING 2022

In fulfilling its responsibilities, the Committee had to consider the requirements of Section 36 (2) of the Act. Medical schemes may only appoint auditors accredited by the Registrar of the CMS to conduct audits on medical schemes.

The Committee met several times during the process to discuss key considerations that needed to be addressed by the request for information and request for proposal, including the resources and time required during this process from both executive management and the Audit Committee.

The MAFR and Audit Committees deliberated on the proposals submitted and the presentations made to them on 31 August 2022. The Committees identified a suitable audit firm to succeed PwC, and made a recommendation to the Trustees for approval.

COMPOSITION AND MEETINGS IN 2022

The Committee comprised two members of the Audit Committee, the Chairperson and an Independent Committee Member of the Audit Committee, and two members of the Scheme's executive management, being the Principal Officer and the Chief Financial Officer. The Committee was chaired by the Chairperson of the Audit Committee.

Mandatory Audit Firm Rotation Committee attendance in 2022		02 Jun	06 Jul	31 Aug
Independent Member/ Chairperson	Mr Eric Mackeown	✓	✓	✓
Committee Members	Ms Melanie Bosman (Independent Member)	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	✓	✓	✓
	Ms Joy Malete (Chief Financial Officer) %	✓	✓	✓

% *Scheme Executive. All other Committee Members are non-executive.*

FUTURE FOCUS AREAS

The Committee will be dissolved following the appointment of an audit firm to take over from PwC.

CLINICAL GOVERNANCE COMMITTEE

While there is no statutory requirement for the Clinical Governance Committee, it was established in terms of Scheme Rule 19.3, which gives power to the Board to appoint and delegate authority to a subcommittee consisting of Board members and other experts it may deem necessary. This Committee was established to ensure compliance with the Act, and alignment with best practice governance principles. The Committee comprises members with the requisite skills to consider the complexities in healthcare funding. It includes medical professionals with specialist expertise in areas relevant to the Scheme's burden of disease, such as primary healthcare, mental health, oncology, and health economics.

The Committee's primary purpose is to assist the Board in overseeing funding policies and practices, and clinical governance, and providing access to evidence-based, clinically appropriate, cost-effective, affordable, quality healthcare in a consistent and equitable manner. It oversees the functions performed by Discovery Health in terms of the managed care agreement and therefore has insight into clinical and utilisation risk management, management of clinical exceptions and ex-gratia funding, funding pilot projects, member complaints, appeals and disputes, and health benefit formulation.

It also oversees engagement strategies with healthcare providers facilitated by Discovery Health, to foster shared purpose and value. This includes reducing inefficiencies in healthcare delivery and improving quality of care and health outcomes.

The Committee engages with Health Quality Assessment (HQA), an independent industry body that measures and reports on quality of care in the private medical industry. The Scheme is represented in the HQA Board of Directors and its Clinical Advisory Committee by the Scheme's Chief Medical Officer, and indirectly through Discovery Health representatives.

ACTIVITIES DURING 2022

During 2022, the Committee held four regular meetings as per the annual work plan, through which it provided oversight on key strategic risk management initiatives implemented by Discovery Health during the year. The Committee considered relevant risk intelligence and risk management reports, including key indicators on scheme demographic and claims utilisation risk, and programme-specific reports. In addition, the Clinical Governance, Product and Audit Committees held an ad hoc meeting to deliberate on proposals to enhance the Scheme's oncology benefits from 2023. Inter-Committee deliberations are in line with the Clinical Governance Committee's terms of reference to support the Product Committee in evaluating proposed Scheme benefits from a medical and health systems perspective.

Given its concern over the increasing mental health disease burden, particularly since the COVID-19 pandemic, the Clinical Governance Committee invited an expert psychiatrist to share relevant insights.

The Committee considered the results of the 2021 committee effectiveness review and is satisfied that its activities, recommendations and reporting to the Trustees during 2022 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Committee comprised two Trustees (one of whom chaired the Committee), two Independent Committee Members and the Chief Medical Officer of the Scheme. Regular attendees of Committee meetings include experts from Discovery Health's clinical and risk management teams.

Clinical Governance Committee attendance in 2022

		03 Mar	26 May[A]	26 May	01 Sep	03 Nov
Trustee/Chairperson	Dr Dhesan Moodley *	✓	✓	✓	–	–
Trustee/Chairperson	Dr Max Price (Trustee) ◊	–	–	–	✓	✓
Committee Members	Ms Lalita (Gita) Harie (Trustee)	✓	✓	✓	✓	✓
	Prof Laurel Baldwin-Ragaven (Independent Member) ▫	✓	✓	✓	✓	✓
	Ms Nonkululeko Mlaba (Independent Member)	✓	✓	✓	✓	✓
	Dr Unati Mahlati (Chief Medical Officer) %	✓	✓	✓	✓	✓
Invitees	Ms Joan Adams (Trustee) #	–	–	–	–	✓
	Mr Marius du Toit (Trustee) #	–	–	–	–	✓
	Dr Susette Brynard (Trustee) #	–	–	–	–	✓

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee Members are remunerated according to the preparation and duration of such meetings.
» *A Joint Audit, Clinical Governance and Product Committee meeting was convened on 26 May 2022 to discuss the Oncology Benefit Proposal.*

* *Term ended on 22 June 2022. Chairperson of the Clinical Governance Committee until the end of his term.*
◊ *Appointed as Chairperson of the Clinical Governance Committee effective 15 July 2022.*
▫ *Appointed as a Committee Member effective 1 February 2022.*
% *Scheme Executive. All other Committee Members are non-executive.*
\# *Invited to attend the Clinical Governance Committee meeting of 3 November 2022.*
– *Not required to attend.*

FUTURE FOCUS AREAS

The Committee remains focused on championing partnerships with healthcare providers to progressively scale up value-based care (VBC) and improve members' health outcomes, while ensuring the broader sustainability of healthcare providers and the healthcare system. The Committee monitors and evaluates the impact of benefits, funding policies, and risk management initiatives on members and healthcare providers. Key focus areas in 2023 will include scaling up of existing and new managed care interventions to mitigate the Scheme's aging profile and increasing burden of disease, and improving members' health outcomes. Such interventions signify a heightened focus on wellness, health promotion and early disease interventions, and scaling up VBC programmes.

The Committee will continue to exercise due care and responsibility in fulfilling its mandate.

DISPUTE COMMITTEE

The independent Dispute Committee hears and adjudicates on all formally lodged member and forensic-related healthcare provider disputes in a transparent and equitable manner. The Committee's purpose is to make fair and consistent decisions, carefully considering the provisions of the Act, all applicable laws and the Scheme Rules, which are binding on the Committee. The Committee is not empowered to make discretionary rulings or rulings which contravene applicable legislation or the latest registered Scheme Rules; however, the Committee can, at its discretion, refer relevant questions to a specially convened Treating Customers Fairly (TCF) Committee. In these instances, the TCF Committee provides specialist insight into issues of fairness in accordance with recognised TCF standards, and makes non-binding recommendations to the Dispute Committee. In the event of a member being dissatisfied with a ruling made by the Committee, the member can lodge a complaint with the CMS in terms of Section 47 of the Act.

The responsibilities of the Committee include:

- Receiving submissions from members or healthcare providers involved in the dispute, as well as the Scheme's representatives;
- Convening dispute hearings in person, virtually, telephonically or in absentia (if selected by the member/provider). All hearings were convened virtually during the COVID-19 related national state of disaster to comply with lockdown restrictions;
- Ensuring that it has sufficient information to adjudicate cases objectively;
- Adjudicating disputes and drafting rulings with due regard for all facts presented at hearings and in line with relevant legislation and the Scheme Rules;
- Referring questions of fairness that are not catered for in either the Scheme Rules or the Act to a specially convened TCF Committee to provide a non-binding recommendation; and
- Ensuring that the process at hearings and in adjudicating disputes is managed as efficiently as possible and without undue delay.

Access to the Committee is available to members. Access is also available to healthcare providers in respect of forensic (fraud, waste and abuse-related) disputes; the Committee heard its first healthcare providers' matters in early 2021. Professionals who wish to lodge a dispute about forensic processes and investigations are encouraged to utilise this channel for independent, expeditious and cost-effective resolution of such disputes.

ACTIVITIES DURING 2022

In 2022, 694 (79.5%) of the 875 member disputes and one forensics dispute lodged in terms of Rule 27[1], were settled or withdrawn prior to a hearing (2021: 697-member related disputes, two forensic disputes, 627 or 90% settled or withdrawn). There were 21 member-lodged dispute hearings during 2022 with 18 rulings issued; 14 were in favour of the Scheme, three in favour of members, and one was partially in favour of both the member and the Scheme. No dispute rulings were challenged further by members in a complaint to the CMS, lodged in terms of Section 47 of the Act. The single forensic dispute hearing resulted in a ruling in favour of the Scheme.

As the Committee's work covers the full spectrum of stakeholder concerns, its activities are overseen by the Stakeholder Relations and Ethics Committee (SREC) on behalf of the Board. The Dispute Committee considered the results of the self-evaluations of its effectiveness and is satisfied that it has fulfilled its responsibilities in accordance with its operating framework, and reported this to the SREC.

1 Rule 27 of the DHMS Rules deals with complaints and disputes. The Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.

COMPOSITION AND MEETINGS IN 2022

All Dispute Committee panellists have either legal or medical expertise. Each panel must include at least one legal and one medical expert, and consists of three members drawn from the greater Committee according to availability. A practising attorney is always the Chairperson of each hearing. Dispute hearings are scheduled as and when required and individual panels can be constituted several times a week if needed. Committee Members are independent and not employed by the Scheme but are remunerated for their time and expertise regardless of the outcome of the hearings. All hearings during 2022 were properly constituted. Due to the frequency of hearings and variation of panellists, an attendance register is not shown.

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate.

INVESTMENT COMMITTEE

The Investment Committee recommends and oversees the implementation and maintenance of investment policies and mandates. It advises the Trustees on strategic and operational matters relating to investing the Scheme's reserves, ensuring that investments made are in the best interest of members and within the Scheme's risk appetite, as determined by the Trustees. The Committee assists the Board and supports the Scheme management with investment analysis and management of service provider inputs. It also makes recommendations to the Board for consideration and approval.

The responsibilities of the Committee include:

- Recommending an Investment Policy to the Trustees, with due regard to the requirement that the assets invested should maximise returns while maintaining solvency;
- Monitoring the effectiveness and implementation of the Investment Policy;
- Making recommendations to the Trustees regarding strategic asset allocation and approving plans for implementation;
- Approving any tactical asset allocation plans;
- Reviewing investment strategies, performance of the investment portfolio and of asset managers against established benchmarks, and reporting to the Trustees quarterly on the performance of the portfolio;
- Monitoring the performance of each asset class with a view to maximising the total return, while considering the risk appetite of the Scheme;
- Reporting to the Trustees annually on overall investment performance;
- Making recommendations to the Trustees on the appointment of asset consultants and asset managers, including fees payable and the terms of appointment;
- Approving dis-investment from non-cash asset managers;
- Supervising the safekeeping and handling of the Scheme's investments;
- Monitoring all reported investment activities in line with the Scheme's Investment Policy and statutory requirements, and where there is deviation from the Investment Policy, investigating the reasons for this and recommending corrective action to the Trustees;
- Monitoring the Scheme's responsible investing initiatives for compliance with the Responsible Investing Policy;
- Monitoring the Scheme's compliance with the Credit Risk Policy; and
- Assisting the Trustees in preparing their annual report on investment performance and compliance.

ACTIVITIES DURING 2022

- Considered the Scheme's strategic asset allocation across various asset classes, considering the prevailing economic outlook, and oversaw the implementation of the asset allocation plan.
- Transferred assets from the Short Duration Bond and Money Market mandates to the Flexible Fixed Income and Equity mandates.
- Reviewed the investment strategies and performance of asset managers relative to their benchmarks.
- Monitored the equity benchmark considering the concentration risk arising from Naspers and Prosus and ongoing changes to related equity indices.
- Given prevailing market conditions and the Scheme's risk appetite, approved the tactical implementation of foreign currency hedges.
- Received updates on the Scheme's responsible investing strategy.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included onsite visits by the Scheme.
- Recommended an updated Investment Policy for Board approval.
- Reviewed the effectiveness of services provided by the investment consultant.
- Reviewed its terms of reference with appropriate changes being approved by the Trustees.

The Committee considered the results of the 2021 committee effectiveness review, and is satisfied that its activities, recommendations and reporting to the Board during 2022 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Committee consisted of three Trustees and two Independent Committee Members. The Committee receives investment advice and quarterly reports from the Scheme's investment consultants, RisCura, who attend all Committee meetings. Asset managers are invited to attend meetings on a rotational basis to report on their strategy and performance.

Investment Committee attendance in 2022

		17 Feb	12 May	04 Aug	27 Oct
Trustee/Chairperson	Dr Dhesan Moodley *	✓	✓	–	–
Trustee/Chairperson	Mr Johan Human ◊	✓	✓	✓	✓
Committee Members	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓
	Ms Henda van Deventer (Independent Member) ▯	✓	✓	✓	✓
	Ms Joan Adams SC (Trustee) ~	–	–	✓	✓
	Mr Marius du Toit (Trustee) ~	–	–	✓	✓
	Mr Neil Morrison (Trustee) *	✓	✓	–	–

** Term ended on 22 June 2022. Chairperson of the Investment Committee until the end of his term.*
◊ Appointed as Chairperson of the Investment Committee effective 15 July 2022.
▯ Appointed as a Committee Member effective 1 January 2022.
~ Appointed as a Committee Member effective 15 July 2022.
– Not required to attend.

FUTURE FOCUS AREAS

During 2023, the Committee will review the Scheme's asset allocation across the various asset classes to account for changes in market conditions and the Scheme's risk appetite. This will include continuing to optimise the combination of equity portfolio managers.

NOMINATION COMMITTEE

The Nomination Committee is an independent committee of the Board, comprised of members who are not Trustees of the Scheme. The Committee oversees the nomination and vetting process to elect and/or appoint suitably fit and proper persons as Trustees or Independent Committee Members. In terms of the Scheme Rules, this Committee may be assisted by an independent third-party service provider as determined by the Trustees to assist in carrying out its functions. For the 2022 AGM and Trustee election, the Trustees approved the appointment of Deloitte as the independent third-party service provider to assist the Nomination Committee.

ACTIVITIES DURING 2022[1]

The 2022 AGM and Trustee elections were successfully convened on 23 June 2022. The Nomination Committee oversaw this process from a governance perspective in terms of its mandate. The following activities and this process were undertaken by Deloitte in 2022 as an independent third-party service provider, to assist the Nomination Committee to:

- Oversee the procedural aspects of the nominations process, including approving communications to members;
- Ensure that adequate vetting processes and procedures are adhered to, with each nominee subject to stringent vetting criteria to ensure that candidates standing for election are fit and proper;
- Manage the proxy appointment and vetting processes;
- Review and discuss the draft candidate list compiled by the Independent Electoral Body, and provide the final list of candidates for election to the Trustees; and
- Oversee any other aspects that members are required to vote on.

The Committee reported to the Trustees on its activities for the 2022 election and fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

The Committee's members successfully served their first year of a three-year term. The Committee comprises three members who are independent of the Board and Board Committees. Nomination Committee meetings are attended by the IEB and its representatives.

Nominations Committee attendance in 2022		09 Feb	17 Feb	22 Feb	01 Mar	08 Mar	15 Mar	22 Mar	29 Mar	05 Apr	13 Apr	19 Apr	21 Apr	22 Apr	26 Apr	04 May	10 May	17 May	31 May	07 Jun	14 Jun	30 Jun	07 Jul	01 Aug	05 Sep
Independent Member/ Chairperson	Andrew Bryce ▫	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee Members	Alexandra Muller (Independent Member) ▫	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Berenice Lue Marais (Independent Member) ▫	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

▫ *Appointed as a Committee Member effective 1 January 2022.*

FUTURE FOCUS AREAS

The 2023 AGM and Trustee election is scheduled to take place in June 2023. The Nomination Committee will oversee the process, supported by the Scheme's IEB partner to ensure the independence of the nominations and election process.

1 *The Nomination Committee is not included in Committee effectiveness reviews as this Committee is independent and excludes Trustee representation to maintain impartiality and independence in fulfilling its duties.*

PRODUCT COMMITTEE

While there is no statutory requirement for the Product Committee, it was established in terms of Scheme Rule 19.3, as the Trustees consider it necessary for ensuring compliance with both the legislative and regulatory requirements of the Act, and best practice governance principles pertaining to benefit and product development. The Committee comprises members with the requisite skills including actuarial and medical expertise.

The Committee oversees product development, amendments to benefits, proposed benefit plans, and the development of annual product communication and marketing materials, with due regard for clinical appropriateness, financial affordability and sustainability, and the interests of members and healthcare providers.

ACTIVITIES DURING 2022

The Committee held five meetings during 2022, of which two were combined meetings with one or more of the Audit Committee, Clinical Governance Committee, and the Board. As per the Committee's annual work plan, the Committee considered matters pertaining to the Scheme's research and development strategy, marketing strategy and plan, financial performance, and current benefits utilisation. The Committee considered the proposals and actuarial valuation report for 2023 products and benefits enhancements, and related Scheme Rule changes. The Committee continuously monitors developments in the policy and regulatory space, including the proposed National Health Insurance (NHI) and LCBO framework development.

The Committee considered the results of the 2021 committee effectiveness review and is satisfied that it has fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022 the Committee comprised four Trustees, one of whom chaired the Committee and one of whom is the Chairperson of the Clinical Governance Committee, which serves to facilitate the required sharing of information between the two Committees. The Principal Officer is also a member. The Committee obtains regular reports and presentations from Discovery Health, and relevant individuals are regularly invited to Committee meetings for this purpose.

The Product and Audit Committees jointly considered the actuarial valuation and contribution increases, and invited the Scheme's external auditors, PwC, and the Scheme's independent actuaries, Insight Actuaries & Consultants, to attend the meeting.

Product Committee attendance in 2022

		10 Mar	26 May[A]	28 Jul	01 Aug[A]	25 Aug
Trustee/Chairperson	Mr Johan Human	✓	✓	✓	✓	✓
Committee Members	Dr Dhesan Moodley (Trustee) *	✓	✓	–	–	–
	Mr Marius du Toit (Trustee) ~	–	–	✓	✓	×
	Dr Max Price (Trustee) ~	–	–	✓	✓	✓
	Dr Susette Brynard (Trustee)	✓	✓	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	–	✓	✓	✓	✓
	Mr Selwyn Kahlberg (Acting Principal Officer) %	✓	–	–	–	–

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee Members are remunerated according to the preparation and duration of such meetings.
- *A Joint Audit, Clinical Governance and Product Committee meeting was convened on 26 May 2022 to discuss the Oncology Benefit Proposal.*
- *A joint Board, Audit and Product Committee meeting was convened on 1 August 2022 to discuss the Revised DHMS Actuarial Valuation Report.*

* *Term ended on 22 June 2022.*
~ *Appointed as a Committee Member effective 15 July 2022.*
% *Scheme Executive. All other Committee Members are non-executive. Mr Kahlberg was Acting Principal Officer during Ms Mbewu's leave and attended in that capacity.*
– *Not required to attend.*
× *Apology tendered.*

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate to ensure the Scheme remains the leading open medical scheme in the industry. This is done through continuous product and benefit innovations and enhancements while also ensuring the Scheme is sustainable and compliant with the regulated reserves, and able to meet the needs of members in the case of significant unforeseen events.

REMUNERATION COMMITTEE

The Remuneration Committee assists the Board in ensuring that the Scheme's remuneration practices are fair, responsible and transparent. It also assists with overseeing human resources strategies and policies, and ensuring compliance with these policies. It further oversees the remuneration of Trustees and Independent Committee Members and makes recommendations to the Board regarding remuneration structures for Trustees and Independent Committee Members. Such recommendations must also be tabled at the Scheme's AGM for approval by the Scheme's members. Finally, it ensures that reporting disclosures relating to remuneration are made according to regulatory guidelines, and that a formal, rigorous and transparent process is followed for appointing senior staff.

The responsibilities of the Committee include:

- Reviewing and approving the employee remuneration framework, remuneration packages and annual increases applicable to employees, including executives;
- Recommending to the Board the remuneration structure and fees for Trustees for approval by the Scheme's members;
- Recommending to the Board the remuneration structure and fees for Independent Committee Members;
- Ensuring that remuneration policies are established and administered in the Scheme's long-term interests; and
- Ensuring, where possible[1], that succession plans are in place to maintain an appropriate balance of skills in the Scheme's management and governance structures.

1 *At least half of the Trustees must be elected by Scheme members at any time. Succession planning is therefore not possible for these positions.*

ACTIVITIES DURING 2022

- Recommended Trustee and Independent Committee Member remuneration to the Board for approval and advised the Board on regulatory aspects of remuneration implementation including tabling the matter at the Scheme's 2022 AGM.
- Considered and recommended the Trustee and Independent Committee Member Remuneration Policy to the Board and Scheme members for approval.
- Considered and recommended employee remuneration to the Trustees for approval.
- Considered the outcomes of the first phase of the Scheme employees salary benchmarking exercise, which will be completed in 2023.
- Considered and recommended Scheme human resources policies to the Board for approval.
- Considered and approved training and development requirements for Scheme employees.
- Considered plans to address the impact of COVID-19 on Scheme employees.
- Considered the results of the 2021 committee effectiveness review making changes where required.
- Considered and recommended the filling of Board Committee vacancies.

The Committee is satisfied its activities, recommendations and reporting to the Board during 2022 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Committee comprised three Trustees and two Independent Committee Members. The Principal Officer attends Committee meetings by invitation.

Remuneration Committee attendance in 2022

		31 May	10 Nov
Trustee/Chairperson	Mr Dave King *	✓	–
Independent Member / Chairperson	Mr Bongani Hlophe ◊	–	✓
Committee Members	Ms Joan Adams SC (Trustee) □	–	✓
	Mr John Butler SC (Trustee)	✓	✓
	Mr Ndumiso Luthuli (Independent Member)	✓	✓
	Mr Neil Morrison (Trustee) *	✓	–
	Dr Susette Brynard (Trustee)	✓	✓

* *Term ended on 22 June 2022. Chairperson of the Remuneration Committee until the end of his term.*
◊ *Appointed as Chairperson of the Remuneration Committee effective 1 July 2022.*
□ *Appointed as a Committee Member effective 15 July 2022.*

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. Key focus areas will include:

- Completing the salary benchmarking exercise to ensure that employee remuneration is commensurate with industry norms and practices;
- Continuing to engage with the Principal Officer and Board on the Scheme's Remuneration Policy and ensuring the appropriateness of remuneration and reward arrangements and/or systems;
- Reviewing the Scheme's remuneration practices where appropriate, and ensuring these comply with changing legislative and regulatory requirements, including those relating to King IV; and
- Continuing to review the Scheme's succession planning processes to ensure that the Scheme can adequately respond to vacancies.

RISK COMMITTEE

The Risk Committee oversees risk management, compliance, IT governance, fraud, ethics, whistleblowing, legal and regulatory matters, non-healthcare expenses, outsourcing and operations. The purpose of the Committee is to exercise ongoing oversight of risk management, and the Committee's responsibilities include:

- Assessing the risks and opportunities emanating from the triple context in which the Scheme operates and the capitals that the Scheme utilises and affects, by fostering an environment where consideration of risk is embedded in the Scheme's culture, business planning, decision-making and day-to-day activities;
- Assessing both the potential opportunities and negative effects inherent in risks that may impact on organisational objectives;
- Assessing the organisation's dependence on resources and relationships represented by the various forms of capital;
- Designing and implementing appropriate risk responses by continually assessing mitigation plans and their implementation by management, and recommending measures which may enhance the risk management process;
- Establishing and implementing business continuity arrangements that allow the organisation to operate under volatile conditions and to withstand and recover from acute shocks; and
- Integrating and embedding risk management in the business activities and culture of the organisation through continual risk monitoring and identification.

COMPLIANCE MANAGEMENT

The Trustees recognise their responsibility to internal and external stakeholders in terms of the regulatory requirements applicable to the Scheme. The Scheme has implemented a co-ordinated compliance framework to ensure all operations are conducted in accordance with applicable legal, regulatory and supervisory requirements and guidelines. The Scheme outsources certain compliance activities to the Discovery Group Compliance function. The framework is structured to facilitate the process of obtaining information from Discovery Health to monitor and oversee the outsourced operations, and a compliance monitoring plan is approved on an annual basis.

Changes to regulations that could impact the Scheme's strategy and operations are monitored. Where required, action plans implemented by management are monitored and reported to the Committee.

RISK MANAGEMENT

The Trustees recognise that risk management is an integral part of the strategy-setting process and delegates the responsibility of designing, implementing and monitoring the risk management process and system to Scheme management. Risk management is facilitated by the Chief Operations Officer who ensures that risk management is embedded in daily management activities.

The Trustees are satisfied that the risk management process effectively and continuously identifies and evaluates risks, and ensures that these risks are managed in line with business strategy.

ACTIVITIES DURING 2022

- Participated in the annual risk register assessment, which included representatives of the Committee, the Scheme Office, and the administration and managed care provider.
- Regularly considered risk management reports and key risk indicators, and reviewed the risk appetite which was recommended to the Trustees for approval.
- Regularly reviewed compliance reports and monitored exposure and actions taken to mitigate compliance risks.
- Received reports to assist in managing the Scheme's IT governance obligations and reviewed the updated policy on the adoption of Discovery Group IT Policies. This included a focus on cybersecurity and business continuity.
- Considered the results of the annual disaster recovery and business continuity tests.
- Considered a review of the effectiveness of the Risk Management Function.
- Reviewed and monitored reports on the service levels delivered by Discovery Health.
- Assessed the value added to the Scheme by Discovery Health.
- Reviewed the Scheme's non-healthcare expenses against budget.
- Reviewed the Committee's terms of reference.

The Committee considered the results of the 2021 committee effectiveness review and is satisfied its activities, recommendations and reporting to the Board during 2022 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Committee comprised two Independent Committee Members, two members of the Scheme Office, and two Trustees, one of whom chaired the Committee. The external auditors, PwC, as well as the Discovery Group Risk Management function and Discovery Group Compliance function attend every Committee meeting. Representatives from Discovery Health also attend to provide detailed operational insight.

Risk Committee attendance in 2022		10 Mar	26 Jul	11 Aug	20 Oct
Trustee/ Chairperson	Mr Dave King *	✓	–	–	–
Trustee/ Chairperson	Ms Lalita (Gita) Harie ◊	✓	✓	✓	✓
Committee Members	Dr Alewyn Burger (Independent Member)	✓	✓	✓	✓
	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓
	Ms Joan Adams SC (Trustee) ▯	–	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	×	✓	✓	×
	Mr Selwyn Kahlberg (Chief Operations Officer) %	✓	✓	✓	✓

* *Term ended on 22 June 2022. Chairperson of the Risk Committee until the end of his term.*
◊ *Appointed as Chairperson of the Risk Committee effective 15 July 2022.*
▯ *Appointed as a Committee Member effective 15 July 2022.*
% *Scheme Executive. All other Committee Members are non-executive.*
– *Not required to attend.*
× *Apology tendered.*

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. Key focus areas will include maintaining high-quality affordable benefits, developments in the regulatory landscape and cyber risks.

STAKEHOLDER RELATIONS AND ETHICS COMMITTEE

The purpose of the Stakeholder Relations and Ethics Committee is to assist the Trustees to oversee stakeholder relationship management, responsible corporate citizenship and the ethics activities and culture of the Scheme. The roles and responsibilities of the Committee are as follows:

Ethics and society:

- Oversee, monitor and evaluate the ethics of the Scheme in a way that supports an ethical culture.
- Oversee, monitor and evaluate the corporate citizenship of the Scheme such that the Scheme is, and is known to be, a responsible corporate citizen.
- Oversee and monitor the development of adequate processes and procedures for managing the Scheme's ethics and corporate citizenship.
- Provide feedback to the Board regarding risks related to ethical and societal matters, and provide steps or enhanced process recommendations to mitigate these risks.

Stakeholder relations:

- Identify material stakeholder groupings and individuals, along with their legitimate needs, interests and expectations.
- Oversee, monitor and evaluate engagement with the Scheme's material stakeholders.
- Provide feedback and updates to the Board regarding stakeholder interactions, risks identified, or opportunities for new channels of engagement.

The Committee may rely on the governance frameworks and structures of other Board Committees, the Scheme Office and where appropriate, the administration and managed care provider, in fulfilling its governance and oversight responsibilities.

ACTIVITIES DURING 2022

- Reviewed the impact on and responses of various stakeholders to the launch of the new regional plan in 2022, as well as the response to the announcement of DHMS benefit and plan changes for 2023.
- Reviewed the outcomes and suggested improvements emanating from the Health Professionals Reference Group, established to advise on measures to counter fraud, waste and abuse conducted by Discovery Health on the Scheme's behalf.
- Closely considered the relative benefits and drawbacks of engaging in action regarding polymerase chain reaction (PCR) test pricing, with reference to the interests of various impacted stakeholders.
- Reviewed reports relating to the Committee's social and ethics mandate, including overall stakeholder engagement and risk, disputes and complaints, the Scheme's workplace, Treating Customers Fairly and high-risk medical cases.
- Adopted a new Customer Engagement Report that collates information about engagements with various stakeholder groups via various channels.
- Considered the latest Stakeholder Assessment Report and was satisfied that stakeholder engagement is adequately and appropriately implemented.
- Reviewed the activities of the Dispute Committee, and the operational Relationship Management and Research Governance Committees.
- Discussed legal and regulatory matters which may affect the Scheme's members, other stakeholders, and the operations of the Scheme.
- Considered the results of the 2021 self-evaluation of committee effectiveness and was satisfied that it operates in a way to adequately fulfil its mandate.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2022 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Committee comprised five Trustees, one of whom chaired the Committee, and the Principal Officer.

The Committee obtains regular reports from Discovery Health, which engages in some stakeholder relations activity on the Scheme's behalf. Individuals from Discovery Health are regularly invited to Committee meetings in this regard. External experts are also occasionally invited to address the Committee.

Stakeholder Relations and Ethics Committee attendance in 2022

		08 Mar	18 Aug	30 Aug[A]	10 Nov
Trustee/ Chairperson	Dr Susette Brynard (Trustee) ∞	✓	✓	✓	✓
Committee Members	Mr Dave King (Trustee) *	✓	–	–	–
	Dr Dhesan Moodley (Trustee) *	✓	–	–	–
	Ms Joan Adams SC (Trustee) ◊	–	✓	✓	✓
	Mr John Butler SC (Trustee)	✓	✓	✓	✓
	Ms Lalita (Gita) Harie (Trustee)	✓	✓	✓	✓
	Dr Max Price (Trustee) ◊	–	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	–	✓	✓	✓
	Mr Selwyn Kahlberg (Acting Principal Officer) %	✓	–	–	–

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee Members are remunerated according to the preparation and duration of such meetings.
» *A meeting was convened on 30 August 2022 to address the held over agenda items of the meeting of 18 August 2022.*

∞ *Appointed as Chairperson of the Stakeholder Relations and Ethics Committee effective 1 January 2022.*
* *Term ended on 22 June 2022.*
◊ *Appointed as a Committee Member effective 15 July 2022.*
% *Scheme Executive. All other Committee Members are non-executive. Mr Kahlberg was Acting Principal Officer during Ms Mbewu's leave and attended in that capacity.*
– *Not required to attend.*
× *Apology tendered.*

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate, including an ongoing consideration of the impact of the Scheme on its members and other stakeholders.

ACCREDITATION COMMITTEE

The Accreditation Committee was an ad hoc committee, established by the Trustees on 30 January 2020 in terms of Scheme Rule 19.3, which gives power to the Board to appoint and delegate authority to a subcommittee consisting of Board members and other experts it may deem necessary. Its purpose was to deliberate on matters raised by the CMS regarding the accreditation of Discovery Health (Pty) Ltd, and provide feedback to the Trustees.

ACTIVITIES DURING 2022

The Committee was not required to meet during 2022, and having fulfilled its mandate was formally dissolved by the Board on 13 April 2022.

COMPOSITION AND MEETINGS IN 2022

The Committee comprised four Trustees.

SERVICES RENEWAL COMMITTEE

The Services Renewal Committee, an ad hoc subcommittee of the Board, was established during 2021 to oversee the potential renewal of the administration and managed care agreements with Discovery Health (which were otherwise due to terminate on 31 December 2022), to provide recommendations to the Board and, if renewed, consider the terms of such renewal. In 2021 the Board, on recommendation from this Committee, resolved to renew the agreements with Discovery Health for a period of five years, commencing on 1 January 2023. The renewal was subject to DHMS and Discovery Health reviewing and agreeing on the terms and commercial elements of the agreements for the forthcoming contractual period.

This Committee was established in terms of Scheme Rule 19.3, which gives power to the Board to appoint and delegate authority to a subcommittee consisting of Board members and other experts it may deem necessary.

ACTIVITIES DURING 2022

The Services Renewal Committee assessed various analyses of potential administration and managed care fee models to apply for the five-year period starting 1 January 2023. The Committee recommended to the Board, which was subsequently approved, that the Scheme Office be given a mandate within which the Scheme could conduct negotiations with Discovery Health. Negotiations were concluded successfully within the specified mandate, after which the Committee recommended the fee model to the Board, which the Board then approved.

The Committee considered the wording of the administration and managed care agreements to apply for the five-year period starting 1 January 2023. The Committee recommended the agreements to the Board, which were subsequently approved.

COMPOSITION AND MEETINGS IN 2022

At the end of 2022, the Committee comprised of four Trustees.

Services Renewal Committee attendance in 2022		28 Feb^A	07 Jun^A	22 Jun^A	20 Jul^A	09 Aug^A	19 Aug^A	05 Sep^A
Trustee/ Chairperson	Mr Johan Human	✓	✓	✓	✓	✓	✓	✓
Committee Members	Mr Dave King (Trustee) *	✓	✓	✓	–	–	–	–
	Mr John Butler SC (Trustee)	✓	✓	✓	×	×	✓	✓
	Mr Marius du Toit (Trustee) ◊	–	–	–	✓	✓	✓	✓
	Dr Max Price (Trustee) ◊	–	–	–	✓	✓	✓	✓
	Mr Neil Morrison (Trustee) * ▯	–	–	–	–	–	–	–

* *Term ended on 22 June 2022.*
◊ *Appointed as a Committee Member effective 15 July 2022.*
▯ *Appointed as an alternate Committee Member to attend only in the absence of other Members.*
– *Not required to attend.*
× *Apology tendered.*

FUTURE FOCUS AREAS

During 2023 the Committee will consider the processes for calculating the annual increase in administration and managed care fees. Once it has fulfilled its duties as set out in its terms of reference, the Services Renewal Committee will be dissolved during 2023.

INDEPENDENT COMMITTEE MEMBER TERMS[1]

Independent Committee Member	Designation	Appointments	Start of Term	End of Term
Mr Eric Mackeown	Chair of the Audit Committee, Independent Risk and Investment Committee Member	Appointed	01 Sep 19	31 Aug 22
	Chair of the Audit Committee, Independent Risk and Investment Committee Member	Re-appointed	01 Sep 22	31 Aug 25
Dr Alewyn Burger	Independent Audit and Risk Committee Member	Appointed	01 Jan 20	31 Dec 22
	Independent Audit and Risk Committee Member	Re-appointed	01 Jan 23	31 Dec 25
Mr Ndumiso Luthuli	Independent Remuneration Committee Member	Appointed	18 Apr 18	17 Apr 21
	Independent Remuneration Committee Member	Re-appointed	18 Apr 21	31 Mar 24
Dr Nonkululeko Mlaba	Independent Clinical Governance Committee Member	Appointed	28 Aug 18	27 Aug 21
	Independent Clinical Governance Committee Member	Re-appointed	01 Sep 21	31 Aug 24
Mrs Susan Ludolph	Independent Audit and Risk Committees Member	Appointed	19 Jan 16	19 Jan 19
	Independent Audit and Risk Committees Member	Re-appointed	20 Jan 19	19 Jan 22
Ms Melanie Bosman	Independent Audit Committee Member	Appointed	01 Jan 22	31 Dec 24
Ms Henda van Deventer	Independent Investment Committee Member	Appointed	01 Jan 22	31 Dec 24
Ms Alexandra Muller	Independent Nomination Committee Member	Appointed	01 Jan 22	31 Dec 24
Mr Andrew Bryce	Chair of the Nomination Committee	Appointed	01 Jan 22	31 Dec 24
Ms Berenice Lue Marais	Independent Nomination Committee Member	Appointed	01 Jan 22	31 Dec 24
Prof Laurel Baldwin-Ragaven	Independent Clinical Governance Committee Member	Appointed	01 Feb 22	31 Jan 25
Mr Bongani Hlope	Chair of the Remuneration Committee	Appointed	01 Jul 22	30 Jun 25

1 Due to the variation of Dispute Committee panellists, individual Committee Members are not listed. Each Dispute Panel consists of three Independent Members drawn from the greater Dispute Committee, each of whom have either legal or medical expertise. Dispute hearings are scheduled as and when required, and draw from the legal and medical panellists available at the time. If required, the Committee can be constituted several times a week to attend to increased caseloads.

Independent Board Committee Members[1]

Prof Laurel Baldwin-Ragaven **66**

AB (Smith College)[2]; MDCM (McGill)[3]; FCFP (Canada)[4]; FCFP (SA)[5]

Member of the Clinical Governance Committee

Internationally experienced academic family physician, health and human rights advocate and medical ethics teacher and researcher. Vast clinical expertise in primary care, knowledge of public health systems and passion for interventions into the social determinants of health and disease.

Ms Melanie Bosman **51**

CA(SA)

Member of the Audit Committee

Experienced non-executive director in the financial services industry, notably short-term and life insurance. Formerly an audit partner at a large accounting firm. In-depth knowledge of governance, International Financial Reporting Standards (IFRS) and financial sector regulation.

Mr Andrew Bryce **67**

CA(SA); BSc (Hons) Biochemistry; BCompt (Hons)

Member of the Nomination Committee

Extensive corporate experience at executive level, with particular focus on corporate governance, risk management, business and internal controls. Previously chaired a pension fund and the audit committee of a medical scheme, and has also been a director on several companies within a group.

Dr Alewyn Burger **71**

MSc (Mathematical Statistics); PhD (Mathematical Statistics); Advanced Executive Programme (UNISA); Advanced Management Programme (Harvard Graduate School)

Member of the Audit and Risk Committees

Extensive experience in IT architecture, implementation and operations, as well as governance, planning, strategy, research and development at global CTO, CIO and global group executive director level. Previously chaired various IT risk governance committees, experienced banking institutions board member and an IT expert board member.

Ms Henda van Deventer **46**

CA(SA); BA Law

Member of the Investment Committee

Independent consultant with over 20 years' financial services experience in credit and investment, including in development finance, investment banking, alternative assets and credit risk policy development and implementation. Track record as non-executive member or chair of various investment and credit committees and similar governance forums.

Mr Bongani Hlophe **48**

BA Law; BA, Hons (Human Resources Management); Dip Company Direction; ECOOP[6]; Bus Strategy Specialisation

Chairperson of the Remuneration Committee

23 years spent as an HR professional in the mining, higher education, and banking sectors. A former senior management consultant with a US-based global constancy. A former chairperson of a subsidiary of a listed coal mining corporate. Significant knowledge of the employee benefits industry as a former employer representative. Currently serving as an independent non-executive director of a state-owned entity and an auditing firm.

1 *Note: all ages as at 31 December 2022.*
2 *AB: Bachelor of Arts.*
3 *MDCM: Doctor of Medicine and Master of Surgery.*
4 *FCFP (Canada): Fellowship in the College of Family Physicians of Canada.*
5 *FCFP (SA): Fellowship of the College of Family Physicians of South Africa.*
6 *The Emerging COO Executive Programme offered by Stanford.*

Independent Committee Members *continued*

Mrs Sue Ludolph[1]
59

CA(SA)

Member of the Audit Committee

Technical expert in IFRS and financial and integrated reporting, including standard setting for accounting in South Africa. Established and implemented the strategy and work plan for South Africa's first top 100 CFO Forum to guide, influence and lead on issues affecting CFOs and business. Experienced independent non-executive director and member of audit, risk, and social, ethics and sustainability committees.

Mr Ndumiso Luthuli
47

BProc; LLB BCL[2]; MBA

Member of the Remuneration Committee

Member of the Johannesburg Society of Advocates, practising commercial, administrative and constitutional law.

Mr Eric Mackeown
65

CA(SA)

Chairperson of the Audit Committee and member of the Risk and Investment Committees

More than 40 years' experience in the accounting and auditing profession. Was lead audit partner for numerous major multinational and JSE-listed companies. Non-executive director and chairperson of the audit committee of Assore Holdings. Thorough and deep understanding of the health and medical aid industries.

Ms Berenice Lue Marais
58

MBA (International Business); BA Economics

Member of the Nomination Committee

Extensive leadership, governance, strategic business development, and international experience of over 20 years. Multiple senior leadership and non-executive director positions including on the board of directors and HR and remuneration committees for The Ethics Institute; chairperson of the Governance, HR and Remuneration Committee, and member of the board of directors for Save the Children South Africa. Currently serving as an expert adviser and independent non-executive director for various companies in the private, public and non-profit sectors.

Dr Nonkululeko Mlaba
51

MBBCh; MPH; PGDHE; FC Rad Onc (SA); MMed

Member of the Clinical Governance Committee

Seasoned healthcare professional with a medical degree and postgraduate public health and health economics qualifications, working as a specialist radiation oncologist at Charlotte Maxeke Academic Hospital. Deep understanding of managed healthcare, healthcare regulation and clinical research. Executive member and secretary of the South African Society for Clinical and Radiation Oncologists.

Mrs Alexandra Muller
46

CA(SA)

Member of the Nomination Committee

20 years spent at a professional services firm, ten of which were as a partner specialising in governance, risk and internal audit. Significant knowledge of medical schemes having provided services to such organisations in addition to other financial services businesses, both listed and unlisted. Currently serving as an independent non-executive director on various companies.

1 *Term ended on 19 January 2022.*
2 *BCL: Bachelor of Civil Law.*

Our approach to remuneration

In accordance with King IV Principle 14, which states "The governing body should ensure that the organisation remunerates fairly, responsibly and transparently to promote the achievement of strategic objectives and positive outcomes in the short, medium and long term", the Board is responsible for the development and implementation of a Remuneration Policy for the Trustees and Board Committee Members.

The Board of Trustees has delegated oversight of Scheme remuneration to our Remuneration Committee, a Board Committee established in terms of the DHMS Board charter, which assists the Board in fulfilling its remuneration governance and oversight obligations and responsibilities in terms of the Act, Scheme Rules and best practice governance principles.

When required, the Committee uses independent expert consultants and independent market benchmarking to assist with developing and implementing best remuneration practices, as detailed in the approved Remuneration Policy. Trustee remuneration disclosure occurs:

- At the AGM;
- To the CMS, the Scheme's Regulator; and
- In the Scheme's Integrated Report.

Trustee remuneration is based on a professional hourly rate, discounted due to the Scheme's non-profit status. This forms the foundation of all Trustee and Board Committee remuneration and is the rate that members are required to vote on annually via ballot at the AGM.

The purpose of the Remuneration Policy is to:

- Provide the guiding principles underpinning the Scheme's employee remuneration philosophy;
- Set out the guiding principles and application for each component of reward (i.e. short- and long-term incentives);
- Stipulate the role and function of the Remuneration Committee; and
- Define the remuneration procedures of the Scheme.

The Remuneration Policy is based on the requirement set out by the CMS in Circular 41 of 2014 and was presented to members for the first time at the 2014 AGM, where it was approved by a majority of members in attendance. The Policy is reviewed annually by the Committee for Board approval and is tabled each year at the AGM for a non-binding vote by members.

The total remuneration paid to Trustees is determined by the following elements:

- Number of meetings planned per year;
- Preparation time for each meeting;
- Duration of meetings;
- Estimated time required between meetings[1]; and
- The number of actual meetings attended.

In addition to their other duties, Trustees are members of Board Committees, each of which differs regarding preparation time, duration of meetings, and number of meetings in the year.

The total annual fees payable to Trustees and Board Committee Members is calculated based on the number of planned Board and Board Committee meetings (per the annual meeting plan) and is split into:

- An annual base fee (70% of total annual fees, paid as a quarterly retainer in arrears); and
- A fee per meeting (30% of total annual fees, paid at the end of the month in which the meeting took place).

If an unplanned ad hoc meeting is required outside of the annual meeting plan, the attendee is remunerated at the hourly rate.

Trustee and/or Board Committee Member fees are exclusive of VAT. Where Trustees and/or Board Committee Members are registered for VAT, they issue a tax invoice to the Scheme clearly reflecting the VAT amount in addition to their total fees for the period.

1 *The Chairperson of the Board is required to make additional preparations for Board meetings and is expected to attend to various requirements between meetings as an inherent part of the role.*

Managing the Scheme Office

As one of their fiduciary duties, the Trustees appoint and delegate accountability for the day-to-day management of the Scheme to the Principal Officer, who is the chief executive and accounting officer of the Scheme. The Principal Officer is required to execute the decisions of the Trustees and bears ultimate responsibility for all management functions. The Principal Officer must be fit and proper to hold this office and may appoint any staff, in accordance with the approved human capital plan, required for the proper execution of the business of the Scheme.

The Principal Officer is supported by an executive management team to execute the strategic objectives of the Scheme. The team works in collaboration with Discovery Health, which provides it with administration and managed care services, to implement strategy. The Scheme Office oversees the work done by Discovery Health on the Scheme's behalf.

The management team's expertise encompasses a broad range of capabilities including medicine, actuarial science, risk management, accounting, business management, strategic development, financial management, investment, governance, law, ethics, compliance and research.

Delegation of authority

A formal delegation of authority, implemented by the Trustees, provides a framework for achieving strategic priorities and effectively managing the Scheme within compliance requirements, while also balancing the interests of the Scheme's stakeholders, minimising and avoiding conflicts of interest, and practicing good corporate behaviour. The delegation of authority supports the effective exercise of authority and responsibility required for optimal operation of the Scheme, promoting independent judgement, and ensuring appropriate checks and balances. The delegation of authority is reviewed and updated whenever necessary to ensure relevance to operating requirements and alignment with the accountabilities and authorities of Scheme employees.

Our employees and their remuneration

The Trustees and the Remuneration Committee direct and oversee remuneration for employees of the Scheme. Informed by best practice, remuneration is carefully structured and independently benchmarked according to experience and skills required. In late 2022, the Scheme commenced a benchmarking exercise which will be concluded in 2023. The aim of the benchmarking exercise is to ensure that the remuneration practices of the Scheme are competitive and enable the Scheme to attract and retain high-calibre staff capable of managing and overseeing its complex operations.

In 2022, the Scheme Office consisted of 13 staff members, including a team of six executives who report to the Principal Officer and are supported by the Scheme Secretariat and administration departments. This lean employee complement makes succession planning challenging; to mitigate this risk, the Scheme employs a mature knowledge management and retention strategy, including a notice period sufficient to allow for transition and recruitment of scarce skills.

Scheme secretariat

The Scheme has an experienced secretariat function within its operational structure that provides the Board and its Committees with support regarding their duties, responsibilities and powers. The secretariat team is responsible for ensuring sound corporate governance practice. In addition, the secretariat function assists to develop and educate the Trustees and Independent Committee Members, ensuring they are equipped to fulfil fiduciary and other governance responsibilities. The function also ensures that the Board and its Committees adhere to all rules and legislation applicable to the Scheme during meetings, and that Board decisions are adequately documented and implemented.

Executive team

PRINCIPAL OFFICER

Ms Charlotte Mbewu

BCom (Hons) Accounting; CA (SA)

Council member of iFHP[1], board member of HFA[2] and a member of SAICA[3] Medical Schemes Project Group.

Chief Executive Officer of the Scheme.

HEAD: SPECIAL PROJECTS AND STAKEHOLDER RELATIONS (HSPSR)

Ms Michelle Culverwell

BA (Hons); MBA in Executive Management

Member of the HFA[4] Technical Advisory Committee.

The HSPSR advises on and oversees effective stakeholder relations, ethics and responsible corporate citizenship, and engages in special projects to enhance the strategic direction and sustainability of the Scheme.

CHIEF OPERATIONS OFFICER (COO)

Mr Selwyn Kahlberg

BSc (Hons) Actuarial; CFA; FASSA; FIA

The COO advises on and oversees investments, enterprise risk management and outsourced operations, ensuring the optimisation of Scheme investment performance in the best interest of members, as well as operational efficiency and adherence to the Scheme's defined risk appetite.

CHIEF MEDICAL OFFICER (CMO)

Dr Unati Mahlati

MBChB; FCPHM[5]; MMed; MBA

Member of the Board and Clinical Advisory Committee of HQA[6].

The CMO advises on and oversees strategic and operational clinical governance and risk management, product development and marketing. The CMO also ensures that Scheme resources in this regard are fully optimised in the best interest of members and sustainability.

CHIEF FINANCIAL OFFICER (CFO)

Mrs Joy Malete

BCom (Hons) Accounting; CA(SA); CIMA

Member of SAICA[7] Medical Schemes Project Group.

The CFO advises on and oversees strategic and operational finance and audit matters, and ensures that Scheme resources are optimised fully in the best interest of members.

HEAD: COMPLIANCE AND GOVERNANCE (HCG)

Mrs Lusani Nelufule-Mugivhi

LLB; Postgraduate Diploma in Compliance Management; Postgraduate Certificate in Data Protection and Privacy; Certified Ethics Officer

Board member of the Corporate Counsel Association of South Africa.

The HCG provides guidance to the Scheme on governance matters to ensure informed and legally sound decision making. This includes the management, co-ordination, and responsibility for the Scheme Secretariat function as well as ensuring that the Scheme is compliant with applicable legislative and regulatory requirements.

HEAD: LEGAL AND ETHICS (HLE)

Mr Howard Snoyman

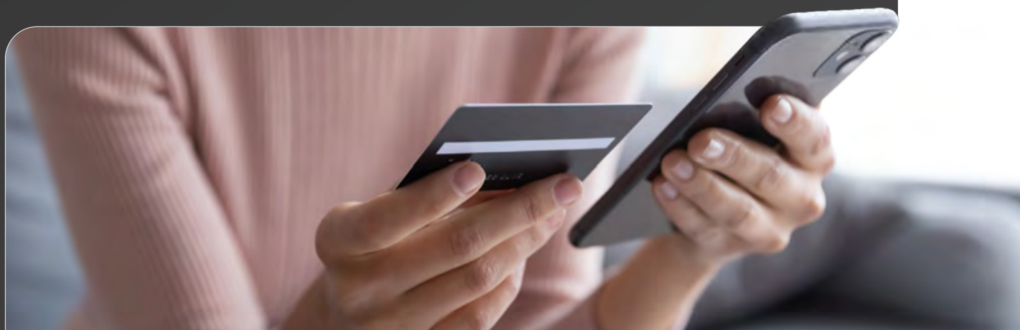
LLB; MSc Med (Bioethics and Health Law); PhD (Bioethics and Health Law) (in progress); Dip Sports Management; Adv Dip Sports Management; Certified Deal Architect[8]; (EP) SA[9]; Certified Ethics Officer; Certified Fraud Examiner

Board member of the Marketing Code Authority, member of the IRBA Committee for Auditor Ethics, member of the Fraud, Waste, Abuse and Errors Committee of the iFHP[10].

The HLE advises on, formulates, and oversees strategic and operational legal and ethics frameworks and activities, including escalated member disputes and complaints, governance, oversight of all Scheme contracts and litigation, as well as ensuring the incorporation of all relevant requirements into the legislative universe of the Scheme.

1 *iFHP: International Federation of Health Plans.*
2 *HFA: Health Funders Association. Elected to the Board on 30 September 2022.*
3 *SAICA: South African Institute of Chartered Accountants.*
4 *HFA: Health Funders Association.*
5 *FCPHM: Fellow of the College of Public Health Medicine of South Africa.*
6 *HQA: Health Quality Assessment.*
7 *SAICA: South African Institute of Chartered Accountants.*
8 *The Vested® Certified Deal Architect (CDA) programme, offered by the University of Tennessee, certifies individuals as experts in the field of collaborative supply chain optimisation, contracting and negotiations.*
9 *Ethics Practitioner SA.*
10 *iFHP: International Federation of Health Plans.*

Regulatory and industry matters dealt with in 2022



FRAUD, WASTE AND ABUSE

In recognition of the severe impact of fraud, waste and abuse (FWA) on medical schemes and their members, the CMS has held FWA summits, and taking industry submissions into account, the CMS has developed a code of good practice and rules for establishing a tribunal that will assist with resolving FWA matters. These developments should aid in standardising good practice across the industry and result in more efficient processing and consideration of FWA-related matters.

These developments are a result of an inquiry convened by the CMS in 2019 on the scope and use of Section 59 of the Act which confers medical schemes the power to recover funds unduly paid to either members or healthcare professionals. Various healthcare providers, facilities, medical schemes and medical scheme administrators testified at the inquiry, including Discovery Health and DHMS. The Scheme and Discovery Health explained the processes and principles of their activities to combat FWA, demonstrated that they are legal and ethical, and made written submissions in support of this testimony.

Although publication of the investigation report was delayed, an interim report was published for stakeholder comment in early 2021 and Discovery Health made a submission to the Panel on 5 April 2021 in this regard. The interim report found no fault with the processes and practices operated by Discovery Health on DHMS' behalf. At the time of writing, we await publication of the final report.

CMS MATTERS

For the protection of our greater membership, in 2016 the Scheme sought to register an amendment to Rule 11 to prevent members re-joining DHMS immediately after committing fraud or intentional material non-disclosure. Two unsuccessful appeals were lodged that year and, following legal advice, on 17 May 2017 the Scheme lodged a High Court application for review of the non-registration of this Rule in terms of the Promotion of Administrative Justice Act. The High Court review has yet to be scheduled.

From a procedural perspective, a Scheme Rule, once registered, remains registered until such time that the Scheme's Trustees amend the Rule and has the Rule registered by the CMS, or until a Court rescinds the Rule in question upon application by the Registrar of the CMS. With this in mind, Scheme Rule 14.7, dealing with the rejection of claims from providers where these claims place the Scheme at risk, was submitted to the CMS and registered in 2012; subsequent iterations of the Rule have been the subject of debate with the CMS and not registered. The non-registration matter was taken on appeal in terms of Section 49 of the Act and set down for hearing on 13 July 2018. Prior to the appeal hearing, the CMS conceded that the Rule was, in effect, still registered and by agreement, the hearing was no longer necessary.

The effect of this concession is that the Rule, as it stood when last registered in 2012, remains legally registered and enforceable. At the time of writing, iterations of the Rule from 2014, up to and including 2022, remain unregistered by the CMS; however this does not affect the validity of the 2012 registration.

The explanatory notes to Annexure A of the Regulations to the Act acknowledge that, due to constantly changing medical practice and health technology, Prescribed Minimum Benefits (PMBs) must be reviewed every two years taking cognisance of the impact, effectiveness and appropriateness of the PMB package. In 2017 the CMS convened the PMB review project, with industry stakeholders including medical schemes and administrators represented in the Advisory and Costing Committees. A draft Primary Healthcare Package was published in October 2019. The Scheme and Discovery Health contributed to the industry submission through the HFA submission in November 2019, however, there has not been any material movement in the project since then.

In December 2019, CMS Circulars 80 and 82 announced that no further LCBO exemptions would be granted by the CMS, and that all existing products exempted from the requirements of the Act in terms of the Demarcation Exemption Framework must be wound up before March 2021.

CMS matters *continued*

To develop a roadmap for the products, the CMS subsequently held stakeholder engagements and established two advisory committees incorporating stakeholders from the insurance and medical scheme industries. In Circular 56 of 2020, the CMS extended the exemption period to 31 March 2022, further extending it to 31 March 2024 in Circular 9 of 2022.

Circular 53 of 2022 requested industry submissions on the draft LCBO guidelines; DHMS contributed to these and awaits publication of the updated guidelines. DHMS will continue to engage with and support expanding access to quality and appropriate care for low-income and uninsured households, which will expand and improve medical scheme risk pools while reducing pressure on public sector resources and infrastructure.

The CMS inspection of DHMS initiated in 2017 was completed in 2018; the Scheme fully co-operated with the inspector, submitted a response to the CMS and awaits finalisation of the matter.

In 2022, the CMS initiated a routine inspection of DHMS in terms of Section 44 (4) (b) of the Act. The Scheme has submitted requested documents to the CMS in line with the request for information accompanying the notice of inspection. In early 2023, we engaged with the CMS on subsequent queries and provided additional information required. The CMS has subsequently issued a draft report to the Scheme, to which the Scheme is in the process of responding. A final report will be issued in due course.

As per Circular 52 of 2021, the CMS requires medical schemes to report on income received from investments as investing cashflows (rather than as operating cashflows) in their financial statements from the year ended 31 December 2021 onwards. In our assessment, the circular may conflict with International Financial Reporting Standards (IFRS), which are a set of principle-based (as opposed to rules-based) standards requiring interpretation and judgement to best depict information for users. Auditors are required to provide an opinion on the presentation of the financial statements in accordance with IFRS, and the Audit Committee and the Trustees are also required to attest to the fair presentation of the financial statements; the inability to do so may lead to a modification of the audit opinion by the auditors. The South African Institute of Chartered Accountants (SAICA) Medical Schemes Project Group engaged the CMS on this matter, resulting in the CMS postponing implementation of the classification of investment income under investing activities. The CMS has also indicated that they will be engaging further with schemes that report investment income under operating cashflows.

In 2017, the Department of Health (DoH) published a notice of intent to declare certain practices regarding designated services provider (DSP) networks and co-payments undesirable, and submissions were made to the CMS in response. In April 2021 DoH Notice 214 of 2021 was published, declaring certain practices pertaining to the selection of DSPs and imposition of excessive co-payments undesirable. The notice indicated that the CMS would publish guidelines on the selection of DSPs and imposition of co-payments within 180 days of the publication date. On behalf of its members, the HFA lodged a Promotion of Administrative Justice Act request to the Registrar and Council at both the CMS and the DoH to understand how the declaration was arrived at, and has also lodged a Section 50 Appeal regarding the declaration. The CMS has indicated that the development of guidelines has been put on hold, pending the outcome of the appeal.

To develop a roadmap for the products, the CMS subsequently held stakeholder engagements and established two advisory committees incorporating stakeholders from the insurance and medical scheme industries.

During 2021, the CMS notified DHMS that the Scheme was not compliant with Explanatory Note 2 of Annexure B as the Scheme's assets in category 1 (a) (i) and 1 (a) (ii) of Annexure B fell below 20% of the Scheme's Regulation 30 assets. This assessment by the CMS was conducted using the aggregate fair value of liabilities and total accumulated funds rather than "minimum accumulated funds" as stated in Regulation 29. The Scheme measures the assets against the aggregate fair value of liabilities and "minimum accumulated funds", namely 25% of gross annual contributions as stated in Regulation 29, on which basis the Scheme is compliant. The Scheme further obtained a legal opinion from Knowles Husain Lindsay Inc. on 25 February 2022 to confirm the application of the Act and its Regulations, which demonstrated that the Scheme is compliant with Explanatory Note 2 of Annexure B. In November 2022 the CMS advised the Scheme that, while the parties engage to resolve the matter, the Scheme is not expected to perform any action to correct any alleged non-compliance. At the date of this Report, the matter had not been concluded and DHMS will continue to engage the CMS.

DISCOVERY HEALTH ACCREDITATION

All administration and managed care providers in the industry must renew their CMS accreditation every two years. In December 2019, the CMS informed the Scheme that administration accreditation was granted to Discovery Health to perform administration services for a further two-year period, extending this to 31 December 2021.

This accreditation was subject to conditions which Discovery Health was required to fulfil; the Trustees and Principal Officer closely monitored the fulfilment of these conditions in line with their governance responsibilities and fiduciary duties. In 2020 and 2021, Discovery Health submitted evidence of compliance to the CMS. Discovery Health has received feedback on some of these submissions, resulting in amendment to some of the conditions. Two appeals related to the conditions were lodged by Discovery Health and set-down dates for the hearings are still awaited.

In December 2021, the CMS granted accreditation to Discovery Health for two years to 31 December 2023 subject to compliance with the conditions stipulated.

NATIONAL HEALTH INSURANCE

In Chapter 2 of the Bill of Rights, Section 27, the South African Constitution stipulates that all citizens have the right of access to healthcare. In accordance with this principle, the NHI policy seeks to progressively move the country towards universal health coverage and ensure that all citizens have access to affordable quality healthcare.

The NHI policy was approved by Cabinet in June 2017, and two draft NHI Bills were released for public consultation in June 2018 and July 2019. The Scheme and Discovery Health made joint submissions on both Bills and engaged in other consultative forums including the HFA and Business Unity South Africa, both of which also made submissions. These submissions support the provision of universal healthcare to all South Africans within a social solidarity framework, but protect the rights of individual citizens to purchase and access cover beyond their mandatory contributions to the NHI Fund. DHMS fully supports the progressive realisation of universal health coverage for South Africans. Universal health coverage is aligned with United Nations Sustainable Development Goal 3 which prioritises risk protection, access to quality essential healthcare services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The Parliamentary Committee on Health (PCH) conducted extensive stakeholder engagements and received over 100 000 written submissions and many verbal presentations in response to the Bill. In 2022 the PCH conducted a clause-by-clause review of the Bill, and during 2023, the Bill is expected to go to the National Assembly and thereafter to the National Council of Provinces for debate and further public engagement, whereafter it will go back to the National Assembly. Amendments may be made at any of these stages before the Bill can be passed into law, and DHMS will closely monitor its progress and contribute to constructive debate wherever possible. Some of the concerns we have previously raised include possible constitutional challenges, the potential impact on the right of access to healthcare, alternative funding models, and inadequate governance structures.

MANDATORY AUDITOR ROTATION

In June 2017, the IRBA issued a rule prescribing that auditors of public interest entities in South Africa must comply with mandatory audit firm rotation (MAFR) as of 1 April 2023. As DHMS is a public interest entity, DHMS established the MAFR Committee to oversee the audit firm recruitment process and support the Audit Committee to find a suitable CMS-accredited audit firm to succeed PwC for the financial year beginning 1 January 2024.

The Audit and MAFR Committees were able to identify a suitable audit firm to take over from PwC, and made a recommendation to the Trustees, which was approved. The new auditor will be appointed during the course of 2023 when the matter is tabled at the AGM for approval by members.

ROAD ACCIDENT FUND

RAF TARIFFS

The Road Accident Fund (RAF) provides compulsory statutory cover to all users of South African roads, against injuries sustained or death arising from accidents involving motor vehicles within the borders of South Africa. This cover is in the form of indemnity insurance to persons who cause the accident, as well as personal injury and death insurance to victims of motor vehicle accidents and their families.

In January 2022, the RAF unilaterally set tariffs for refunds which are inadequate to cover costs, despite a prior Constitutional Court ruling that a tariff that denies a road accident victim treatment in the private health sector is "not rationally related to the objectives sought to be achieved[1]". The proposed tariffs for medical treatments and related care were approximately 62% lower than general medical scheme tariffs in 2022. This would have the effect of leaving large co-payments for non-medical scheme members that seek private medical care, meaning that the vast majority of these will have no option but to be treated in a State facility. Additionally, for claimants who are medical scheme members, this would translate into dramatically lower recoveries on behalf of DHMS and other schemes, once the RAF reimburses the claimant for any medical expense already incurred. Representing the medical schemes and their members, the HFA has made several submissions including evidence that the tariffs deprive victims of road accidents of an effective remedy and are unreasonable.

In December 2022 the Gauteng High Court, on application by the National Council for Persons with Disabilities, interdicted the implementation of the tariffs retrospectively from January 2022. A further application is expected to be heard in May 2023, in which the court would be asked to review and set aside the tariffs.

RAF REFUSING TO REFUND MEDICAL SCHEME MEMBERS

On 12 August 2022, a directive was issued by the acting head of claims at the RAF that no medical expense claims should be paid in respect of medical scheme members, proposing that there is no liability on the member as they are insured elsewhere. This is legally unsound action and contrary to the RAF's mandate. Discovery Health, on behalf of the schemes it administers, including DHMS, successfully interdicted the directive from being implemented by the RAF. The RAF has since applied for (and has been denied) leave to appeal from the High Court (Pretoria). However, at the time of publication, the RAF continues to deny these claims. As RAF claims are settled on a once and for all basis, every settlement that is accepted excluding medical expenses cannot be reopened thereafter. The RAF has since applied for leave to appeal to the Supreme Court of Appeal (SCA), but Discovery Health has in turn applied in terms of S18 (3) of the Superior Courts Act to remove the suspensive effect of the RAF's appeal, pending decision by the SCA.

1 *Judgement in the case of the Law Society of South Africa and Others v Minister for Transport and Another (CCT 38/10) [2010] ZACC 25; 2011 (1) SA 400 (CC); 2011 (2) BCLR 150 (CC) (25 November 2010).*

COMPETITION COMMISSION – COVID-19 PCR TESTS PRICING MATTER

On behalf of 35 participating medical schemes including DHMS, and representing over 5.6 million scheme members, in March 2023 the HFA submitted a complaint to the Competition Commission regarding the high prices charged for COVID-19 PCR tests by the three largest private pathology laboratory groups in South Africa during the COVID-19 pandemic in 2020 and 2021.

In October 2021, the CMS lodged a complaint with the Competition Commission against the three main private pathology groups regarding COVID-19 PCR test prices. The HFA's complaint is on a similar basis to that of the CMS, which resulted in an immediate 41% reduction in the price of COVID-19 PCR tests, from R850 to R500.

The HFA's complaint aims to ensure that the excess costs borne by medical schemes associated with any excessive pricing of COVID-19 PCR tests during this period is refunded to medical schemes for the members' benefit. These recoveries represent member funds and will accrue to the reserves of medical schemes; the reserves have a direct bearing on schemes' abilities to pay claims, and may impact future contribution increases for members.

07

Our performance

Scheme performance for the 2022 financial year

Discovery Health Medical Scheme's (DHMS' or the Scheme's) limited sources of financial capital (derived only from member contributions and returns from investing member funds) require that we carefully balance the resources needed to meet our strategic objectives in caring for our members, ensuring Scheme stability and sustainability, and meeting the regulatory solvency requirements set out in the Medical Schemes Act (the Act).

The Scheme has a fiduciary obligation to maximise investment returns with due regard for related risks, requiring that we consider issues that can impact longer-term investment performance.

Overview

For the year ended 31 December 2022, DHMS delivered a planned negative net healthcare result of R3 281 million (2021: planned negative R1 165 million), attributable to the delayed contribution increase for the 2022 benefit year. Despite this, results are significantly better than expected due to lower-than-expected utilisation for most of 2022. The Scheme generated investment income of R2 222 million (2021: R1 772 million), contributing to a net deficit of R1 489 million (2021: R2 044 million surplus) for the year.

Members' funds decreased to R28.3 billion (2021: R30.4 billion) with a solvency level of 35.11% (2021: 38.01%), exceeding 25% required by regulators. Receiving a credit rating of AAA from Global Credit Rating Co (an independent credit rating agency), the Scheme has achieved the highest possible rating for a medical scheme in South Africa for the 23rd consecutive year, confirming the Scheme's financial strength and ability to pay claims. It is the Board of Trustees' (the Board or the Trustees) view that despite challenging and unusual market conditions, DHMS ended 2022 in a strong financial position and remains well placed to meet members' needs in the event of anticipated increased utilisation due to postponement of care since 2020 and consequently worsened states of health of our members.

INVESTMENT INCOME
R2 222 million
(2021: R1 772 million)

NET DEFICIT
R1 489 million
(2021: R2 044 million)

MEMBERS' FUNDS
R28.9 billion
(2021: R30.4 billion)

SOLVENCY LEVEL
35.11%
(2021: 38.01%)

CREDIT RATING
AAA
The Scheme has achieved the highest possible rating for a medical scheme in South Africa for the **23rd consecutive year**

Key performance information

Ensuring the Scheme's sustainability

The Scheme's financial strength, its ability to pay claims, and its long-term sustainability are crucial to members. A summary of key sustainability outcomes metrics for the Scheme is presented to the right and on the next page, together with an explanation of why we consider these important.

1 *An increase of less than one year per annum is favourable as this indicates that young people are joining the Scheme.*
2 *Based on beneficiaries' dates of birth.*
3 *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Annual Report for the year ended December 2021 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/). At the end of 2021 there were 17 open schemes registered with the CMS, with approximately 54% of the total medical schemes market, and 55 restricted schemes with approximately 46% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately two million beneficiaries. Source: Annexures to the CMS Annual Report 2021-2022.*
4 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*
5 *The methodology for calculating the contribution differentials has been amended to reclassify a competitor plan and to correct a calculation error. The differential reported for 2022 was 14.9%, which has now been amended to 14.6%.*

GROWTH AND SUSTAINABILITY

Membership growth

Growth in the number of young and healthy members improves risk pooling through cross-subsidisation principles and reflects the attractiveness and competitiveness of the Scheme.

NET MEMBERSHIP INCREASE
1.67%
(2021: 1.69%)

NET BENEFICIARY INCREASE
0.94%
(2021: 0.96%)

AVERAGE AGE AT YEAR-END[1]
36.57
(2021: 36.17)

PENSIONER RATIO[2]
11.77%
(2021: 11.25%)

ANNUALISED LAPSE RATE
5.49%
(2021: 5.13%)

Membership size

Greater risk pooling makes for more predictable claims experiences and pricing accuracy, leading to stable performance.

1 375 544
PRINCIPAL MEMBERS AT 31 DECEMBER 2022
(2021: 1 353 012)

2 810 992
BENEFICIARIES AT 31 DECEMBER 2022
(2021: 2 784 793)

57.6%[3]
SHARE OF OPEN SCHEME MARKET
(2019: 57.5%)

Plan movements

Low movement between plans indicates member satisfaction and appropriate benefit design and pricing. From December 2022 – January 2023:*

PLANS DID NOT CHANGE	PLANS WERE UPGRADED	PLANS WERE DOWNGRADED
97.15%	**1.50%**	**1.35%**
Sep-Oct 2022: 98.68%	Sep-Oct 2022: 0.75%	Sep-Oct 2022: 0.57%
Dec-Jan 2022: 96.53%	Dec-Jan 2022: 1.89%	Dec-Jan 2022: 1.58%

* *We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans. Our next contribution increase will be in April 2023.*

Relative contribution levels

Reflects value for money for members, effective risk management and value added by the administration and managed care provider.

AVERAGE CONTRIBUTIONS FOR 2023 ARE
12.2%
lower than the next seven largest open medical schemes[4]
(2022: 14.6%)[5].

FINANCIAL STRENGTH AND MANAGEMENT

Absolute reserves

Demonstrates our ability to meet large, unexpected variation in claims.

ACCUMULATED FUNDS EXPRESSED AS A PERCENTAGE OF GROSS ANNUAL CONTRIBUTIONS

35.11%
(2021: 38.01%)
exceeding the statutory solvency requirement of 25%.

AAA
Independent credit rating for claims paying ability[1]
(2021: AAA).

Prudent investment management

Ensuring that investment returns, to bolster member funds, are maximised within an acceptable and conservative level of risk.

GROSS RETURN ON INVESTMENTS

6.18%
(2021: 10.31%)

Pricing sufficiency

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims. In 2022, the Scheme deferred the contribution increase to 1 October, providing relief to its members and passing on the benefit of excess reserves. The deferral of the increase resulted in the Scheme generating a planned negative net healthcare result for the year.

NET HEALTHCARE RESULT FOR THE YEAR OF

R3 281 million negative
(2021: R1 165 million negative)

NET DEFICIT FOR THE YEAR OF

R1 489 million
(2021: R2 044 million surplus)

Value-added administration and managed care

FOR EVERY R1.00 SPENT BY DHMS ON ADMINISTRATION AND MANAGED CARE FEES IN 2021, OUR MEMBERS RECEIVED

R2.02
(2020: R1.90[2])
in value from the activities of Discovery Health. This is equivalent to nominal added value of R7.6 billion in 2021 (2020: R6.4 billion).

ADMINISTRATION FEES

7.56%
of gross contributions
(2021: 7.33%)

MANAGED CARE FEES

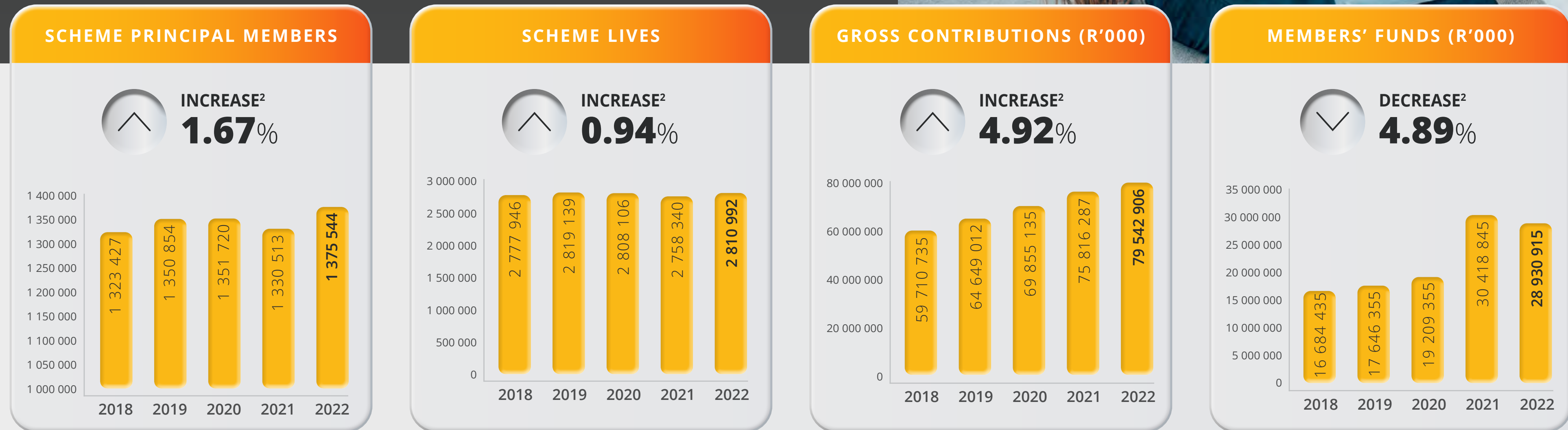
2.64%
of gross contributions
(2021: 2.56%)

1 Rating affirmed in April 2023; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.
2 The 2020 value added has been restated from R1.88 to R1.90 using updated information from the CMS 2020/2021 Annual Report, changes in methodology and finalised settlement values for certain components.

In 2022, the Scheme deferred the contribution increase to 1 October, providing relief to its members and passing on the benefit of excess reserves.

Historical performance indicators

Consistent with the stagnant South African economy and the ongoing impact of COVID-19, the medical scheme industry has remained stagnant over the past decade, with a slight increase in membership of 0.92% in 2021 compared to 2020[1] (vs DHMS' increase of 1.69% in 2021). Despite this, the Scheme's number of principal members and total lives under management recovered from prior year levels, indicating that membership of a trusted scheme like DHMS remains a priority for our members. Members' funds are sufficient to assure members that the Scheme is able to take care of their healthcare needs.



1 According to the 2021 CMS report, a total of 8 938 872 beneficiaries were covered, up from 8 895 152 at the end of 2020.
2 Year-on-year change (2021 to 2022).

MEMBER DISPUTES AND CMS COMPLAINTS

We thoroughly investigate and review all disputes formally lodged by Scheme members, aiming to resolve as many as possible internally so that members do not need to lay complaints with the CMS. The Dispute Committee process is also available to healthcare providers wishing to escalate disputes regarding billing practices and forensic investigations with the Scheme. The first hearings of this nature were held in early 2021.

The Committee is not empowered to make discretionary rulings or those contravening applicable legislation and the latest registered Scheme Rules. However, at its discretion the Committee can refer relevant questions to a specially convened Treating Customers Fairly (TCF) Committee. The TCF Committee provides specialist insight into issues of fairness in accordance with recognised TCF standards and makes non-binding recommendations to the Dispute Committee.

With a total of 55 755 192[1] claims made in 2022, only 439 resulted in complaints to the CMS by DHMS for 2022[2] (2021: 411 relative to 54 556 179 claims). While this reflects a 7% increase in complaints from 2021, the ratio of complaints to the number of claims has decreased. The ratio of internal disputes to CMS complaints has continued to improve from 39% in 2015, to 199.5% in 2022 (i.e. 1.99 internal disputes are lodged, for every CMS complaint lodged).

The majority of cases are resolved amicably and efficiently through the Scheme's disputes mechanism, achieving a high rate of withdrawals and settlements without the member requiring a hearing as the matter is sufficiently aired and explained in the process. In 2022, 694 (79%) of the 875 member disputes and one forensics dispute lodged in terms of Rule 27[3], were settled or withdrawn prior to a hearing (2021: 697 member-related disputes, two forensic disputes, 627 (90%) settled or withdrawn). For member-lodged disputes, 21 hearings took place during 2022 with 18 rulings issued; 14 in favour of the Scheme, three in favour of members, and one partially in favour of both the member and the Scheme. No dispute rulings were challenged further by members in a complaint to the CMS, lodged in terms of section 47 of the Act. The single forensic dispute hearing resulted in a ruling in favour of the Scheme.

IN 2022, ONLY ONE COMPLAINT WAS MADE FOR EVERY 127 005 CLAIMS MADE BY MEMBERS.

1 *Total claims made in 2022 extracted during February 2023; claims incurred during 2022 but not submitted by the date of extraction are not included.*
2 *This equates to one complaint to every 127 005 claims (2021: one complaint to every 132 740 claims).*
3 *Rule 27 of the DHMS Rules deals with complaints and disputes. The Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.*

GROSS CONTRIBUTION INCOME

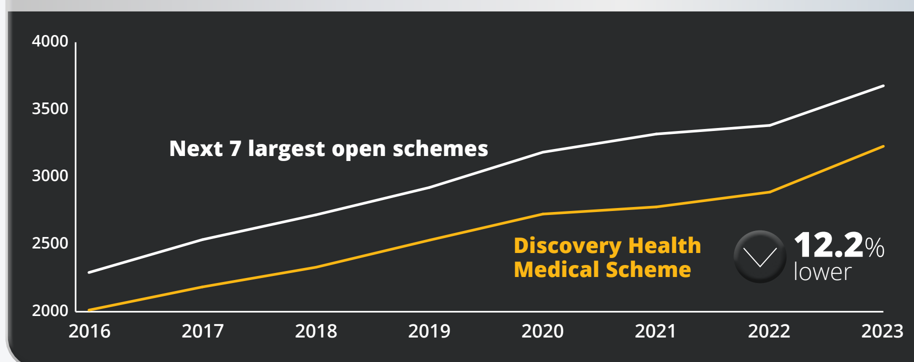
The Scheme remained highly competitive with average contributions for 2023 12.2% lower[1] than the next seven largest open medical schemes (2022: 14.6%)[2]. This is predominantly due to our ability to contain the impact of healthcare inflation.

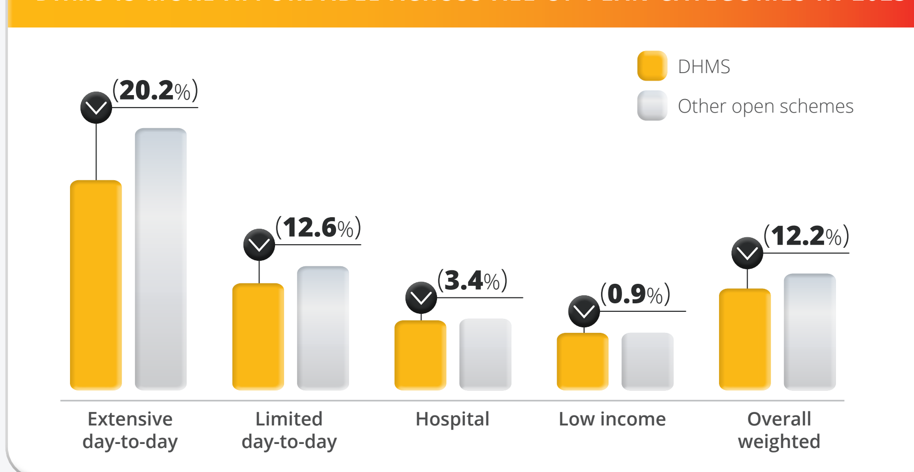
Due to the exceptional utilisation patterns[3] caused by the pandemic, and to assist members to deal with economic pressures, the Scheme has been able to adopt a contribution freeze for the third year in a row. DHMS was the first medical scheme in South Africa to implement a freeze on contribution increases effective from January to July 2021, and again in 2022 when we froze contributions for nine months until 1 October 2022. The delayed implementation of the 2022 contribution increases resulted in a 2.0% effective increase for members for that period, based on the annualised December 2021 rates.

This year, the contribution increase has been delayed to 1 April 2023 with a weighted average contribution increase of 8.2% across the various DHMS plans. Through the delayed implementation of this contribution increase, members will only experience a 6.2% effective increase based on the annualised December 2022 rates.

WE ESTIMATE THAT THESE THREE CONTRIBUTION FREEZES HAVE SAVED MEMBERS R8.6 BILLION, A SIGNIFICANT RESPITE FOR MEMBERS UNDER FINANCIAL PRESSURE.

Gross contribution income (GCI) rose 4.88% to R79.5 billion (2021: R75.8 billion). The most significant net membership growth contributing to the increase in GCI was recorded in mid- to low-tier options, where the Smart series grew by 11 974 net members (2021: 36 221). With a net principal membership decline of 11 820 (2021: 17 685), the Priority series experienced the largest reduction.





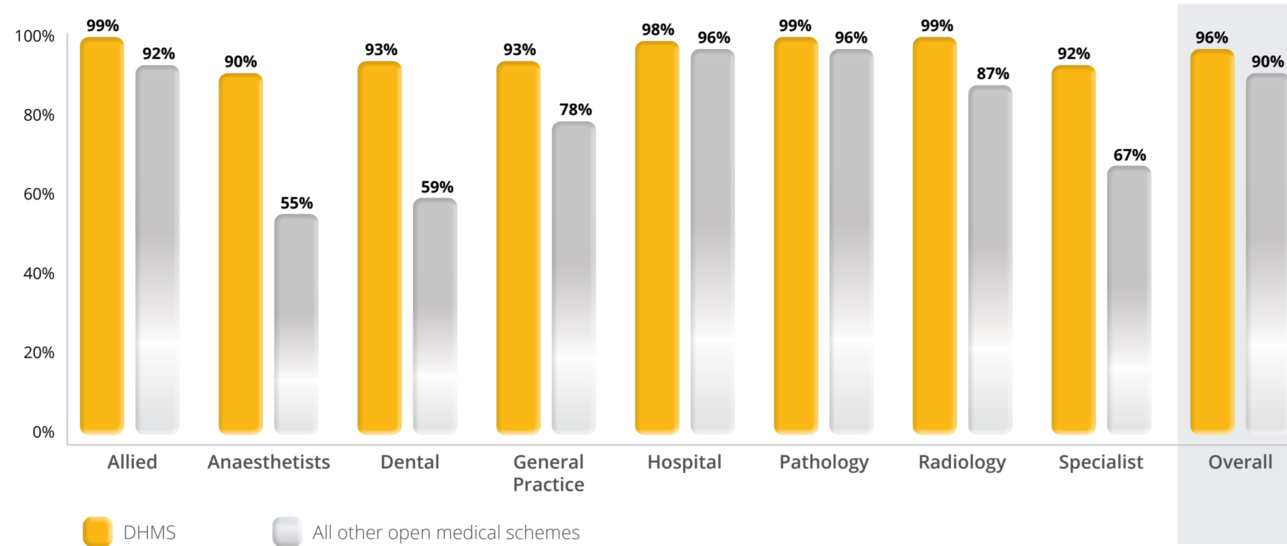
1 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*

2 *The methodology for calculating the contribution differentials has been amended to reclassify a competitor plan and to correct a calculation error. The differential reported for 2022 was 14.9%, which has now been amended to 14.6%.*

3 *2020 marked a radical shift in healthcare seeking behaviour, with stringent COVID-19 lockdown measures set in place by government and concerns about the risk of infection at places of care, resulting in 3.5 million fewer member claims than in 2019 and 76.5% of Scheme income funding claims (compared to 87.3% in 2019). In 2021, members began utilising healthcare again, increasing the number of claims made to 54 556 179 (compared to 47 675 525 in 2020) and the percentage of Scheme income spent on funding claims to 89.1%. In 2022, the number of claims made was 55 755 192 and 91.7% of the Scheme's income funded claims.*

IN RETURN FOR THEIR CONTRIBUTIONS, DHMS CONTINUES TO PROVIDE EXCEPTIONAL CLAIMS COVER FOR MEMBERS.

IN 2021, WE PAID 96% OF OVERALL IN-HOSPITAL CLAIMS, VS 90% FOR ALL OTHER OPEN SCHEMES[1]



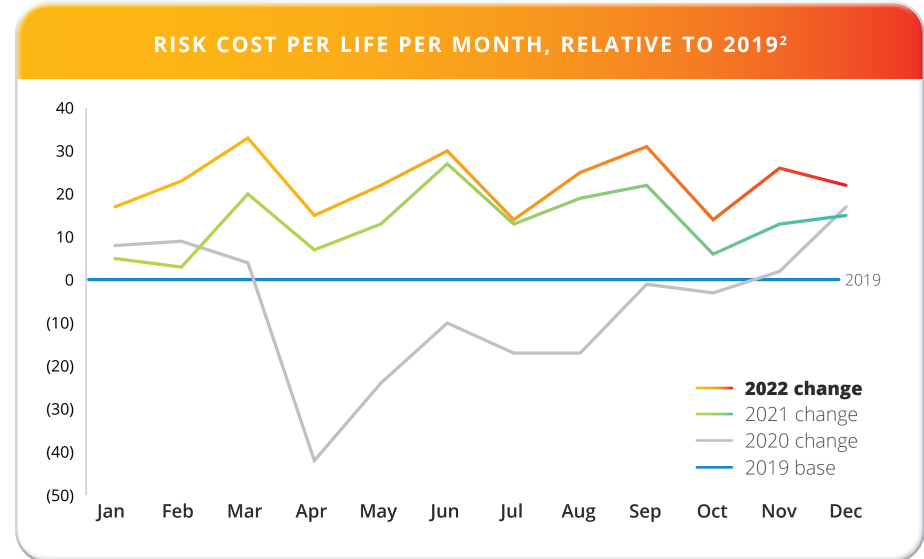
1 *Source: CMS Annual Report 2021-2022. Comparative data not yet available for 2022.*

NET CLAIMS INCURRED

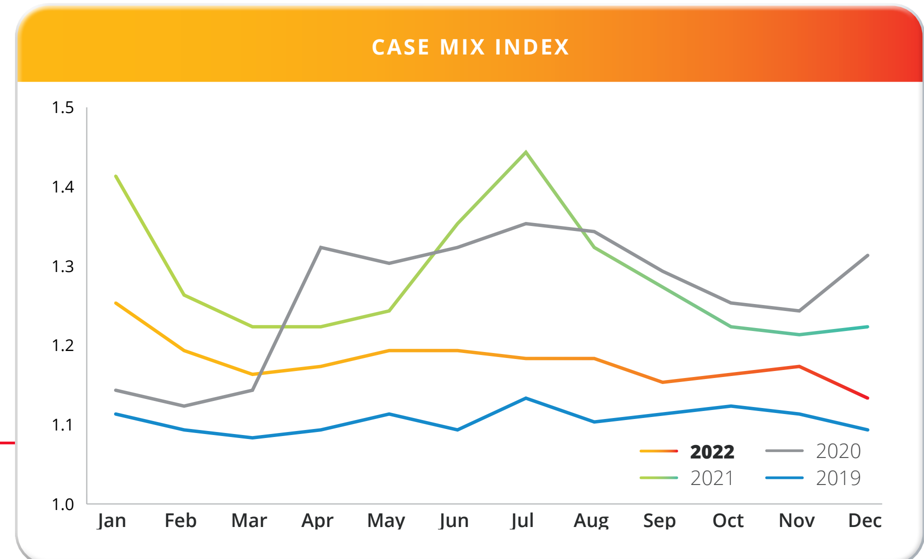
Net claims incurred increased by 8.27% to R58.9 billion (2021: R54.4 billion). Claims reverted to pre-COVID-19 levels towards the end of 2022 and the Scheme expects this trend to continue in 2023, likely with a more severe disease case mix, as members' postponed healthcare needs fully return to the healthcare system and drive increased utilisation.

The gross claims ratio[1] increased to 92.90% (2020: 90.09%) due to the deferral of the 2022 contribution increases to October 2022. The impact of the deferral was offset by robust risk management interventions implemented by the Scheme's administration and managed care provider.

CLAIM PATTERNS IN 2020, 2021 AND 2022, FROM A 2019 BASE, SHOWING THE RETURN TO CLOSE-TO-NORMAL CLAIMING PATTERNS IN 2022



HIGHER SEVERITY ADMISSIONS IN 2020, 2021 AND 2022, WITH 2020 AND 2021 INDICATING THE HEIGHT OF THE PANDEMIC.



1 The percentage of risk contributions utilised to fund relevant healthcare expenditure (net claims incurred, accredited managed healthcare services fees and net income/(loss) on risk transfer arrangements).

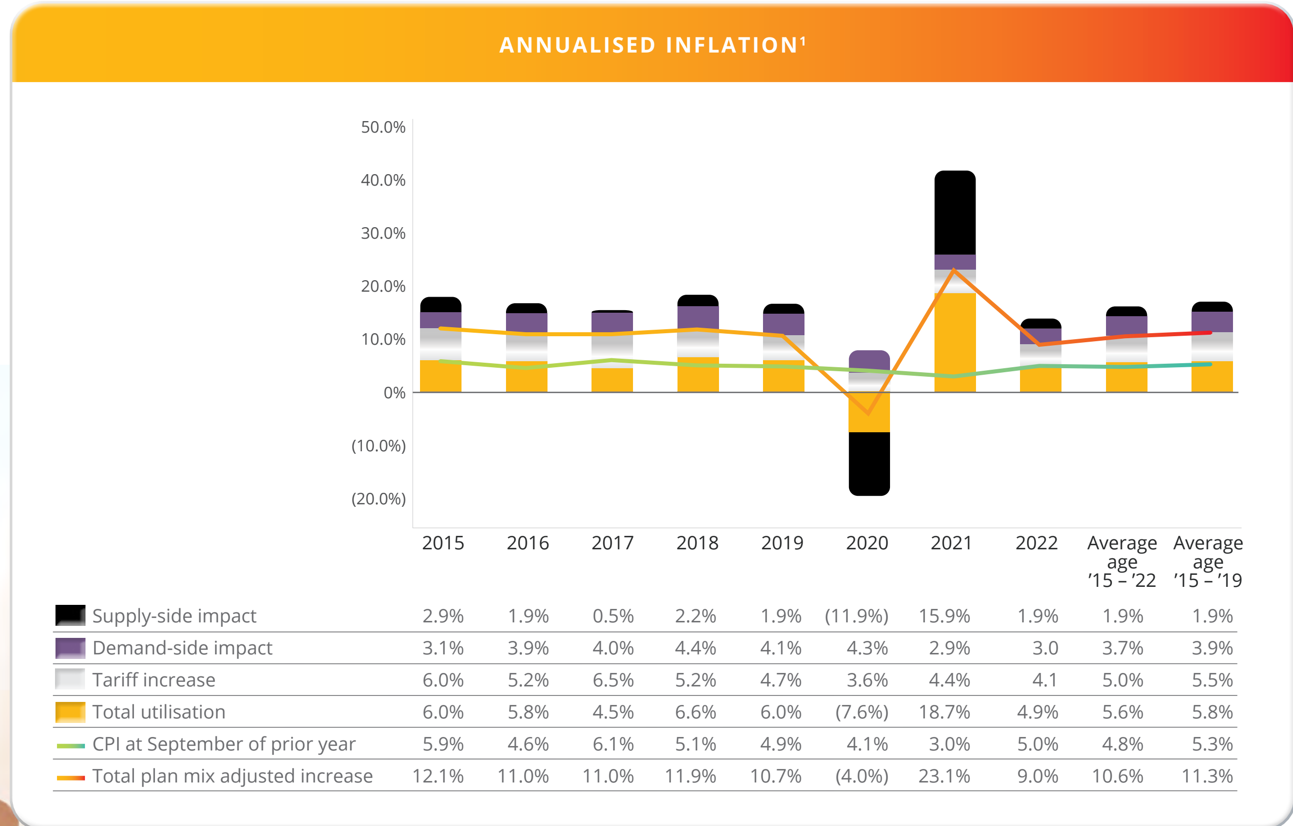
2 Not adjusted for tariff increases.

NET CLAIMS INCURRED *continued*

Consistently above consumer price index (CPI) inflation, healthcare inflation continues to be a concern for medical schemes. The primary driver of healthcare inflation is the extent of healthcare services utilisation due to demand- and supply-side effects.

Higher supply-side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare. Increases in demand-side utilisation, on the other hand, pertain to change in the demographic profile of beneficiaries, for example with regards to average age and burden of chronic non-communicable diseases.

ANNUALISED INFLATION[1]



	2015	2016	2017	2018	2019	2020	2021	2022	Average age '15 – '22	Average age '15 – '19
Supply-side impact	2.9%	1.9%	0.5%	2.2%	1.9%	(11.9%)	15.9%	1.9%	1.9%	1.9%
Demand-side impact	3.1%	3.9%	4.0%	4.4%	4.1%	4.3%	2.9%	3.0	3.7%	3.9%
Tariff increase	6.0%	5.2%	6.5%	5.2%	4.7%	3.6%	4.4%	4.1	5.0%	5.5%
Total utilisation	6.0%	5.8%	4.5%	6.6%	6.0%	(7.6%)	18.7%	4.9%	5.6%	5.8%
CPI at September of prior year	5.9%	4.6%	6.1%	5.1%	4.9%	4.1%	3.0%	5.0%	4.8%	5.3%
Total plan mix adjusted increase	12.1%	11.0%	11.0%	11.9%	10.7%	(4.0%)	23.1%	9.0%	10.6%	11.3%

The primary driver of healthcare inflation is the extent of healthcare services utilisation due to demand- and supply-side effects.

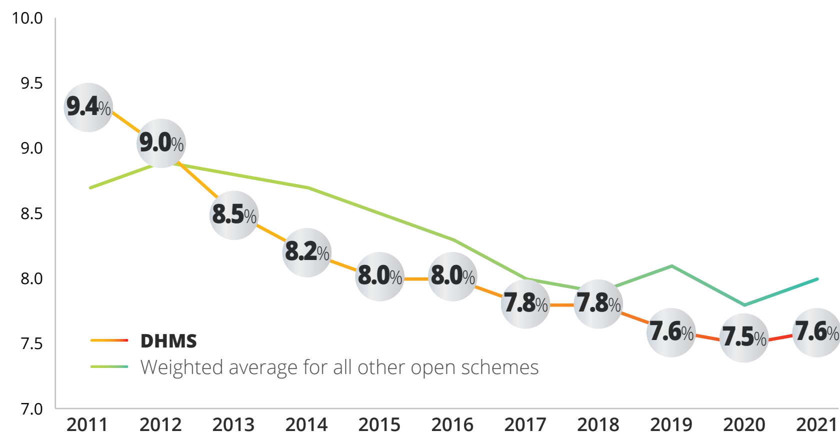
1 *The annualised inflation graph is produced prior to the finalisation of the financial data used. Any discrepancies that may occur between publication and finalisation of the data are amended in the following year's Integrated Report.*

GROSS ADMINISTRATION EXPENDITURE

Gross administration expenditure comprises administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's administration provider (Discovery Health). During 2022, gross administration fees increased by 8.21% to R6.011 billion (2021: R5.555 billion), driven by an increase in the average administration fee per member of 6.6% to R368.28 (2021: R345.49), largely due to an annual CPI-linked increase.

The Scheme's analysis of the CMS Annual Report 2021-2022 shows that, at 7.6% for 2021, DHMS continued to rank below the weighted average gross administration expenditure for open schemes when considered as a proportion of GCI, which was 8.0% excluding the Scheme. The Scheme's gross administration expenditure is the fifth lowest out of 17 open medical schemes in the market.

The Scheme's members benefit through a continuously reducing administration expenditure percentage that is among the lowest in the industry. The graph below depicts the continued decrease in gross administration expenses as a percentage of GCI, compared to the weighted average of other open medical schemes.

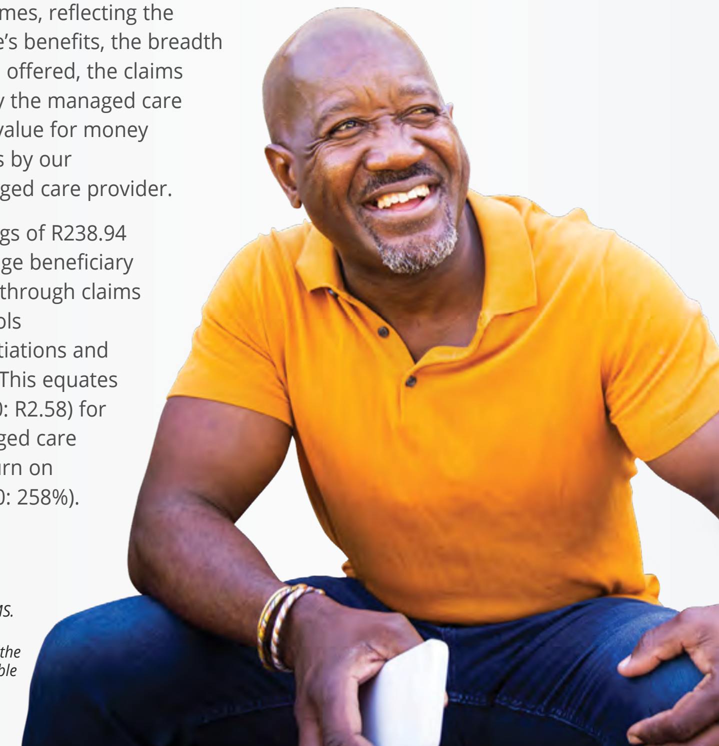


ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 8.16% to R2.12 billion (2021: R1.96 billion) is predominantly attributable to the CPI-linked increase of 6.54% from R121.93 to R129.91, in accredited average managed care costs per member per month. Managed care costs as a percentage of GCI increased slightly from 2.59% in 2021 to 2.67% in 2022 due to the deferred increase in contributions. An analysis of the CMS Annual Report 2021-2022 demonstrates that the Scheme's managed care cost as a proportion of GCI was 2.6% compared to the weighted average for open schemes (2.2%[1]).

Our managed care costs are slightly higher than those of other open schemes, reflecting the complexity of the Scheme's benefits, the breadth of managed care services offered, the claims cost savings generated by the managed care services, and the overall value for money provided to our members by our administration and managed care provider.

In 2021, claims cost savings of R238.94 (2020: R203.06) per average beneficiary per month were realised through claims review processes, protocols implemented, price negotiations and drug utilisation reviews[2]. This equates to a saving of R3.04 (2020: R2.58) for every Rand paid in managed care costs, an exceptional return on investment of 304% (2020: 258%).



1 *Weighted average excludes DHMS.*
2 *Source: The Value-Added Assessment report presented to the Trustees; figures are only available for the preceding year.*

INVESTMENT RESULTS

The Scheme's investment portfolio is suitably diversified and managed to optimise returns within our approved risk appetite. Asset allocation is managed and monitored from an asset and liability perspective, while ensuring sufficient liquid funds are available to meet claims and other liabilities as they fall due. Given the short-term nature of Scheme liabilities, a significant portion of our assets are invested in cash and money market instruments and short-duration bonds. Allocations are also made to longer-duration bonds (local and foreign) and equities.

The Scheme earned a gross investment return of 6.18% for 2022 (2021: 10.31%).

PRUDENT FINANCIAL MANAGEMENT

The Scheme has a duty to timeously collect all contributions due. The table below indicates the high level of contribution collection management achieved during the year, with average outstanding collection days at 11.76 for 2022 (11.18[1] in 2021). At year-end, only a very small proportion of contributions had not yet been collected.

Year ended	2022	2021
Gross contributions	**79 542 906**	75 816 287
Total outstanding – excluding December contributions	**58 747**	58 747
% Outstanding	**0.07**	0.08

1 *Corrected from last year's report, which indicated 11.95 days in 2020.*

SOLVENCY

The Act requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29 (2).

At 31 December 2022, the Scheme's solvency level of 35.11% (2021: 38.01%) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R8 billion (2021: R9.9 billion).

R'000	2022	2021
Total Members Funds	**28 930 015**	30 418 845
Less: cumulative unrealised net gain on re-measurement of investments	**(1 002 934)**	(1 603 656)
Total net assets (Regulation 29)	**27 927 081**	28 815 189
Gross annual contributions	**79 542 906**	75 816 287
Solvency ratio	**35.11%**	38.01%

RESERVE ACCOUNTS

OUTSTANDING CLAIMS

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2022

Circular 11 of 2006 issued by the CMS deals with issues to be addressed in the audited financial statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them to be material or not.

During 2022, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

SUSTAINABILITY OF BENEFIT PLANS

In terms of Section 33 (2) of the Act, each benefit plan is required to be self-supporting in terms of membership and financial performance, and be financially sound.

For the year ended 2022 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/surplus (R'000)
Executive	**(318 453)**	**(309 560)**
Classic Comprehensive	**(1 540 380)**	**(1 421 736)**
Classic Core	**(46 403)**	**25 749**
Classic Priority	**(193 709)**	**(110 263)**
Essential Comprehensive	**(136 488)**	**(122 659)**
Coastal Core	**(352 589)**	**(241 399)**
Coastal Saver	**(535 036)**	**(340 773)**
KeyCare Plus	**(1 272 181)**	**(943 906)**
KeyCare Core	**(3 385)**	**22 149**

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes. Different strategies are continually evaluated to address the deficit in these plans while considering the overall financial stability of the Scheme.

When structuring benefit options, the financial sustainability of all the options and the requirements of the CMS are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy for plans' sustainability must balance short- and long-term financial considerations, fairness to both healthy and sick members, and continued affordability of cover for members with different levels of income and healthcare needs. While the Scheme is committed to complying wherever possible with applicable legislation, it also focuses intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

DHMS continually provides the CMS with updates on both the Scheme and individual benefit option performance through monthly management accounts and quarterly monitoring meetings.

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2022 *continued*

INVESTMENTS IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide and the CMS has granted DHMS exemption for a three-year period effective from 1 December 2022.

INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE THE REPUBLIC OF SOUTH AFRICA

The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by international swaps and derivatives association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied.

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS exemption for a three-year period effective from 1 December 2022.

CONTRIBUTIONS RECEIVED AFTER DUE DATE

Section 26 (7) of the Act states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment becomes due. There are instances where the Scheme received contributions after the three-day period, however, there are no contracts in place agreeing to this practice. It is important to note that the Scheme has no control over the timely payment of contributions. The legal obligation resides with the members/employers to pay contributions within the prescribed period. The Scheme employs robust credit control processes dealing with the collection of outstanding contributions, including suspending membership for non-payment.

CLAIMS PAID IN EXCESS OF 30 DAYS

Section 59 (2) of the Act states that: "A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme".

During the year, there were instances where claims were not paid within 30 days. These represent a negligible amount of total claims paid for the year. There is a defined process to identify claims that have not been paid within 30 days to ensure that these claims are paid expeditiously.

BROKER FEES PAID

In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis on receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2), limited to one broker as required by Regulation 28 (8).

In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible. The exceptions relate to transactions that do not occur frequently and the administrator has developed exception reporting to identify and correct these transactions and has a well-established claw-back system to rectify commission overpayments.

PRESCRIBED MINIMUM BENEFITS

Section 29 (1) (o) and Regulation 8 provide the scope and level of minimum benefits that the Scheme must provide to members and dependants. During the year under review there were isolated instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims are being reprocessed to ensure that they are correctly paid.

DIRECT OR INDIRECT BORROWING OF MONEY

In terms of Section 35 (6) (c) of the Act, a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were instances during the year where the Scheme inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of re-occurrence.

AMOUNTS DEBITED TO SCHEME BANK ACCOUNT

Section 26 (4) (b) provides that no amount may be debited to a scheme bank account other than costs incurred by the medical scheme in the carrying on of the business as a medical scheme. During the year under review, a total of R212 808 was debited to the Scheme's bank account that was not related to the Scheme. This debit arose from the incorrect allocation of bank accounts for certain payments. The amount and related interest have subsequently been refunded to the Scheme and additional quality assurance processes have been implemented to mitigate this occurring again.

NON-COMPLIANCE TO THE CMS DIRECTIVE ISSUED IN CIRCULAR 26 OF 2022 – BROKERS MAY NOT RECEIVE BROKER COMMISSION ON OWN POLICIES

During 2022 CMS published Circular 26 of 2022: Brokers and Brokerages who earn commission in respect of their own health or medical scheme policies. The CMS directive stated that all arrangements in terms of which any broker is receiving broker commission, whether directly or indirectly, related to their own health or medical scheme policy, must be terminated by 30 June 2022.

During the year, there were two identified instances where brokers earned commission on their own health policies amounting to R840 after 30 June 2022. These represent less than 0.001% of total broker fees paid for the year. The identified policies have been moved to non-commissionable status.

DHMS plans and beneficiary distribution

BENEFIT OPTIONS
17
(2021: 17)

NETWORK EFFICIENCY DISCOUNT OPTIONS*
7
(2021: 6)

Distribution of Scheme beneficiaries on various plans

SAVER SERIES 51.3%	KEYCARE SERIES 14.2%	CORE SERIES 13.1%	COMPREHENSIVE SERIES 8.4%	SMART SERIES 6.5%	PRIORITY SERIES 5.9%	EXECUTIVE SERIES 0.5%
Classic Saver	KeyCare Plus	Classic Core	Classic Comprehensive	Classic Smart	Classic Priority	Executive
Essential Saver	KeyCare Core	Essential Core	Classic Smart Comprehensive	Essential Smart	Essential Priority	
Coastal Saver	KeyCare Start	Coastal Core	Essential Comprehensive			
Classic Delta Saver*	KeyCare Start Regional*	Classic Delta Core*	Classic Delta Comprehensive*			
Essential Delta Saver*		Essential Delta Core*	Essential Delta Comprehensive*			

Operational statistics per benefit plan[1]

FOR THE YEAR ENDED 31 DECEMBER 2022

2022	EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER			CORE			SMART		KEYCARE			TOTAL
		CLASSIC COMP	ESSENTIAL COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	7 652	101 938	11 928	475	71 925	5 034	327 968	167 082	168 227	45 801	51 539	70 304	62 023	50 660	210 260	16 530	6 198	**1 375 544**
Number of beneficiaries at the end of the accounting period	15 300	212 524	21 330	904	157 136	9 917	714 939	354 867	373 336	98 089	112 852	158 280	124 136	58 985	362 594	27 784	8 019	**2 810 992**
Average number of members for the accounting period	7 685	103 157	12 023	473	72 922	5 048	324 581	160 867	168 433	45 965	50 440	71 023	59 667	47 837	207 799	16 207	5 893	**1 360 021**
Average number of beneficiaries for the accounting period	15 463	216 181	21 556	896	159 570	9 953	708 854	343 101	374 820	98 781	110 613	160 265	118 985	55 668	358 663	27 299	7 609	**2 788 276**
Average risk contributions per member per month (R')	9 831.78	7 916.48	6 733.78	7 677.23	5 363.65	4 771.11	4 268.31	3 508.02	3 883.15	4 522.24	3 587.23	3 867.11	3 374.54	1 796.07	2 321.78	1 937.13	1 505.21	**4 021.44**
Average risk contributions per beneficiary per month (R')	4 886.06	3 777.59	3 755.75	4 050.60	2 451.13	2 419.93	1 954.44	1 644.77	1 744.98	2 104.32	1 635.81	1 713.76	1 692.22	1 543.40	1 345.17	1 150.07	1 165.76	**1 961.51**
Average net claims incurred per member per month (R')	12 615.66	8 488.87	7 008.61	4 403.57	4 918.14	3 180.14	3 589.41	2 500.44	3 489.55	3 958.59	2 871.03	3 632.95	2 555.58	1 016.80	2 427.37	1 631.23	789.41	**3 610.34**
Average net claims incurred per beneficiary per month (R')	6 269.55	4 050.73	3 909.04	2 323.38	2 247.54	1 612.98	1 643.58	1 172.36	1 568.10	1 842.04	1 309.22	1 609.99	1 281.54	873.75	1 406.35	968.46	611.39	**1 760.99**
Average administration costs per member per month (R')	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	217.03	116.47	217.91	**368.29**
Average administration costs per beneficiary per month (R')	199.03	191.11	223.38	211.31	183.02	203.14	183.39	187.78	179.97	186.36	182.63	177.49	200.84	344.16	125.74	69.15	168.77	**179.64**
Average managed care: Management services per member per month (R')	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	127.85	127.85	127.85	**128.51**
Average managed care: Management services per beneficiary per month (R')	63.93	61.38	71.75	67.87	58.79	65.25	58.90	60.31	57.81	59.86	58.66	57.01	64.51	110.54	74.07	75.90	99.02	**62.68**
Average family size	2.00	2.08	1.79	1.90	2.18	1.97	2.18	2.12	2.22	2.14	2.19	2.25	2.00	1.16	1.72	1.68	1.29	**2.04**
Loss ratio (%)	129.70%	108.95%	106.08%	59.09%	94.14%	69.38%	87.15%	74.99%	93.22%	90.38%	83.66%	97.31%	79.56%	63.79%	108.77%	90.81%	58.96%	**92.90%**
Total non-healthcare expenses as a percentage of risk contributions (%)	5.36%	6.68%	7.87%	6.80%	9.86%	11.02%	12.32%	14.65%	13.43%	11.33%	14.13%	13.21%	14.93%	26.14%	12.92%	9.75%	18.52%	**11.93%**
Average non-healthcare expenses per member per month	527.13	528.88	530.02	521.85	528.79	525.90	526.07	513.95	521.39	512.51	506.70	510.91	503.69	469.51	299.95	188.81	278.79	**486.51**
Average non-healthcare expenses per beneficiary per month	261.97	252.37	295.62	275.33	241.65	266.74	240.88	240.97	234.30	238.49	231.06	226.42	252.58	403.46	173.78	112.09	215.92	**237.30**
Average age of beneficiaries (years)	48.35	45.18	50.61	41.35	41.75	40.08	36.09	33.21	37.22	42.50	39.41	41.34	32.79	35.80	31.64	35.90	35.87	**36.57**
Pensioner ratio (beneficiaries over 65 years)	30.38%	23.58%	34.35%	15.45%	17.59%	15.04%	10.73%	7.62%	11.54%	19.13%	15.12%	17.14%	5.99%	5.10%	8.58%	13.81%	9.30%	**11.77%**
Average relevant healthcare expenses per member per month	12 751.42	8 625.31	7 143.15	4 536.12	5 049.58	3 310.42	3 719.68	2 630.65	3 619.83	4 087.21	3 001.00	3 763.25	2 684.92	1 145.71	2 525.37	1 759.08	887.51	**3 735.95**
Average relevant healthcare expenses per beneficiary per month	6 337.02	4 115.83	3 984.08	2 393.31	2 307.60	1 679.06	1 703.22	1 233.41	1 626.65	1 901.89	1 368.49	1 667.73	1 346.40	984.53	1 463.13	1 044.36	687.36	**1 822.26**
Net surplus/(deficit) per benefit plan	(309 560)	(1 421 736)	(122 659)	15 569	(110 263)	62 012	439 689	878 483	(340 773)	25 749	124 053	(241 399)	223 962	176 826	(943 906)	22 149	32 974	**(1 488 830)**

1 *Efficiency discount options (Delta, KeyCare Start Regional) are incorporated into their parent plans for operational statistics reporting purposes.*

Operational statistics per benefit plan *continued*

2021	EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER			CORE			SMART		KEYCARE			TOTAL
		CLASSIC COMP	ESSENTIAL COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	7 927	105 496	12 235	454	74 947	5 075	316 368	154 565	169 966	46 937	50 719	73 193	55 372	45 337	211 492	16 903	6 026	**1 353 012**
Number of beneficiaries at the end of the accounting period	16 027	223 204	22 121	874	164 791	10 129	694 333	330 891	380 185	101 414	111 202	165 129	110 256	52 930	365 033	28 462	7 812	**2 784 793**
Average number of members for the accounting period	7 998	108 031	12 338	446	76 126	5 051	315 143	148 344	170 788	47 114	49 211	73 919	52 524	41 391	209 431	16 153	5 815	**1 339 822**
Average number of beneficiaries for the accounting period	16 306	229 611	22 400	883	167 543	10 151	692 010	317 558	382 386	102 019	107 799	166 860	104 546	48 119	362 434	26 949	7 527	**2 765 100**
Average risk contributions per member per month (R')	9 455.29	7 606.24	6 489.40	7 653.41	5 129.41	4 626.75	4 092.64	3 372.66	3 716.18	4 337.87	3 428.50	3 681.13	3 204.54	1 710.20	2 211.90	1 842.82	1 411.87	**3 884.80**
Average risk contributions per beneficiary per month (R')	4 638.05	3 578.70	3 574.32	3 863.53	2 330.63	2 302.38	1 863.80	1 575.51	1 659.78	2 003.31	1 565.12	1 630.74	1 609.95	1 471.07	1 278.14	1 104.59	1 090.74	**1 882.37**
Average net claims incurred per member per month (R')	11 106.92	7 726.02	6 062.97	4 314.71	4 631.16	3 289.29	3 386.06	2 371.16	3 219.97	3 497.81	2 646.87	3 259.92	2 439.80	1 021.70	2 196.63	1 471.40	843.38	**3 383.53**
Average net claims incurred per beneficiary per month (R')	5 448.22	3 635.06	3 339.45	2 178.12	2 104.24	1 636.83	1 542.02	1 107.67	1 438.16	1 615.35	1 208.30	1 444.15	1 225.75	878.84	1 269.31	881.96	651.55	**1 639.48**
Average administration costs per member per month (R')	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	203.98	109.47	203.98	**345.49**
Average administration costs per beneficiary per month (R')	184.64	177.10	207.32	190.02	171.03	187.31	171.42	175.84	168.12	173.83	171.83	166.75	189.11	323.78	117.87	65.62	157.58	**167.41**
Average managed care: Management services per member per month (R')	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.88	120.13	120.13	120.13	**120.75**
Average managed care: Management services per beneficiary per month (R')	59.29	56.87	66.58	61.02	54.92	60.15	55.05	56.47	53.99	55.82	55.18	53.55	60.73	103.97	69.42	72.01	92.81	**58.51**
Average family size	2.02	2.12	1.81	1.93	2.20	2.00	2.19	2.14	2.24	2.16	2.19	2.26	1.99	1.17	1.73	1.68	1.30	**2.06**
Loss ratio (%)	118.78%	103.22%	95.34%	58.00%	92.67%	73.72%	85.71%	73.90%	89.91%	83.43%	80.74%	91.85%	79.92%	66.82%	103.29%	86.36%	65.48%	**90.09%**
Total non-healthcare expenses as a percentage of risk contributions (%)	5.20%	6.52%	7.68%	6.44%	9.66%	10.65%	12.04%	14.29%	13.14%	11.03%	13.78%	12.96%	14.70%	25.80%	12.70%	9.54%	18.45%	**11.56%**
Average non-healthcare expenses per member per month	492.14	495.57	498.53	492.77	495.43	492.86	492.84	482.00	488.45	478.42	472.51	476.93	470.93	441.20	280.98	175.75	260.48	**457.39**
Average non-healthcare expenses per beneficiary per month	241.41	233.16	274.59	248.76	225.11	245.26	224.44	225.16	218.16	220.94	215.70	211.28	236.60	379.51	162.36	105.34	201.24	**221.63**
Average age of beneficiaries (years)	47.46	44.51	50.36	42.66	41.09	40.04	35.49	32.76	36.58	41.73	38.87	40.60	32.26	35.46	31.27	35.54	35.56	**36.17**
Pensioner ratio (beneficiaries over 65 years)	28.52%	22.41%	34.28%	18.13%	16.68%	15.16%	9.94%	7.12%	10.67%	18.11%	14.16%	16.02%	5.31%	4.72%	8.17%	13.18%	8.95%	**11.25%**
Average relevant healthcare expenses per member per month	11 231.46	7 851.03	6 186.96	4 439.11	4 753.23	3 411.01	3 507.62	2 492.51	3 341.30	3 619.21	2 768.28	3 381.26	2 560.93	1 142.69	2 284.78	1 591.53	924.43	**3 499.91**
Average relevant healthcare expenses per beneficiary per month	5 509.31	3 693.88	3 407.74	2 240.92	2 159.71	1 697.40	1 597.38	1 164.36	1 492.35	1 671.42	1 263.72	1 497.90	1 286.61	982.91	1 320.25	953.96	714.17	**1 695.87**
Net surplus/(deficit) per benefit plan	(200 506)	(728 149)	(2 564)	15 697	54 328	54 669	1 025 293	1 027 975	133 761	255 589	236 171	30 779	242 855	168 544	(356 593)	55 758	30 648	**2 044 255**

PERSONAL MEDICAL SAVINGS ACCOUNTS

Personal Medical Savings Accounts (PMSAs) enable members to manage their day-to-day healthcare expenses. If members select a plan with a PMSA, they pay either 15% or 25% of their gross contributions, depending on plan choice, into their PMSA. The Scheme advances the full annual amount to members for immediate use, although members only contribute monthly.

PMSAs provide a variety of benefits to members for medical expenses such as day-to-day medicines, visits to general practitioners and specialists, dental care and optometry.

The balance remaining in the PMSA at the end of each calendar year is carried over to the following year for the benefit of the member. PMSAs are reported with the balance of the Scheme's assets.

The Scheme's liability to members in respect of PMSAs is reflected as a current liability in the Financial Statements and is repayable in terms of Regulation 10 of the Act.

GOING CONCERN

Since the start of the COVID-19 pandemic in South Africa, the Scheme has faced uncertainties around COVID-19's impact on healthcare utilisation and these continue into 2022 and 2023; although we see utilisation returning to pre-COVID-19 levels, the longer-term effects of COVID-19 remain an unknown. However, given the Scheme's strong financial position and reserve levels, and based on the projected claims experience for 2023, the Trustees believe there will be no impact on the Scheme's ability to pay claims as they arise.

AUDITOR INDEPENDENCE

PricewaterhouseCoopers Inc. has audited the Scheme's Financial Statements. The Audit Committee is satisfied that the external auditor is independent of the Scheme.

Personal Medical Savings Accounts (PMSAs) enable members to manage their day-to-day healthcare expenses. If members select a plan with a PMSA, they pay either 15% or 25% of their gross contributions, depending on plan choice, into their PMSA.

How Discovery Health supports the Scheme's value creation

We outsource administration and managed care services to Discovery Health.

In accordance with the Act and the Scheme Rules, the Trustees appoint an accredited administration and managed care provider to deliver approved services to DHMS and our members. We utilise a single provider, as the Trustees believe that an integrated model (rather than one employing multiple service providers) is better suited to the Scheme's strategic intent, delivering best value for money and optimal efficiency.

Robust relational governance practices underpin the Scheme's relationship with Discovery Health. On occasion, the Trustees commission independent assessments of these practices, benchmarking them against local and international governance practice, contracting principles, independence requirements, and the ability to meet members' needs.

The Scheme's outsourced relationship with Discovery Health is operationalised by the Vested® model and through comprehensive contractual agreements. The model outlines and facilitates the Scheme's governance and oversight role, embedding its independence from Discovery Health while allowing us to leverage Discovery Health's expertise, systems, innovation, and value-added services in the best interests of the Scheme and our members. The relationship is overseen by our operational Relationship Management and Innovation Committees which are mandated to monitor, review and improve the relationship and the innovation that the Vested model is designed to deliver.

In 2023, the agreements in place between DHMS and Discovery Health were renewed for the next five years after an extensive assessment of the services provided by Discovery Health, including the objectives that the Scheme agrees with Discovery Health each year, value added by Discovery Health, innovation, operational elements, marketing and distribution, compliance, the Health Market Inquiry's recommendations and the CMS' requirements. An independent review by Deloitte was also conducted to evaluate Discovery Health against global best practice for:

- Baseline criteria (including current administration and managed care capabilities, value-added services, third-party networks and scale to accommodate a scheme of DHMS' size);
- How they compare to top performing schemes; and
- Degree of innovation and competitive advantage.

The review made use of publicly available information.

As part of the agreements renewal process, a Vested Compatibility and Trust (CaT) assessment was carried out to assess the quality of the relationship against Vested criteria. The results of the assessment and related qualitative feedback were discussed at a workshop. The DHMS-Discovery Health relationship scored as very healthy, with three of the five dimensions falling in the Vested range, and no material problems affecting the relationship being identified.

Value for money from Discovery Health

Our members benefit when our administration and managed care provider adds more value than the fees paid to it by the Scheme. The value that Discovery Health provides includes access to highly effective managed care programmes, innovative provider networks, a wide range of benefit plans, and a significantly lower average contribution paid by our members when compared with the next seven open schemes[1].

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged Deloitte to perform an actuarial review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2020 to 2021 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed[2].

The results are expressed as the value added by Discovery Health for each rand paid to it:

- 2021: **R2.02**
- 2020: **R1.90**[3]
- 2019: **R2.03**
- 2018: **R2.12**
- 2017: **R2.09**
- 2016: **R2.00**

The assessment takes into account the value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members, additional services offered and innovation.

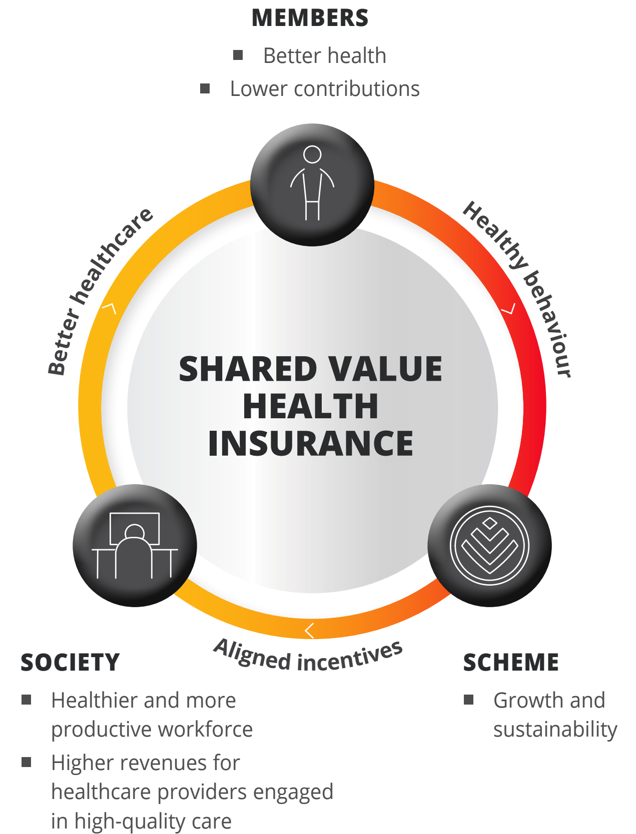
1 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*

2 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2021, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.02 (2020: R1.90) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*

3 *The 2020 value added has been restated from R1.88 to R1.90 using updated information from the CMS 2020/2021 Annual Report, changes in methodology and finalised settlement values for certain components.*

Discovery Health's business model: Shared Value Health Insurance

Discovery Health shares the Scheme's commitment to deliver an integrated value-driven healthcare system, centred on meeting the needs of our members and providing access to the best quality care at the best value for money. Discovery Health's pioneering shared value health insurance model incentivises people to be healthier, and utilises initiatives to slow down the progression of disease, reducing claims costs. It also incentivises healthcare providers through value-based contracting, with an emphasis on quality of care. This model supports the Scheme's sustainability, with shared value healthcare ultimately leading to a better healthcare system.



Discovery Health's work for members and healthcare providers

Discovery Health's innovative and integrated approach provides state-of-the-art medical scheme risk management and service delivery, which extends their services to DHMS well beyond traditional administration and managed care services. Their ongoing investments in digital capabilities and strategic focus on improving value through efficiency and quality of care initiatives promote better healthcare outcomes, supported by a focus on comprehensive care, health support and the latest medical technologies and treatments.

Discovery Health engages extensively with healthcare providers and facilitates the Scheme's ability to offer best-of-breed healthcare programmes and continued access to the highest possible quality of care to our members.

Working with healthcare providers to improve South Africa's healthcare system: the Future of SA Healthcare Inc. Board

This past year, South Africa began to re-imagine what industries might look like after COVID-19. Healthcare is at the forefront of this evolution and in 2022, Discovery Health sought to re-align with healthcare providers to collaboratively identify a core set of activities and solutions designed to support the profession and enhance the country's healthcare system.

A forum called the Future of SA Healthcare Inc. (FOSHI) consisting of representatives from leading clinician societies and Discovery Health leadership was assembled. Since inception in July 2022, the forum's ambition has been to define and identify a positive, uplifting solution to galvanise the profession around a common vision and narrative for a post-pandemic healthcare system. Discovery Health leadership conducted seven listening sessions, engaging with diverse and representative cohorts of doctors to test ideas emerging from the forum; the sessions aimed to provide detailed feedback on these ideas from those familiar with the day-to-day demands and challenges of working in a professional healthcare context. Both the forum and listening sessions have been instrumental in ensuring a truly collaborative approach.

Over the course of 2023, FOSHI aims to lead adoption of the solutions defined. We hope to see a palpable shift in sentiment of healthcare providers and the profession to adopting this shared narrative for the future of South African healthcare, a much-needed voice of hope for a community recovering from the trauma of the COVID-19 pandemic and the economic challenges endemic to South Africa.

Discovery Pay – a new approach to paying for healthcare[1]

For DHMS members and healthcare providers, Discovery Health has introduced a sophisticated and integrated payments platform that facilitates faster, simpler and more convenient direct payments to providers' practices. Health Pay by Discovery Pay integrates medical scheme reimbursement with the payment infrastructure of Discovery Bank allowing clients to transact seamlessly across the healthcare system. Integrating payments for medical bills across all sources of funding, the simple, intuitive system consolidates payment sources into an effortless transactional experience for practices and patients.

From 2022, all DHMS members whether existing Discovery Bank customers or not, can download the Discovery Bank app to access a Discovery Pay account with no regular monthly fees.

1 Discovery Pay is made available by Discovery Bank Limited (Registration number 2015/408745/06) and is not part of the benefits and services offered by DHMS. Discovery Bank is an authorised financial services provider (FSP48657) and registered credit provider (NCRCP9997).

DISCOVERY HEALTH'S CUSTOMER JOURNEYS[1] DEMONSTRATE ITS CAPABILITIES AND THE IMPACT OF THE PANDEMIC

At 31 December 2022, Discovery Health provided administration services to approximately 3.5 million beneficiaries, including over 2.8 million for DHMS. As such, Discovery Health services interact with millions of individuals during any given year. The comprehensive and world-class service offerings, programmes and platforms Discovery Health provides gives DHMS assurance that our members always have access to the best services and information available to suit their healthcare needs.

Discovery Health's infrastructure and member support systems provide a range of engagement options for our members, including comprehensive information on the website and virtual agent capability using artificial intelligence to respond to member questions. Members can also make contact via the call centre, a chat platform, or the member app. On admission, members have access to benefit specialists in many hospitals throughout the country who facilitate their healthcare journeys and support and advise them on their plan entitlements.

Discovery Health was awarded both the "Best Domestic Contact Centre" and the "Best Contact Centre Support Professionals" by the Contact Centre Management Group (CCMG)[2] in 2022. CCMG recognised Discovery Health as a business role model for innovative ways of working.

1 For members of all schemes administered by Discovery Health.
2 The CCMG is the professional body of the Contact Centre industry in South Africa and represents over 2 006 contact centres, 22 500 top and middle managers and 10 000 agents. Source: https://awards.ccmg.org.za/2022-awards/2022-winners/.

In 2022:

NEW BUSINESS

A new membership activated every **26** seconds

SERVICE AND CLAIMS

R8.4 billion billed in contributions per month

R43.9 million paid in claims per hour

329 519 claims received per day

32 210 calls received per day

1 837 hospital admissions approved per day

DIGITAL SUPPORT

154 828 website users per month

42 694 website logins per day

875 818 mobile users per month

28 794 mobile logins per day

520 000 WhatsApp-registered users

1 604 WhatsApp interactions per day

4 139 current HealthID users

1.2 million social media followers

BENEFIT MANAGEMENT

76 768 HIV Programme members

1.0 million CIB Programme members

80 721 Oncology Programme members

MEMBER PROFILES

Average principal member age of **47** years

Oldest member **110** years

23 claims made by average members per year

55% family memberships and **45%** single memberships

28 813 Vitality checks per month

The average user accesses the website **once a month**

Financials

Statement of responsibility by the Board of Trustees

FOR THE YEAR ENDED 31 DECEMBER 2022

The Board of Trustees (the Board or the Trustees) is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the annual Financial Statements of Discovery Health Medical Scheme (DHMS or the Scheme).

The Financial Statements comprise the Statement of Financial Position at 31 December 2022, the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and the Statement of Cash Flows for the year then ended, and Notes to the Financial Statements, including a summary of significant accounting policies. The annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act, (the Act) No 131 of 1998, as amended, and include amounts based on judgements and reasonable estimates.

The Trustees consider that in preparing the annual Financial Statements they have used the most appropriate accounting policies, consistently applied, and that all applicable International Financial Reporting Standards have been followed. The Trustees are satisfied that the information contained in the annual Financial Statements fairly presents the results of operations for the year and the financial position of the Scheme at year-end. The Trustees have also reviewed the other information included in the Integrated Report and are responsible for both its accuracy and its consistency with the Financial Statements.

The Trustees are responsible for the Scheme's systems of internal control and incorporate risk management and internal control procedures, which are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being controlled. Reliance is placed on Discovery Health (Pty) Ltd's system of internal controls.

Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention and the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and, in particular, the presentation of the Financial Statements. To the best of their knowledge and belief, based on the above, the Trustees are satisfied that no material breakdown in the operation of the systems of internal control and procedures has occurred during the year under review.

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2023. In considering this budget, the Trustees considered the uncertainty around the long-term impact of COVID-19 on the utilisation of healthcare services.

With the Scheme's strong financial position at 31 December 2022, the Scheme is in a position to absorb any potential increases in claims resulting from increased utilisation. Based on the 2023 expected claims experience, this is not envisaged to impact the Scheme's ability to pay claims as they arise.

On the basis of this review and in light of the current financial position and available cash resources, the Trustees have no reason to believe that the Scheme will not be a going concern for the foreseeable future. The going concern basis has therefore been adopted in preparing the Financial Statements and these Financial Statements support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Financial Statements and their unmodified report is presented on pages 102 to 104. The Financial Statements, which are presented on pages 105 to 182, were approved by the Board of Trustees on 20 April 2023 and are signed on its behalf by:

John Butler
Chairperson

Johan Human
Trustee

Charlotte Mbewu
Principal Officer

Report of the Audit Committee

FOR THE YEAR ENDED 31 DECEMBER 2022

We are pleased to present our report for the financial year ended 31 December 2022. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit Committee terms of reference and assessment

The Committee's role and responsibilities include statutory duties as per the Act and further responsibilities assigned to it by the Board of Trustees. The Committee has adopted formal terms of reference that have been approved by the Trustees and are reviewed at least annually. The Committee executed its duties and conducted its affairs in accordance with its terms of reference and applicable laws and regulations in force during the financial year and has discharged the responsibilities contained therein.

Members of the Committee collectively keep up to date with key developments affecting their required skill set.

The Committee is assessed on an annual basis either by external independent parties, or through self-appraisals.

Audit Committee members, meeting attendance and assessment

The membership and attendance of the Members of the Committee has been set out on page 58.

External Auditor appointment and independence

The Committee considered the matters set out in Section 36 of the Act and nominated PricewaterhouseCoopers Inc. for appointment as external auditor of the Scheme. Linda Pieterse was approved by the Council for Medical Schemes (CMS) as the statutory auditor of the Scheme for the financial period 1 January 2022 to 31 December 2022 in accordance with section 36 (2) of the Act on 18 October 2022.

The Committee has satisfied itself that the External Auditor is independent of the Scheme as set out in Section 36 (3) of the Act. The Auditor confirmed the audit firm's internal governance processes that support and demonstrate its independence.

The Committee ensured that the appointment of the Auditor at the Annual General Meeting complied with the Act and Scheme Rules relating to the appointment of auditors.

The Committee, following consultation with the Scheme's Executive Officers, approved the engagement letter, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2022. The Committee approved the actual audit fees incurred for the year ended 2021.

There is a formal policy in respect of the provision of non-audit services by the external auditors of the Scheme and a formal procedure governs the process whereby the auditor is appointed to provide any non-audit services. The Committee approves the nature and extent of any non-audit services that the external auditor provides in terms of the agreed pre-approval policy and a schedule of approved non-audit services is reviewed annually by the Committee. Fees in respect of audit, and non-audit services where applicable, are reflected in Note 17 to the Financial Statements.

During the year, the Committee met with the external auditors without management being present. The Chairperson of the Committee also met separately with the external auditors.

Internal Auditors (IA)

The Committee is responsible for ensuring that the IA function is independent and has the necessary resources, standing and authority to enable it to discharge its duties. Furthermore, the Committee oversees co-operation between IA and the external auditors and serves as a link between the Board of Trustees and these functions.

The Committee considered and approved the IA charter.

The IA annual audit plan was approved by the Committee. The results of the work carried out by IA in terms of the audit plan were reviewed and the effect of any action plans to mitigate risks of any matters reported were considered by the Committee.

IA has responsibility for reviewing and providing assurance on the adequacy of the internal control environment across all of the Scheme's operations. The Chief Audit Executive (CAE) is responsible for reporting the findings of the internal audit work, against the agreed IA plan to the Committee on a regular basis.

The CAE has direct access to the Committee, primarily through its Chairperson.

The Committee has assessed and was satisfied with the performance of the CAE and the IA function.

During the year, the Committee met with the CAE without management being present. The Chairperson of the Committee also met separately with IA.

Financial statements and accounting policies

The Committee has reviewed the accounting policies and the Scheme's annual Financial Statements and is satisfied that they are appropriate and comply with International Financial Reporting Standards, the Act and circulars issued by the CMS.

Internal financial controls

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, among other things, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board of Trustees. This included a formal documented review by the IA function of the design, implementation and effectiveness of the administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that a Reasonable Assurance* rating can be placed on the effectiveness of the system of internal control and a High Assurance ** rating on risk management. Furthermore, a Reasonable Assurance* rating can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Financial Statements.

* *Reasonable Assurance – The existing control framework provides reasonable assurance that material risks are identified and managed effectively.*

** *High Assurance – The existing control framework provides a high level of assurance that the annual Financial Statements are fairly presented.*

Evaluation of the expertise and experience of the Chief Financial Officer and Finance function

The Committee is satisfied with the expertise and experience of the Scheme's Chief Financial Officer. The Committee further reviewed and satisfied itself of the appropriateness of the expertise, resources and experience of the administrator's finance function pertaining to the Scheme.

Whistle blowing

The Committee receives and deals with any concerns or complaints, whether from within or outside the Scheme, relating to the accounting practices and IA of the Scheme, the content or auditing of the Scheme's Financial Statements, the internal financial controls of the Scheme and related matters. The administrator's forensic department assists the Committee in discharging this responsibility. No such concerns or complaints were received during the year.

Ethics and compliance

The Committee is responsible for reviewing any major breach of relevant legal and regulatory obligations. The Committee is satisfied that there has been no material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 35 to the Financial Statements. Certain members of the Audit Committee also serve as members of the Risk Committee.

Risk management

The Committee monitors the risk management processes and systems of internal control of the Scheme through review of reports from, and discussions with, the Scheme's internal and external auditors and the risk management function.

The Audit Committee is responsible for ensuring that appropriate systems are in place for the monitoring of risk and compliance with laws, regulations and codes of conduct that may affect the integrity of the Financial Statements.

The Committee is satisfied that the system and the process of risk management is effective.

Going concern

The Committee has reviewed the going concern basis for the preparation of the Scheme's Financial Statements taking into account the operational and financial position at 31 December 2022 as well as the Scheme's budget for the year ending 31 December 2023.

Total members' funds exceeded R28.9 billion with a solvency level of 35.11% at 31 December 2022. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) at 31 December 2022 to cover monthly claims expenditure 6.08 times.

On the basis of this review and taking note of the current net deficit of R1.5 billion, the Committee considers that:

- The Scheme's assets currently exceed its liabilities; and
- The Scheme will be able, in the ordinary course of the Scheme's business, to settle its liabilities as they arise for the foreseeable future.

The Committee agreed that based on the assessment conducted, the Board of Trustees could be advised that there is no reason to believe that the Scheme will not be a going concern in the foreseeable future.

Mr E Mackeown
Chairperson: Audit Committee

20 April 2023

Independent Auditor's Report

To the Members of Discovery Health Medical Scheme

Report on the financial statements

OPINION

We have audited the financial statements of Discovery Health Medical Scheme (the Scheme), set out on pages 105 to 182, which comprise the statement of financial position as at 31 December 2022, and the statement of comprehensive income, the statement of changes in funds and reserves, and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2022, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

BASIS FOR OPINION

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

INDEPENDENCE

We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the International Ethics Standards Board for Accountants' International Code of Ethics for Professional Accountants (including International Independence Standards).

KEY AUDIT MATTERS

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The outstanding claims provision of R1 844 365 000 at year-end as described in Note 7 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end. The outstanding claims provision is calculated by the Scheme's actuaries which is reviewed by management and the Audit Committee and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to project the year-end provision. This model applies a combination of the Basic Chain Ladder (BCL) and Cost Per Event methods (CPE).	We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the outstanding claims provision, which included the design and implementation of controls within the process. The actuarial methods applied by the Scheme is one that is generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the year-ended 31 December 2022. The actual claims data reflects the most recent claims patterns, including the impact of COVID-19, and is taken into account in calculating the outstanding claims provision. We assessed the completeness of the claims data on the member administration system by understanding management's controls and selecting claim transactions from the claim source and agreeing these to the member administration system. No material inconsistencies were noted. We substantively tested a sample of claims received by the Scheme in the 31 December 2022 financial year, selected from the member administration system, and confirmed the accuracy of the service and process dates and the validity of the claim against the relevant Scheme rules. No material inconsistencies were noted. We assessed the completeness of the claims data in the Scheme's actuarial model by understanding management's controls and testing the claims data interface between the member administration system and the actuarial model. No material inconsistencies were noted. To assess the reasonableness of the Scheme actuaries estimation process, we compared the actual claim results in the current year to the prior year provision. We noted no matters for further consideration with respect to the estimation process. Our internal actuarial experts independently calculated the Scheme's outstanding claims provision, taking into account the claims data tested above. We compared our results with that of the Scheme and found the amounts to approximate each other.

Key audit matter	How our audit addressed the key audit matter
The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern could cause a material change to the amount of the provision.	We performed the following procedures to assess the adequacy of the outstanding claim provision: ▪ We obtained the actual claims run-off report up to 31 March 2023 from the Scheme's administrator and compared the claims paid post year-end to the outstanding claims provision at year-end as part of subsequent event procedures. No material inconsistencies were noted. ▪ For a sample of claims from the claims run-off report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates by agreeing the claims to underlying supporting documents on the policy administration system and we identified no material inconsistencies. ▪ We inquired from the Scheme's administrator whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. No such delays were identified. ▪ We obtained a list of pre-authorisations approved prior to year-end from the administrator. For a sample of pre-authorisations with a service date before year-end, we requested the related claim documentation and assessed if the related claim had been included correctly in the claims run-off report up to 31 March 2023. No material inconsistencies were noted.

OTHER INFORMATION

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the document titled "Discovery Health Medical Scheme Integrated Report 2022". The other information does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

RESPONSIBILITIES OF THE SCHEME'S TRUSTEES FOR THE FINANCIAL STATEMENTS

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Scheme's trustees are responsible for assessing the Scheme's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless the Scheme's trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

AUDITOR'S RESPONSIBILITIES FOR THE AUDIT OF THE FINANCIAL STATEMENTS

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on

the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Scheme's trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

From the matters communicated with the Scheme's trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report, unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on Other Legal and Regulatory Requirements

NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT OF SOUTH AFRICA

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, as amended, that have come to our attention during the course of our audit:

- **Non-compliances with Regulation 28 (2), 28 (5) and 28 (8) of the Act:**
  There were instances where some brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid.
- **Non-compliance with Section 29 (1) (o) and Regulation 8 of the Act:**
  There were instances where the Scheme did not pay claims in accordance with the scope and level of prescribed minimum benefits.
- **Non-compliance with Section 33 (2) (b) of the Act:**
  Certain benefit options were not self-supporting in terms of financial performance.

AUDIT TENURE

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Discovery Health Medical Scheme for 22 years.

The engagement partner, Linda Pieterse, has been responsible for Discovery Health Medical Scheme's audit for 4 years.

PricewaterhouseCoopers Inc.

PRICEWATERHOUSECOOPERS INC.

Director: Linda Pieterse

Registered Auditor

Johannesburg, South-Africa

28 April 2023

Statement of Financial Position

AT 31 DECEMBER 2022

	NOTES	2022 R'000	2021 R'000
ASSETS			
Non-current assets		**24 348 071**	24 719 222
Property and equipment	1	**8 317**	9 658
Long term employee benefit plan asset	28	**8 314**	7 998
Financial assets at fair value through profit or loss	3	**24 331 440**	24 701 566
Current assets		**15 478 904**	16 566 181
Financial assets at fair value through profit or loss	3	**8 842 232**	9 987 157
Derivative financial instruments	8	**38 525**	–
Trade and other receivables	4	**2 974 013**	2 729 850
Cash and cash equivalents		**3 624 134**	3 849 174
– Personal Medical Savings Accounts trust assets arising from amalgamation	5	**–**	10 860
– Medical Scheme assets	6	**3 624 134**	3 838 314
TOTAL ASSETS		**39 826 975**	**41 285 403**
FUNDS AND LIABILITIES			
Members' funds		**28 930 015**	30 418 845
Accumulated funds		**28 930 015**	30 418 845
LIABILITIES			
Non-current liabilities		**7 735**	8 671
Leases	2	**7 735**	8 671
Current liabilities		**10 889 225**	10 857 887
Leases	2	**2 098**	1 961
Outstanding claims provision	7	**1 844 365**	2 257 054
Personal Medical Savings Account liabilities	9	**7 310 364**	7 081 549
Trade and other payables	10	**1 732 398**	1 517 323
TOTAL FUNDS AND LIABILITIES		**39 826 975**	**41 285 403**

Statement of Comprehensive Income

FOR THE YEAR ENDED 31 DECEMBER 2022

	NOTES	2022 R'000	2021 R'000
Risk contribution income	11	**65 630 927**	62 459 297
Relevant healthcare expenditure		**(60 971 703)**	(56 271 074)
Net claims incurred	12	**(58 921 666)**	(54 399 878)
Risk claims incurred	12	**(59 059 966)**	(54 467 338)
Third party claim recoveries	12	**138 300**	67 460
Accredited managed healthcare services (no risk transfer)	13	**(2 120 208)**	(1 960 416)
Net income on risk transfer arrangements	14	**70 171**	89 220
Risk transfer arrangement fees paid		**(312 221)**	(271 813)
Recoveries from risk transfer arrangements		**382 392**	361 033
Gross healthcare result		**4 659 224**	6 188 223
Broker service fees	15	**(1 612 455)**	(1 438 916)
Expenses for administration	16	**(6 010 611)**	(5 554 748)
Other operating expenses	17	**(208 627)**	(224 677)
Net impairment losses on healthcare receivables	19	**(108 215)**	(135 524)
Net healthcare result		**(3 280 684)**	(1 165 642)
Other income		**2 256 202**	3 638 788
Investment income	23	**2 221 987**	1 771 609
Net gains on financial assets	24	**3 117**	1 838 553
Sundry income	25	**31 098**	28 626
Other expenditure		**(464 348)**	(428 888)
Asset management fees	26	**(103 130)**	(93 213)
Finance costs	27	**(1 266)**	(1 242)
Interest paid on savings accounts	27	**(359 952)**	(334 433)
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE YEAR		**(1 488 830)**	**2 044 258**

Statement of Changes in Funds and Reserves

FOR THE YEAR ENDED 31 DECEMBER 2022

	NOTES	2022 R'000 Accumulated funds	2021 R'000 Accumulated funds
Balance at beginning of the year		**30 418 845**	28 215 475
Total comprehensive (loss)/income for the year		**(1 488 830)**	2 044 258
Reserves transferred from other Medical Schemes	32	**–**	159 112
TOTAL MEMBER FUNDS END OF THE YEAR		**28 930 015**	**30 418 845**

Statement of Cash Flows

FOR THE YEAR ENDED 31 DECEMBER 2022

	NOTES	2022 R'000	2021 RESTATED* R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers		**79 523 558**	75 880 364
Cash received from members – contributions	30	**79 514 258**	75 876 638
Cash received from members and providers – other	30	**9 300**	3 726
Cash paid to providers, employees and members		**(83 334 508)**	(76 611 068)
Cash paid to providers and members – claims	30	**(74 927 970)**	(68 679 150)
Cash paid to providers and employees – non-healthcare expenditure	30	**(7 915 944)**	(7 438 509)
Cash paid to members – savings plan refunds		**(490 594)**	(493 409)
Cash used in operations		**(3 810 950)**	(730 704)
Purchase of financial assets	30	**(7 774 847)**	(8 738 440)
Proceeds from disposal of financial assets	30	**9 410 317**	7 735 859
Increase in long-term employee plan asset	28	**(5 770)**	(5 360)
Interest received	30	**1 588 234**	1 345 399
Dividend income	23	**473 318**	322 814
Interest paid	27	**(102)**	(4)
Asset manager fees paid	26	**(103 130)**	(93 213)
Net cash outflow from operating activities		**(222 930)**	(163 649)
CASH FLOWS FROM FINANCING ACTIVITIES			
Purchases of right-of-use asset	2	**(145)**	–
Payment of lease liabilities	2	**(1 965)**	(1 832)
Net cash outflow from financing activities		**(2 110)**	(1 832)
Net decrease in cash and cash equivalents		**(225 040)**	(165 481)
Cash and cash equivalents at beginning of the year		**3 849 174**	4 008 668
Transfer of cash and cash equivalents due to amalgamation		**–**	5 987
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**3 624 134**	**3 849 174**
Cash and cash equivalents comprise			
Personal Medical Savings Account trust assets		**–**	10 860
Medical Scheme assets		**3 624 134**	3 838 314
		3 624 134	**3 849 174**

* *The restatement of the specific line items has been included in Note 30.*

Accounting policies

FOR THE YEAR ENDED 31 DECEMBER 2022

General information

Discovery Health Medical Scheme (DHMS or the Scheme) offers the insurance of hospital, chronic illness and day-to-day benefits and is administered by Discovery Health (Pty) Ltd, a wholly owned subsidiary of Discovery Limited, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

The Scheme is an open medical scheme registered in terms of the Act, and is domiciled in South Africa.

Basis of preparation

The Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS), which are set by the International Accounting Standards Board (IASB). The Financial Statements are also prepared in accordance with the Act, which requires additional disclosures for registered medical schemes.

The detailed accounting policies have been set out in the respective Note to the Financial Statements, with the general accounting policies applied in the preparation of these Financial Statements set out below. These policies have been consistently applied to all years presented, except for changes required by the mandatory adoption of new and revised IFRS and changes in accounting policies.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the Financial Statements, are disclosed in Note 35.

The Financial Statements are prepared in accordance with the going concern principle using the historical cost basis except for certain financial assets and liabilities, which include:

- Financial instruments at fair value through profit or loss; and
- Derivative financial instruments carried at fair value through profit or loss.

All monetary information and figures presented in these financial statements are stated in thousands of rand (R'000), unless otherwise indicated.

Implementation of new standards

NEW STANDARDS, AMENDMENTS AND INTERPRETATIONS EFFECTIVE AND RELEVANT TO THE SCHEME

STANDARD	SCOPE	EFFECTIVE DATE
Amendment to IFRS 3, 'Business combinations'	The IASB has updated IFRS 3, 'Business combinations', to refer to the 2018 Conceptual Framework for Financial Reporting, in order to determine what constitutes an asset or a liability in a business combination. In addition, the IASB added a new exception in IFRS 3 for liabilities and contingent liabilities. The exception specifies that, for some types of liabilities and contingent liabilities, an entity applying IFRS 3 should instead refer to International Accounting Standard (IAS) 37, 'Provisions, Contingent Liabilities and Contingent Assets', or IFRS Interpretations Committee (IFRIC) 21, 'Levies', rather than the 2018 Conceptual Framework. The IASB has also clarified that the acquirer should not recognise contingent assets, as defined in IAS 37, at the acquisition date. No amalgamations took place during the year. Therefore, the amendment to the standard has no impact on the Scheme.	1 January 2022

NEW STANDARDS, AMENDMENTS AND INTERPRETATIONS NOT YET EFFECTIVE AND RELEVANT TO THE SCHEME:

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact on the Scheme's assets, liabilities and results but may result in additional disclosure in the Financial Statements.

STANDARD	SCOPE	EFFECTIVE DATE
IFRS 17: Insurance contracts	The Standard was issued in May 2017 and supersedes IFRS 4 Insurance Contracts. The Standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The Standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and takes into account any uncertainty relating to insurance contracts. The Standard provides for a simplified approach (premium allocation approach) for the measurement of a group of insurance contracts only if, at the inception of the group, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the general measurement model or if the coverage period is one year or less. The Scheme has assessed the requirements of the standard and agreed a project plan to implement the standard. The main outcomes of the assessment are summarised below. The contracts issued by the Scheme to members are included in the scope of IFRS 17 as they insure against the cost of a health event arising from either out-of-hospital (day-to-day) events, in-hospital events or chronic illnesses, or any combination of these events. The contracts issued by the Scheme are subject to similar risks and managed together, and fall into the same portfolio with no further disaggregation into groups. The level of aggregation is set at the overall Scheme level. Personal Medical Savings Accounts are not distinct, are highly interrelated and cannot be purchased separately from the risk component. Under IFRS 17, PMSAs do not meet the criteria to separate these from the insurance component, they are non-distinct investment components with the balances included in either Insurance Contract Assets or Liabilities in the Statement of Financial Position. While the cash flows are not recorded in the Statement of Comprehensive Income, they are considered in assessing onerous contracts. The Scheme's insurance contracts are included in a single portfolio and the coverage period is aligned with the reporting period (financial year). The insurance contracts will be recognised from 1 January or from inception of cover should a member join the Scheme after 1 January. Where the Scheme as a whole is priced for a deficit position at the Net Healthcare Result level, all contracts would be onerous and the loss would need to be recognised when the contracts become onerous. As pricing for the Scheme is done in September for the following year, the onerous contract test would be assessed at this time, with the following year's loss being recognised in the current financial year. No discounting will be applied as no contract exceeds 12 months.	Annual periods beginning on or after 1 January 2023

<table>
<tr><th>STANDARD</th><th>SCOPE</th><th>EFFECTIVE DATE</th></tr>
<tr><td>IFRS 17: Insurance contracts continued</td><td>
The contract boundary for the Scheme's insurance contracts does not exceed 12 months and is generally aligned with the Scheme's financial year. With the coverage period and the Scheme's financial year being the same, there would be no liability for remaining coverage at the year-end reporting date.
The Premium Allocation Approach (PAA) will be used to measure the Scheme's insurance contracts.
The only liability remaining at year-end is the liability for incurred claims which is measured at the fulfilment cash flows related to past service, allocated to the group at year-end, and only for cash flows within the contract boundary. There is no requirement to adjust future cash flows for the time value of money and the effect of financial risk as these cash flows are expected to be paid within one year or less from the date the claims are incurred. In the Scheme the majority of cash flows are settled within four months from date of service.
The estimate of the future cash flows in terms of the liability for incurred claims shall be adjusted to reflect the compensation that the Scheme requires for bearing the uncertainty about the amount and timing of the cash flows arising from non-financial risk. IFRS 17 does not specify the estimation technique(s) used to determine the risk adjustment for non-financial risk. The Scheme intends using the bootstrapping method and/or a comparison of the historical actual experience compared to budgeted experience and applying a confidence level of 75% in determining the risk adjustment for non-financial risk.
With the Scheme using the Premium Allocation Approach, it shall disclose:
(a) which of the criteria included in IFRS 17 has been satisfied for the Scheme to apply the Premium Allocation Approach;
Both criteria set out in Paragraph 53 are met.
Even though the Scheme is not expected to have a liability for remaining coverage as the financial year and coverage period/contract boundary are aligned, as there is no significant variability in the cash flows there is a reasonable expectation that the simplification would produce a similar measurement of the liability for remaining coverage.
The coverage period for the group is one year or less.
(b) whether it makes an adjustment for the time value of money and the effect of financial risk;
No adjustment is made for the time value of money and the effect of financial risk.
(c) the method it has chosen to recognise insurance acquisition cash flows.
Insurance acquisition costs are expensed as incurred.
In assessing the impact of IFRS 17 on the line items comprising the financial statements, cash flows that fall under the insurance contract (the fulfilment cash flows) needs to be determined and then assessed as to whether they fall within the boundary of the insurance contract. The single activity carried out by the Scheme effectively results in the majority of expenses incurred by the Scheme being required to fulfil the insurance contract and therefore being included as fulfilment cash flows. The only exception would be acquisition costs incurred for contracts expected to be acquired in future periods and costs related to pricing, research and development for the next benefit year and other operating expenses where costs are not directly attributed to members. These would not fall within the boundary of the insurance contract.
</td><td></td></tr>
</table>

STANDARD	SCOPE	EFFECTIVE DATE
IFRS 17: Insurance contracts continued	The Scheme budgeted for a net loss for the 2022 and 2023 financial years. The budgeted losses result in an onerous contract. The onerous contract losses will need to be recognised and accounted for in the year that the Scheme became aware of them and will unwind the following year. The losses will therefore have an impact on the accumulated funds of the Scheme previously disclosed in the financial statements.	
Narrow scope amendments to IAS 1 'Presentation of Financial Statements', Practice statement 2 and IAS 8 'Accounting Policies, Changes in Accounting Estimates and Errors'	The amendments aim to improve accounting policy disclosures and to help users of the financial statements to distinguish changes in accounting policies from changes in accounting estimates. The Scheme discloses the accounting policy for each note as well as the critical judgements and estimates applicable to the individual financial statement line items. The standard has no further impact on the Scheme.	Annual periods beginning on or after 1 January 2024

Foreign currency translation

FUNCTIONAL AND PRESENTATION CURRENCY

Items included in the Financial Statements are measured using the currency of the primary economic environment in which the entity operates (functional currency). The functional and presentation currency of the Scheme is the South African Rand (R).

TRANSACTIONS AND BALANCES

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions, and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies are recognised in the Statement of Comprehensive Income.

Classification, recognition, presentation and derecognition of financial instruments

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, derivatives, and other receivables. Other receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Other receivables are disclosed under "Trade and other receivables".

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition. All purchases and sales of financial instruments are recognised on the trade date, which is the date on which the Scheme commits to purchase the financial asset or assume financial liability.

OFFSETTING FINANCIAL INSTRUMENTS

This applies where a legally enforceable right to set off exists for recognised financial assets and financial liabilities, and there is an intention to realise the asset, and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position or accompanying notes if the above conditions are met.

DERECOGNITION OF FINANCIAL ASSETS AND LIABILITIES

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset but assumes the obligation to pay one or more third parties the cash flow without material delay.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

Members' funds

The funds represent the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act.

Financial liabilities

Financial liabilities are initially recognised at fair value, net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest rate method. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6) (c) of the Act. The Scheme therefore has no long-term financial liabilities.

Provisions

The Scheme recognises a provision once the following conditions are met:

- It has a present legal or constructive obligation as a result of past events.
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation.
- A reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Contingent liability

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation.
  - The amount of the obligation cannot be measured with sufficient reliability.

Member insurance contracts

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts.

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are disclosed in Note 33.

Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services (no risk transfer) and net income or expense from risk transfer arrangements.

Liability adequacy test

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities at the reporting date. In performing these tests, current estimates of future cash flows under the Scheme's insurance contracts are used. Any deficiency is immediately recognised in the Scheme's surplus or deficit for the year.

Income tax

In terms of Section 10 (1) (d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

Allocation of income and expenditure to benefit plans

The following items are directly allocated to benefit plans:

- Contribution income.
- Claims incurred.
- Risk transfer arrangement fees.
- Accredited managed healthcare service fees.
- Expenses for administration.
- Broker service fees.
- Interest paid on Personal Medical Savings Accounts.

The remaining items are allocated as detailed below:

- For contributions that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net contribution income per plan.
- For claims that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net claims incurred per plan.
- The following items are apportioned based on the number of members per benefit plan:
  - Other operating expenditure;
  - Investment income;
  - Net fair value gains/(losses) on financial assets at fair value through profit or loss;
  - Other income;
  - Expenses for asset management services rendered; and
  - Interest paid, excluding Personal Medical Savings Accounts.

Structured entities

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual agreements. A structured entity often has some or all of the following features or attributes:

- Restricted activities.
- A narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors.
- Insufficient equity to permit the structured entity to finance its activities without subordinated financial support.
- Financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has determined that some of its investments in pooled funds and in collective investments (funds) are investments in unconsolidated structured entities. Disclosure of these investments has been made in Note 34. The objectives include achieving medium- to long-term capital growth. The investment strategy does not include the use of leverage.

These funds are managed by independent asset managers who apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the Statement of Comprehensive Income in "Net gains/(losses) on financial assets".

Notes to the Financial Statements

FOR THE YEAR ENDED 31 DECEMBER 2022

1. Property and equipment

ACCOUNTING POLICY:

Property and equipment are stated at historical cost less depreciation and impairment. Historical cost includes expenditure that is directly attributable to the acquisition of the items.

Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme, and the cost of the item can be measured reliably. All other repairs and maintenance are charged to the surplus or deficit during the financial period in which they are incurred.

Property and equipment are depreciated using the straight-line method to allocate their cost to their residual values over their estimated useful lives, as follows:

Right of Use Asset – Land and Buildings	Shorter of estimated life or period of lease
Leasehold improvements	Shorter of estimated life or period of lease

The term of the lease and the right of use asset has been determined as 10 years when assessing the term under International Financial Reporting Standards (IFRS) 16 Leases.

The asset's residual values and useful lives are reviewed at each reporting date and adjusted if appropriate. An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount. The recoverable amount is the higher of the asset's fair value less costs to dispose and value-in-use.

Gains or losses on disposals are determined by comparing the proceeds with the carrying amount. These are recorded in the surplus or deficit.

Note:

R'000	Right-of-Use Asset Land and Buildings	Leasehold Improvements	Total
Non-current			
Gross carrying amount	12 015	2 844	14 859
Accumulated depreciation	(4 205)	(996)	(5 201)
Balance at 31 December 2021	7 810	1 848	9 658
Gross carrying amount	12 015	2 844	14 859
Additions	145	–	145
Accumulated depreciation	(5 407)	(1 280)	(6 687)
BALANCE AT 31 DECEMBER 2022	6 753	1 564	8 317

R'000	Right-of-Use Asset Land and Buildings	Leasehold Improvements	Total
Non-current			
Balance at 1 January 2021	9 011	2 133	11 144
Depreciation charge	(1 201)	(285)	(1 486)
Balance at 31 December 2021	7 810	1 848	9 658
Additions	145	–	145
Depreciation charge	(1 202)	(284)	(1 486)
BALANCE AT 31 DECEMBER 2022	6 753	1 564	8 317

LEASED ASSETS

The right-of-use asset arises from the lease agreement for the Scheme's offices (Note 2).

2. Leases

ACCOUNTING POLICY:

At inception of a contract, the Scheme assesses whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time, in exchange for consideration. To assess whether a contract conveys the right to control the use of an identified asset, the Scheme assesses whether:

- the contract involves the use of an identified asset – this may be specified explicitly or implicitly, and should be physically distinct or represent substantially all of the capacity of a physically distinct asset. If the supplier has a substantive substitution right, then the asset is not considered to be an identified asset;
- the Scheme has the right to obtain substantially all of the economic benefits from the use of the asset throughout the period of use;
- the Scheme has the right to direct the use of the asset. The Scheme has this right when it has the decision-making rights that are most relevant to changing how, and for what purpose the asset is used. In rare cases, where all the decisions about how and for what purpose the asset is used are predetermined, the Scheme has the right to direct the use of the asset if either:
  - the Scheme has the right to operate the asset; or
  - the Scheme designed the asset in a way that predetermines how and for what purpose it will be used.

At inception, or on reassessment of a contract that contains a lease component, the Scheme allocates the consideration in the contract to each lease component on the basis of their relative stand-alone prices.

The Scheme recognises a right-of-use asset and a lease liability at the lease commencement date.

RIGHT-OF-USE ASSET

The right-of-use asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for any lease payments made at or before the commencement date, plus any initial direct costs incurred. An estimate of the costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located are also included in the cost. The total cost is reduced by any lease incentives received.

The right-of-use asset is subsequently depreciated using the straight-line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term. The estimated useful lives of right-of-use assets are determined on the same basis as those of property and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain remeasurements of the lease liability.

LEASE LIABILITY

The lease liability is initially measured at the present value of the lease payments that are not paid at the commencement date, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, the Scheme's incremental borrowing rate. Generally, the Scheme uses its incremental borrowing rate as the discount rate.

Lease payments included in the measurement of the lease liability comprise fixed payments, increasing annually at a rate set out in the lease agreement.

The lease liability is measured at amortised cost using the effective interest method. The lease liability is remeasured by discounting the revised lease payments using a revised discount rate if there is a change in the lease term, or if the Scheme changes its assessment of whether it will exercise an extension option.

When the lease liability is remeasured in this way, a corresponding adjustment is made to the carrying amount of the right-of-use asset or is recorded in the surplus or deficit if the carrying amount of the right-of-use asset has been reduced to zero.

LEASES OF LOW-VALUE ASSETS

The Scheme has elected not to recognise right-of-use assets and lease liabilities for leases of low-value assets, with a value of less than R100 000.

DISCLOSURE

The Scheme represents right-of-use assets in "Property and equipment" and lease liabilities in “Leases” in the Statement of Financial Position. The Scheme recognises the lease payments associated with short-term leases, with a lease term not exceeding 12 months, and leases of low-value assets as an expense on a straight-line basis over the lease term.

2. **Leases** continued

Note:

NATURE OF LEASING ACTIVITIES

The Scheme leases land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of five years and includes an option to renew the lease for an additional period of the same duration, after the end of the initial term. It is reasonably certain that the renewal option will be exercised, and the term of this lease has been determined as 10 years when assessing the term under IFRS 16. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred. Detail of this lease is presented below.

The Scheme leases IT equipment and certain office equipment with contract terms of one to two years. These leases are leases of low-value items.

R'000	Land and Buildings	Total
Right-of-use asset		
Gross carrying amount	12 015	12 015
Accumulated depreciation	(4 205)	(4 205)
BALANCE AT 31 DECEMBER 2021	**7 810**	**7 810**
Gross carrying amount	12 015	12 015
Additions	145	145
Accumulated depreciation	(5 406)	(5 406)
BALANCE AT 31 DECEMBER 2022	**6 754**	**6 754**
Lease Liability		
Gross carrying amount	12 015	12 015
Interest expense	4 537	4 537
Lease payments	(5 920)	(5 920)
BALANCE AT 31 DECEMBER 2021	**10 632**	**10 632**
Gross carrying amount	12 015	12 015
Interest expense	5 701	5 701
Lease payments	(7 883)	(7 883)
BALANCE AT 31 DECEMBER 2022	**9 833**	**9 833**

2. **Leases** continued

R'000	2022	2021
Maturity analysis – contractual undiscounted cash flows		
Less than one year	**2 098**	1 961
One to five years	**11 388**	12 065
More than five years	**–**	1 421
TOTAL UNDISCOUNTED LEASE LIABILITIES AT 31 DECEMBER 2022	**13 486**	**15 447**
Lease liabilities included in the Statement of Financial Position at 31 December 2022		
Non-current	**7 735**	8 671
Current	**2 098**	1 961
	9 833	10 632
Amounts recognised in the Statement of Comprehensive Income		
Depreciation	**1 201**	1 201
Interest on lease liabilities	**1 164**	1 238
Expenses relating to leases of low-value assets	**76**	73
Amounts recognised in the Statement of Cash Flows		
Total cash outflow for leases	**1 965**	1 832

3. Financial assets at fair value through profit or loss

ACCOUNTING POLICY:

The Scheme's investment strategy (business model objective) is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at the respective portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolio under management.

The business model objective is achieved through the selling of assets per the documented strategy for realisation of gains with the collection of contractual cash flows being incidental to the primary business model objective. The financial assets are managed together and grouped into specific portfolios. Based on the business model objective the financial assets are measured at fair value through profit and loss.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the surplus or deficit section of the Statement of Comprehensive Income.

The fair value of the portfolios where the underlying financial instruments are traded in an active market is determined by using quoted market prices or dealer quotes of the underlying financial instruments.

The fair value of the portfolios where the underlying financial instruments are not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value are recognised under "Other Income" in the Statement of Comprehensive Income within the period in which they arise.

3. Financial assets at fair value through profit or loss continued

The methodology applied to assess assets as non-current or current is summarised below:

MEASUREMENT CLASS	METHODOLOGY
Offshore bonds	Offshore bonds are in collective investment schemes. The Scheme's intention is not to liquidate these portfolios however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result, these portfolios have been included as open ended.
Equities	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.
Short duration bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Flexible fixed income bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Money market instruments	Assets that are expected to be realised to fund operating activities within 12 months from the reporting date are considered to be settled within 12 months. All other instruments are classified as open ended.
Property	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.

Note:

R'000	2022	2021
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:	**33 173 672**	34 688 723
– Offshore cash and bonds	**2 196 242**	2 299 286
– Equities	**8 937 682**	7 578 533
– Short duration bonds	**5 488 733**	10 604 304
– Flexible fixed income bonds	**8 639 881**	5 229 271
– Money market instruments	**7 313 485**	8 367 829
– Property	**597 649**	609 500
	33 173 672	34 688 723
Open ended, available on demand (Included as non-current)	**24 331 440**	24 701 566
Expected to settle within twelve months (Included as current)	**8 842 232**	9 987 157
	33 173 672	**34 688 723**
Reconciliation of the balance at the beginning of the year to the balance at the end of the year:		
At the beginning of the year	**34 688 723**	31 430 492
Acquisitions	**7 930 674**	8 841 598
Disposals	**(9 410 317)**	(7 582 315)
Transfer due to amalgamation	**–**	155 632
Net (losses)/gains on revaluation of financial assets at fair value through profit or loss (Note 24)	**(35 408)**	1 843 316
AT THE END OF THE YEAR	**33 173 672**	**34 688 723**

A register of investment portfolios is available for inspection at the registered office of the Scheme.

4. Trade and other receivables

ACCOUNTING POLICY:

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Receivables are initially recognised at fair value, plus transaction costs. The Scheme holds its insurance receivables and other receivables with the objective to collect the contractual cash flows and measures them subsequently at amortised cost using the effective interest method, less provision for impairment.

"Trade and other receivables" comprise insurance receivables, arising from the Scheme's insurance contracts with its members and other receivables.

IMPAIRMENT OF INSURANCE RECEIVABLES – LOSS EVENT

The Scheme assesses at each reporting date whether there is objective evidence that an insurance receivable is impaired. An insurance receivable, or group of insurance receivables is impaired, and impairment losses are incurred if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the insurance receivable (a loss event) and that loss event (or events) has an adverse impact on the estimated future cash flows of the insurance receivable that can be reliably estimated.

Objective evidence that an insurance receivable or group of insurance receivables is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service providers or member debtors.
- Breach of contract, such as non-payment of member contributions when due, and if these remain unpaid for extended periods.
- Default or delinquency in payments due by service providers and other debtors.
- Adverse changes in the payment status of members of the Scheme.
- National or local economic conditions that correlate with non-payment of debtor contributions.

The Scheme first assesses whether objective evidence of impairment exists, individually for insurance receivables that are individually significant, such as service provider debtors. In the case of insurance receivables which are not individually significant, such as contribution debtors, receivables are grouped on the basis of similar credit characteristics, such as type of receivable and past due status. These characteristics are used in the estimation of future recoverable cash flows.

If there is objective evidence that an impairment loss on an insurance receivable has been incurred, the amount of the loss is measured as the difference between the carrying amount and the present value of estimated future cash flows. The carrying amount of the receivable is reduced and the amount of the loss is recognised in the Statement of Comprehensive Income.

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary collection procedures have been completed and the amount of the loss has been determined. Where a provision for impairment has not been raised, the receivable is written off directly to the Statement of Comprehensive Income. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed by adjusting the allowance account. The amount of the reversal is recognised in the Statement of Comprehensive Income.

4. Trade and other receivables continued

IMPAIRMENT OF OTHER RECEIVABLES – EXPECTED CREDIT LOSS

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for other receivables. To measure the expected credit losses, other receivables are grouped based on shared credit risk characteristics and days past due. Note 34 sets out information about impairment of other receivables.

Note:

R'000	2022	2021
Insurance receivables		
Contribution receivables	**2 623 948**	2 349 186
Contributions outstanding	**2 649 250**	2 380 960
Less: Provision for impairment	**(25 302)**	(31 774)
Member and service provider claims receivables	**110 673**	98 046
Amount due	**440 649**	405 176
Less: Provision for impairment	**(329 976)**	(307 130)
Other risk transfer arrangements	**1 490**	372
Recoveries due from other risk transfer arrangements	**204**	52
Share of outstanding claims provision (Note 7)	**1 286**	320
Broker fee receivables	**592**	685
Amounts due from brokers	**2 797**	5 598
Less: Provision for impairment	**(2 205)**	(4 913)
Other insurance receivables	**27 915**	63 385
Balance due by related party (Note 28)	**25 164**	13 058
Discovery Third Party Recovery Services (Pty) Ltd	**25 164**	13 044
Discovery Life Ltd	**–**	14
Forensic receivables	**178 191**	194 390
Amount due	**192 867**	207 216
Less: Provision for impairment	**(14 676)**	(12 826)
Total receivables arising from insurance contracts	**2 967 973**	2 719 122
Other receivables		
Sundry accounts receivable	**271**	9 567
Interest receivable	**5 769**	1 161
Total receivables arising from other receivables	**6 040**	10 728
	2 974 013	**2 729 850**

At 31 December 2022, the carrying amounts of "Trade and other receivables" approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

5. Cash and cash equivalents – Personal Medical Savings Account trust assets arising from amalgamation

(Monies managed by the Scheme on behalf of members)

ACCOUNTING POLICY:

The members' Personal Medical Savings Account (PMSA), which constitutes a portion of the members' monthly contributions allocated for the exclusive benefit of a member and his/her dependants, represents savings contributions (which are a deposit component of the insurance contracts) and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules.

The deposit component of the insurance contracts has been unbundled, since the Scheme can measure the deposit component separately. The insurance component is recognised as an insurance liability.

Unspent savings at the year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Act, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded by the Scheme's funds, and the risk of impairment is carried by the Scheme.

No interest accrues to members on positive PMSA balances.

Note:

R'000	2022	2021
Personal Medical Savings Account trust portfolio (Managed by Coronation)		
Balance at beginning of the year	**10 860**	–
Net additional Investments	–	10 687
Interest Income	–	173
Transfers to Scheme funds (Active members)	**(9 670)**	
Refunds to withdrawn members	**(612)**	
Unclaimed Personal Medical Savings amounts written off to Scheme funds	**(578)**	
BALANCE AT THE END OF THE YEAR	–	**10 860**

Quantum Medical Aid Society (QMAS) amalgamated into Discovery Health Medical Scheme (DHMS or the Scheme) effective 1 August 2021. In accordance with the QMAS' rules, the PMSA monies belong to the members. This resulted in the creation of a trust relationship between the Scheme and the member. Personal Medical Savings Accounts accordingly constitute trust money as defined in section 1 of the Financial Institutions (Protection of Funds) Act 28 of 2001 read with Regulation 10 to the Act.

Personal medical savings are invested separately from scheme funds, which are further clarified by section 4 (5) of the Financial Institutions (Protection of Funds) Act 28 of 2001.

The PMSA trust relationship remains for QMAS members who did not transfer to DHMS on the amalgamation date, either due to leaving QMAS prior to the amalgamation date or choosing not to transfer to DHMS on amalgamation ("withdrawn members").

The difference between total Personal Medical Savings Account assets and Personal Medical Savings Account liabilities (Note 9) is reconciled monthly and arises from timing of cash flows to and from the portfolios.

6. Cash and cash equivalents – medical scheme assets

ACCOUNTING POLICY:

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value. These instruments are not held for investment purposes.

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Money on call and short notice.
- Balances with banks.
- Money market funds.

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes and are carried at cost, which, due to their short-term nature, approximates fair value.

Note:

R'000	2022	2021
Current accounts	**3 022 200**	901 508
Money market funds	**601 934**	2 936 806
	3 624 134	**3 838 314**

At the reporting date cash and cash equivalents are carried at amortised cost, which approximates fair value.

The money market funds are held in an actively managed portfolio by an independent asset manager. The asset manager invests in line with its best investment view, subject to the investment mandate which includes investment in interest bearing – money market and/or interest-bearing short-term collective investment scheme portfolios, subject to the Collective Investment Schemes Control Act 2002. The targeted return is the Short-Term Fixed Interest (STeFI) Call Deposit Index, and the weighted average term to final maturity never exceeds 90 days. The portfolio is highly liquid with 100% of the portfolio being available within three working days.
60% of the portfolio must be available for same-day value with the balance available within two working days.

7. Outstanding claims provision

ACCOUNTING POLICY:

Claims outstanding comprise provisions for the Scheme's best estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. Claims outstanding are determined as accurately as possible based on a number of factors. These include previous experience in claims patterns, claims settlement patterns, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

Claims handling expenses are not separately accounted for as this service is provided by the administrator and a fixed fee is paid for the full administration service, including claims handling. No provision for claims handling expenses is required as the Scheme has no further liability to the administrator at year-end.

Estimated co-payments and payments from members' Personal Medical Savings Accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims since the effect of the time value of money is considered to not be material.

Note:

R'000	2022	2021
Outstanding claims provision – not covered by risk transfer arrangements	**1 843 079**	2 256 734
Outstanding claims provision – covered by risk transfer arrangements (Note 4)	**1 286**	320
	1 844 365	**2 257 054**
Analysis of movement in outstanding claims		
Balance at beginning of the year	**2 257 054**	1 769 008
Payments in respect of prior year	**(2 117 813)**	(1 705 525)
Over provision in prior year (Note 12)	**139 241**	63 483
Outstanding claims provision raised in current year	**1 705 124**	2 193 571
Not covered by risk transfer arrangements	**1 703 838**	2 193 251
Covered by risk transfer arrangements (Note 4)	**1 286**	320
BALANCE AT END OF THE YEAR	**1 844 365**	**2 257 054**
Analysis of outstanding claims provision		
Estimated gross claims	**1 920 867**	2 351 130
Less:		
Estimated recoveries from savings plan accounts (Note 9)	**(76 502)**	(94 076)
BALANCE AT END OF THE YEAR	**1 844 365**	**2 257 054**

8. Derivative financial instruments

ACCOUNTING POLICY:

Derivative financial instruments are not designated as effective hedging instruments and are carried at fair value through profit or loss.

The Scheme initially recognises derivative financial instruments in the Statement of financial position at fair value on the date which a derivative contract is entered into (the best evidence of fair value on day one is the transaction price) and subsequently re-measures these instruments to fair value. Fair values are obtained from quoted prices in active markets, including recent market transactions, and valuation techniques, including discounted cash flow models and options pricing models, as appropriate. All derivatives are carried as assets when the fair value is positive and as liabilities when the fair value is negative.

Derivative contracts with a remaining maturity of less than 12 months are classified as a current asset or liability.

Note:

R'000	2022	2021
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	**38 525**	–
DERIVATIVE FINANCIAL ASSET AT THE END OF THE YEAR	**38 525**	–
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset at the beginning of the year	–	158 307
Net realised gain on derivative financial instruments (Note 30)	–	(153 544)
Realised gains on derivative financial instruments	–	(257 574)
– Zero-cost currency collars	–	(211 669)
– Zero-cost equity fences	–	(45 905)
Realised losses on derivative financial instruments	–	104 030
– Zero-cost equity fences	–	104 030
Net fair value gain/(loss) on derivative financial instruments (Note 24)	**38 525**	(4 763)
Gains on revaluation of derivative financial instruments to fair value	**38 525**	64 544
– Synthetic forwards	**38 525**	–
– Zero-cost equity fences	–	15 337
– Zero-cost currency collars	–	49 207
Losses on revaluation of derivative financial instruments to fair value	–	(69 307)
– Zero-cost equity fences	–	(69 307))
DERIVATIVE FINANCIAL ASSET AT THE END OF THE YEAR	**38 525**	–

The Scheme directly enters into derivative contracts to hedge exposure to changes in the Rand/US Dollar exchange rate with respect to its offshore investment portfolios and to hedge the exposure to changes in market prices for investments in the equity portfolios. Detail on these transactions have been included above.

Certain of the Scheme's independent asset managers utilise bond futures and other derivative instruments within their respective portfolios to manage duration risk, for risk mitigation and efficient portfolio construction. These derivatives are included in the financial assets managed together and grouped into specific portfolios. As a result, these transactions are not included above but included in the portfolio balances disclosed in Note 3.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 34).

9. Personal Medical Savings Account liabilities

ACCOUNTING POLICY:

The Scheme Rules for Personal Medical Savings Accounts (PMSAs) were amended, effective from 1 January 2018. The effect of the amendment is that a trust relationship is no longer established and no disclosure around the trust liability is required. Prior to the 2018 reporting period, PMSA's were disclosed as trust liabilities.

Members' PMSAs represent savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered Rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and the Scheme's accounting policies do not otherwise require recognition of all obligations and rights arising from the deposit component.

The savings accounts contain a demand feature and are initially measured at fair value plus transaction costs, which is the amount payable to a member on demand, discounted from the first date that the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest rate method.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Act, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's funds and the risk of impairment is carried by the Scheme.

Interest payable on members' PMSAs is expensed when incurred.

Unclaimed PMSA balances that have prescribed, that is funds older than three years, are written back and included under "Sundry income" on the face of the Statement of Comprehensive Income.

Note:

R'000	2022	2021
Balance on Personal Medical Savings Accounts at the beginning of the year	**7 081 549**	6 675 945
Add:		
Personal Medical Savings Accounts contributions received or receivable (Note 11)	**13 911 979**	13 356 990
Interest on Personal Medical Savings Accounts (Note 27)	**359 952**	334 433
Transfers received from other medical schemes	**39 558**	19 618
Savings plan liabilities transferred to the Scheme upon amalgamation	**–**	11 165
Less:		
Claims paid to or on behalf of members (Note 12)	**(13 592 080)**	(12 823 100)
Refunds on death or resignation	**(489 390)**	(493 293)
Unclaimed Personal Medical Savings Accounts written off to scheme funds (Note 25)	**(1 204)**	(116)
COVID-19 Support: Contributions funded from PMSA	**–**	(93)
BALANCE DUE TO MEMBERS ON PERSONAL MEDICAL SAVINGS ACCOUNTS AT THE END OF THE YEAR	**7 310 364**	**7 081 549**

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2022 but not reported will amount to approximately R77m (2021: R94m) (Note 7).

PMSAs contain a demand feature and members can call on the funds at any time and these balances are categorised as "Available on demand". At 31 December 2022, the carrying amount of members' PMSAs were deemed to be equal to their fair values, which is the amount payable on demand.

Interest is determined from time to time by the Scheme at its discretion and added to the funds allocated to the member's PMSA in terms of the Scheme Rules. The Scheme does not charge interest on negative (overdrawn) PMSA balances.

The Scheme introduced the payment of contributions from positive MSA balances to assist in the adverse impact of COVID-19 on its stakeholders. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R93k in the prior financial year. The Council for Medical Schemes (CMS) granted DHMS exemption on 9 April 2021 for a period of three months effective from 1 April 2021. An extension of the exemption was granted on 4 November 2021 for the period up to 31 December 2021.

10. Trade and other payables

ACCOUNTING POLICY:

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities.

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate method.

UNALLOCATED FUNDS

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, those are funds older than three years, are written back and included under "Sundry income" in the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under "Trade and other payables". The liability is measured at amortised cost using the effective interest rate method.

Note:

R'000	2022	2021
Insurance payables		
Contributions received in advance	**193 801**	179 707
Contribution refunds due to employers	**6 280**	218
Reported claims not yet paid	**797 363**	650 284
Balance at the beginning of the year	**650 284**	635 017
Claims paid (Note 30)	**(74 920 971)**	(68 679 150)
Claims incurred	**75 068 050**	68 694 417
Broker fee creditors	**12 828**	21 006
Accredited brokers	**12 828**	21 006
Total liabilities arising from insurance contracts	**1 010 272**	851 215
Financial liabilities		
Balances due to related parties (Note 28)	**680 811**	631 225
Discovery Health (Pty) Ltd	**680 559**	631 124
Discovery Life Ltd	**71**	–
Discovery Central Services (Pty) Ltd	**181**	101
Unallocated funds	**15 105**	9 884
Total accruals	**26 210**	24 999
General accruals	**26 007**	24 810
Leave pay provision	**203**	189
Total arising from financial liabilities	**722 126**	666 108
	1 732 398	**1 517 323**

At 31 December 2022 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

11. Risk contribution income

ACCOUNTING POLICY:

Gross contributions comprise risk contributions and Personal Medical Savings Account contributions. Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

Risk contributions are shown before the deduction of broker service fees.

Note:

R'000	2022	2021
Gross contributions per registered Scheme Rules	**79 542 906**	75 816 287
Less:		
Personal Medical Savings Account contributions (Note 9)	**(13 911 979)**	(13 356 990)
	65 630 927	**62 459 297**

12. Net claims incurred

ACCOUNTING POLICY:

CLAIMS INCURRED

Gross claims incurred comprise of the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether or not reported by the end of the year.

Risk claims incurred comprise:

- Claims submitted and accrued for services rendered during the year.
- Payments under provider contracts for services rendered to members.
- Over or under provisions relating to prior year claims estimates.
- Claims incurred but not yet reported.
- Claims settled in terms of risk transfer arrangements.

Net of:

- Claims from members' Personal Medical Savings Accounts.
- Recoveries from members for co-payments.
- Recoveries from third parties.
- Discount received from service providers.

Anticipated recoveries under risk transfer arrangements are disclosed separately as assets and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

12. Net claims incurred continued

REIMBURSEMENTS FROM THE ROAD ACCIDENT FUND

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made against the Road Accident Fund, administered in terms of the Road Accident Fund Act No 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged, contractually, to reimburse such payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and measurability of the Road Accident Fund amounts, the Scheme accounts for these amounts on a cash basis. These amounts are recognised as a reduction of net claims incurred.

Note:

R'000	2022	2021
Current year claims per registered Scheme Rules	**73 064 735**	66 802 391
Claims not covered by risk transfer arrangements	**72 682 343**	66 441 358
Claims covered by risk transfer arrangements (Note 14)	**382 392**	361 033
Movement in outstanding claims provision	**(412 689)**	488 047
Over provision in prior year (Note 7)	**(139 241)**	(63 483)
Adjustment for current year	**(273 448)**	551 530
	72 652 046	67 290 438
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 9)	**(13 592 080)**	(12 823 100)
Claims incurred	**59 059 966**	54 467 338
Third party claim recoveries	**(138 300)**	(67 460)
	58 921 666	**54 399 878**

13. Accredited managed healthcare services (no risk transfer)

ACCOUNTING POLICY:

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred.

Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Managed healthcare services are recognised as an expense over the indemnity period on a straight-line basis.

Note:

R'000	2022	2021
The accredited managed healthcare services (no risk transfer) have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Active Disease Risk Management Services and Disease Risk Management Support Services	**671 553**	621 708
Hospital Benefit Management Services	**635 186**	587 575
Managed Care Network Management Services and Risk Management Services	**602 203**	555 526
Pharmacy Benefit Management Services	**211 266**	195 607
	2 120 208	**1 960 416**

14. Net income on risk transfer arrangements

ACCOUNTING POLICY:

Risk transfer arrangements are contractual arrangements entered into by the Scheme and third parties who undertake to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as the related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions, and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid, and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for insurance receivables. The impairment loss is also calculated following the same method used for these receivables. These processes are described in Note 4.

Note:

R'000	2022	2021
Risk transfer arrangement fees	**(312 221)**	(271 813)
Recoveries under risk transfer arrangements (Note 12)	**382 392**	361 033
	70 171	**89 220**

15. Broker service fees

ACCOUNTING POLICY:

Broker service fees are fees paid as acquisition costs for the introduction and provision of ongoing services to members and are expensed as incurred when contributions are received by the Scheme and the related broker is accredited in terms of the Act.

Note:

R'000	2022	2021
Brokers' fees	**1 612 455**	1 438 916
	1 612 455	**1 438 916**

16. Expenses for administration

ACCOUNTING POLICY:

Expenses for administration are paid to the Scheme administrator and are expensed as incurred.

Note:

R'000	2022	2021
The Scheme pays an all-inclusive fee to the Administrator which has been allocated into the following categories of services.		
Accredited administration services	**5 409 233**	4 999 124
Broker remuneration management	**78 365**	72 456
Claims management	**607 946**	561 806
Contribution management	**483 023**	446 398
Customer services	**2 685 017**	2 481 413
Financial management	**19 744**	18 294
Information management and data control	**985 518**	910 822
Member record management	**549 620**	507 935
Other administration services	**601 378**	555 624
Actuarial services	**9 329**	8 574
Advanced data analytics	**64 220**	59 328
Digital service offering	**23 716**	21 968
Distribution services	**41 232**	38 078
Enhanced employer reporting	**1 616**	1 465
Enhanced service offering	**12 974**	11 957
Enterprise risk management services	**12 784**	11 796
Forensic investigations and recoveries	**34 019**	31 422
Governance compliance and human resources	**8 091**	7 510
Internal audit services	**16 332**	15 046
Legal services	**3 808**	3 542
Marketing and stakeholder relations services	**281 070**	259 648
Product innovation	**15 277**	14 166
Quality management and monitoring services	**76 910**	71 124
	6 010 611	**5 554 748**

17. Other operating expenses

ACCOUNTING POLICY:

Other operating expenses include expenses, other than administration fees, and are expensed as incurred.

Note:

R'000	2022	2021
Association fees	**2 200**	1 511
Audit fees	**6 916**	7 065
Audit services for the year ended 2022	**3 533**	–
Audit services for the year ended 2021	**3 383**	3 161
Audit services for the year ended 2020	**–**	3 198
Other services	**–**	706
Audit Committee and Risk Committee fees (Note 18)	**2 107**	1 850
Audit Committee	**1 758**	1 559
Risk Committee	**349**	291
Bank charges	**9 241**	9 238
Benefit management services	**6 494**	26 176
COVID-19 (Note 28)	**6 074**	25 756
Diabetic Retinopathy	**420**	420
Clinical Governance Committee fees (Note 18)	**719**	689
Council for Medical Schemes	**59 617**	58 620
Debt collecting fees	**3 210**	2 884
Depreciation	**1 486**	1 486
Dispute Committee fees	**856**	1 730
Fidelity Guarantee Insurance	**3 221**	26
General meeting costs	**14 728**	15 748
Investment Committee fees (Note 18)	**631**	245
Investment reporting fees	**5 429**	5 429
Legal fees	**594**	488
Nomination Committee fees (Note 20)	**1 148**	1 712
Office operating costs	**4 809**	4 494
Other expenses	**25 861**	32 093
Principal Officer fees – Remuneration	**5 528**	5 248
Principal Officer fees – Unvested long-term employee benefit	**1 770**	1 161
Printing, postage and stationery	**61**	261
Professional fees	**11 698**	10 048
Remuneration Committee fees (Note 18)	**262**	207
Scheme Office costs	**911**	1 292
Staff costs (Note 21)	**28 907**	25 538
Sundry amounts written (back)/off	**(7)**	5
Trustees' remuneration and consideration expenses (Note 22)	**10 230**	9 433
	208 627	**224 677**

18. Board committee fees and considerations

Note:

The following tables record fees and considerations paid to independent members serving on the respective Board Committees and do not include amounts paid to Trustees.

2022 R'000	**Audit**	**Risk**	**Clinical Governance**	**Investment**	**Remuneration**	**Total**
S Ludolph	**7**					**7**
N Luthuli					**147**	**147**
N Mlaba			**358**			**358**
E Mackeown	**1 011**	**182**		**257**		**1 450**
A Burger	**318**	**167**				**485**
H Van Deventer				**374**		**374**
B Hlope					**115**	**115**
L Baldwin-Ragaven			**361**			**361**
M Bosman	**422**					**422**
TOTAL	**1 758**	**349**	**719**	**631**	**262**	**3 719**

2021 R'000	Audit	Risk	Clinical Governance	Investment	Remuneration	Total
S Ludolph	316					316
N Luthuli					207	207
P Maphumulo				1		1
N Mlaba			331			331
S Smith			358			358
E Mackeown	886	162		244		1 292
A Burger	357	129				486
TOTAL	**1 559**	**291**	**689**	**245**	**207**	**2 991**

For detail of the Chairperson of the respective committee refer to pages 53 to 55 and pages 69 to 70.

19. Net impairment losses on healthcare receivables

Note:

R'000	2022	2021
Insurance receivables		
Movement in provision of contributions that are not recoverable	**(6 472)**	9 303
Movement in provision of members' and service providers' portions that are not recoverable	**101 939**	111 873
Movement in provision of amounts due by brokers that are not recoverable	**(2 708)**	3 017
Movement in provision of forensic debtors that are not recoverable	**1 848**	1 048
Receivables written off directly to the Statement of Comprehensive Income	**13 608**	10 283
	108 215	**135 524**

20. Other committee fees

Note:

R'000	2022 R'000	2021 R'000
Nomination Committee fees		
P Goss – Independent Member (Chairperson term ended 30 September 2021)	**–**	648
T Wixley – Independent Member	**–**	498
R Shough – Independent Member (term ended 30 September 2021)	**–**	566
A Bryce – Independent Member (Chairperson)	**425**	–
B Marais – Independent Member	**360**	–
A Muller – Independent Member	**363**	–
	1 148	**1 712**

21. Staff costs

ACCOUNTING POLICY:

PENSION OBLIGATIONS

All employees of the Scheme are members of defined contribution plans. Defined contribution plans are plans under which the Scheme pays fixed contributions to separate legal entities.

The Scheme has no legal or constructive obligation to pay further contributions if the funds do not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

OTHER POST-EMPLOYMENT OBLIGATIONS

The Scheme has no liability for the post-retirement medical benefits of employees.

OTHER LONG-TERM EMPLOYEE BENEFIT

The long-term employee benefit plan refers to awards made to qualifying employees.

The amount recognised in the Statement of Financial Position in respect of the defined benefit plan is the present value of the defined benefit obligation at the end of the reporting period less the fair value of plan assets out of which the obligations are to be settled directly. The defined benefit obligation is calculated using the projected unit credit method.

LEAVE PAY ACCRUAL

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

BONUSES

Management and staff bonuses are recognised as an expense in staff costs as incurred.

Note:

R'000	2022	2021
Salaries and bonuses	**22 357**	19 974
Pension costs – defined contribution plans	**1 482**	1 669
Medical and other benefits	**1 364**	1 254
Long-term employee benefit service cost	**3 684**	2 628
Increase in leave pay accrual	**20**	13
	28 907	**25 538**
Number of employees at 31 December	**13**	13

22. Trustees' remuneration and considerations

Note:

The following table records the remuneration and consideration paid to Trustees during the year:

2022 R'000	**Services as Trustee**	**Committee fees** **Audit**	**Risk**	**Investment**	**Clinical Governance**	**Product**	**Remuneration**	**Stakeholder Relations and Ethics**	**Travel**	**Training**	**Total**
N Morrison (Chairperson term ended 31 Dec 2021)	325	105	–	129	–	19	36	–	11	–	625
D Moodley	325	–	–	163	197	74	–	74	–	33	866
D King	320	–	81	–	–	–	60	65	15	–	541
J Adams SC	378	–	107	129	–	–	–	95	42	–	751
J Butler SC (Chairperson eff 1 Jan 2022)	1 245	–	–	–	–	–	103	153	76	–	1 577
J Human	994	231	–	292	–	230	19	–	126	–	1 892
S Brynard	600	–	–	–	89	98	135	85	91	–	1 098
L Harie	649	–	206	–	301	–	36	167	78	–	1 437
MM Du Toit	342	120	–	112	–	65	–	–	81	–	720
M Price	356	–	–	–	152	79	19	69	48	–	723
TOTAL	**5 534**	**456**	**394**	**825**	**739**	**565**	**408**	**708**	**568**	**33**	**10 230**

The following table records the remuneration and consideration paid to Trustees during the prior year:

2021 R'000	Services as Trustee	Committee fees Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
N Morrison (Chairperson)	1 136		32	274			110	–		11	1 563
D Moodley	695			333	347	181		184		11	1 751
D King	678		197				119	160	5	11	1 170
J Adams SC	470		129		185			132		24	940
J Butler SC	669	251					110	230		11	1 271
J Human	688	237		274		224				–	1 423
S Brynard	562					158	95	160	6	12	993
L Harie	155		46		75			46			322
TOTAL	**5 053**	**488**	**404**	**881**	**607**	**563**	**434**	**912**	**11**	**80**	**9 433**

23. Investment income

ACCOUNTING POLICY:

Investment income comprises dividends and interest received and accrued on investments at fair value through profit or loss and interest on cash and cash equivalents.

Interest income is recognised using the effective interest rate method, taking into account the principal amount outstanding and the effective interest rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income from investments is recognised when the right to receive payment is established – this is on the "last day to trade" for listed shares and on the "date of declaration" for unlisted shares.

Note:

R'000	2022	2021
Financial assets at fair value through profit or loss:	**2 017 168**	1 591 605
Dividend income	**473 318**	322 814
Interest income	**1 543 850**	1 268 791
Cash and cash equivalents interest income	**204 819**	180 004
INVESTMENT INCOME PER STATEMENT OF COMPREHENSIVE INCOME	**2 221 987**	**1 771 609**
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Cash and cash equivalents interest income	**204 819**	180 004
Financial assets at fair value through profit or loss:		
Interest income	**1 543 850**	1 268 791
TOTAL INTEREST INCOME	**1 748 669**	**1 448 795**

24. Net gains/(losses) on financial assets

Note:

R'000	2022	2021
Net fair value losses/gains on financial assets at fair value through profit or loss (Note 3):	**(35 408)**	1 843 316
Fair value gains on financial assets at fair value through profit or loss:	**367 786**	1 852 079
– Equities	**282 492**	1 289 086
– Money market instruments	**65 224**	38 843
– Flexible fixed income bonds	**–**	222 709
– Offshore bonds	**–**	123 083
– Property	**–**	135 712
– Short duration bonds	**20 070**	42 646
Fair value losses on financial assets at fair value through profit or loss:	**(403 194)**	(8 763)
– Equities	**(37 518)**	–
– Flexible fixed income bonds	**(163 664)**	
– Offshore bonds	**(148 272)**	–
– Property	**(53 740)**	–
– Short duration bonds	**–**	(8 763)
Net fair value gains/(losses) on derivative financial instruments (Note 8):	**38 525**	(4 763)
Fair value gains on derivative financial instruments:	**38 525**	64 544
Fair value losses on derivative financial instruments:	**–**	(69 307)
	3 117	**1 838 553**

25. Sundry income

Note:

R'000	2022	2021
Prescribed amounts written back	**29 894**	28 510
Unclaimed Personal Medical Savings Accounts written off to Scheme funds (Note 9)	**1 204**	116
	31 098	**28 626**

26. Asset management fees

ACCOUNTING POLICY:

Asset management fees are fees paid the asset manager for their professional services incurred through the management of the portfolios. The fees are deducted in the individual asset portfolios.

Note:

R'000	2022	2021
Asset management fees	**103 130**	93 213
	103 130	**93 213**

27. Finance costs

Note:

R'000	2022	2021
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings Accounts (Note 9)	**359 952**	334 433
	1 266	1 242
Interest paid – other	**102**	4
Interest on lease liability (Note 2)	**1 164**	1 238
	361 218	**335 675**

28. Related party transactions

The Scheme is governed by the Board of Trustees, the majority of which are elected by the members of the Scheme.

KEY MANAGEMENT PERSONNEL AND THEIR CLOSE FAMILY MEMBERS

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the non-executive Trustees and the Executive Officers of the Scheme. The disclosure deals with full-time Executive Officers who are compensated on a salary basis, and non-executive Trustees who are compensated on a fee basis.

Close family members include close family members of the Trustees and Executive Officers of the Scheme.

PARTIES WITH SIGNIFICANT INFLUENCE OVER THE SCHEME

ADMINISTRATOR

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and wellness programmes. As Discovery Health (Pty) Ltd is a related party, its subsidiaries and fellow subsidiaries within the Discovery Ltd group are related parties to the Scheme. Discovery Ltd's Annual Report provides detail of its group structure.

28. **Related party transactions** continued

TRANSACTIONS WITH RELATED PARTIES

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members which includes Trustees and Executive Officers:

R'000	2022	2021
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	**(18 504)**	(22 395)
Trustee remuneration and consideration (Note 22)	**(10 230)**	(9 433)
Unvested long-term employee benefit	**(5 454)**	(3 789)
Contributions and claims		
Gross contributions received	**1 363**	1 531
Claims paid from the Scheme	**(773)**	(371)
Claims paid from the Personal Medical Savings Account	**(389)**	(395)
Interest paid on Personal Medical Savings Accounts	**(19)**	(38)
Statement of Financial Position transactions		
Long term employee benefit plan asset	**8 314**	7 998
Plan asset	**15 765**	15 269
Plan liability	**(7 451)**	(7 271)
Long-term employee benefit plan asset	**8 314**	7 998
Balance at the beginning of the year	**7 998**	6 427
Additions	**5 770**	5 360
Unvested long-term employee benefit	**(5 454)**	(3 789)
Contribution debtors	**116**	123
Personal Medical Savings Account balances	**(8)**	(133)

28. Related party transactions continued

The terms and conditions of the related party transactions were as follows:

TRANSACTIONS	NATURE OF TRANSACTIONS AND THEIR TERMS AND CONDITIONS
Compensation	This constitutes remuneration and consideration paid to Trustees and Executive Officers, short-term employee benefits and unvested long-term employee benefits.
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates determined by the Scheme from time to time at its discretion. The amounts are all current and would need to be payable on demand as applicable to other members.
Long-term employee benefits	The Restricted Equity Fund (REF) refers to an award of restricted equity instruments in the form of equity shares in companies other than Discovery Limited or its subsidiaries, for the settlement of the obligation that will arise to DHMS on the fulfilment of the requisite vesting conditions by participating employees stipulated in the award letter.

R'000	2022	2021
Transactions with entities that have significant influence over the Scheme		
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid (Note 16)	**(6 010 611)**	(5 554 748)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 10)*	**(503 023)**	(464 858)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 13)	**(2 097 295)**	(1 941 334)
Diabetes management services (Note 13)	**(22 913)**	(19 082)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year-end (Note 10)*	**(177 536)**	(166 266)

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R681 million (2021: R631 million), disclosed in Note 10.*

28. Related party transactions continued

R'000	2022	2021
Transactions between Discovery Health (Pty) Ltd's subsidiaries and the Scheme are provided below		
Discovery Third Party Recovery Services (Pty) Ltd – Third party collection services		
Statement of Comprehensive Income transactions		
Third party collection fees (Note 17)	**(19 317)**	(25 289)
Statement of Financial Position transactions		
Balance due to the Scheme at year-end (Note 4)	**25 164**	13 044
Southern RX Distributors (Pty) Ltd – Specialist pharmaceutical services		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(432 163)**	(401 848)
Statement of Financial Position transactions		
Claims due to provider	**(6 112)**	(1 613)
Grove Nursing Services (Pty) Ltd – Home-based nursing services		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(36 707)**	(41 874)
COVID-19 management services (Note 17)	**(6 074)**	(25 756)
Statement of Financial Position transactions		
Balance due to provider	**(471)**	(2 173)
Medical Services Organisation International (Pty) Ltd – International travel services		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(94 319)**	(55 176)
Statement of Financial Position transactions		
Balance due to provider	**(236)**	(317)
Discovery Life Ltd – Broker services fees		
Statement of Financial Position transactions		
Balance (due to)/from Discovery Life Ltd at year-end (Note 10) (Note 4)	**(71)**	14
Discovery Connect Distribution Services (Pty) Ltd – Broker services fees		
Statement of Comprehensive Income transactions		
Broker fees paid	**(121 412)**	(92 914)
Statement of Financial Position transactions		
Balance due to Discovery Connect Distribution Services (Pty) Ltd at year-end	**(162)**	(1 127)
Discovery Central Services (Pty) Ltd – Contractual lease payments		
Statement of Comprehensive Income transactions		
Contractual lease and non-lease payments	**(6 772)**	(6 327)
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note10)	**(181)**	(101)
Discovery Bank Ltd – Negotiable certificates of deposits		
Statement of Financial Position transactions		
Negotiable Certificates of Deposits	**23 601**	133 964
Discovery Ltd – Floating rate notes		
Statement of Financial Position transactions		
Floating Rate Notes	**69 696**	101 592

28. Related party transactions continued

The terms and conditions of the transactions with entities with significant influence over the Scheme were as follows:

ADMINISTRATION AGREEMENT

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Trustees. The agreement is for a five-year period effective from 1 January 2018. The Scheme and the Administrator shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The administration fees are an all-inclusive fee, calculated on a per member per month basis. The total expense for administration cost changes in line with membership growth and inflation.

The main categories of service provided can be broken down as follows:

- Actuarial services
- Accredited administration services
- Distribution services
- Forensic investigation and recoveries
- Governance compliance and human resources
- Internal audit services
- Marketing and stakeholder relations services

MANAGED HEALTHCARE AGREEMENT

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

The Scheme has contracted with the administrator to provide accredited managed healthcare services (no risk transfer). These services include bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis.

This agreement is in accordance with instructions given by the Trustees. The agreement is for a five-year period and effective from 1 January 2018. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

The agreements in place between the Scheme and Discovery Health (Pty) Ltd for administration and managed healthcare services were renewed for a period of five years, commencing on 1 January 2023, following an extensive assessment of the services provided by Discovery Health (Pty) Ltd.

THIRD-PARTY COLLECTION SERVICES

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third-party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2022 to 31 December 2022 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R19 million (2021: R14 million).

SPECIALIST PHARMACEUTICAL SERVICES

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide specialist pharmaceutical and screening to members of the Scheme.

HOME-BASED NURSING SERVICES

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based care to members of the Scheme in the comfort of their home.

Discovery HomeCare further provides a Hospital at Home programme which gives members the choice of treatment in the comfort of their home for various illnesses.

28. Related party transactions continued

BROKER SERVICE FEES

The Scheme contracted with Discovery Connect Distribution Services (Pty) Ltd, a wholly owned subsidiary of Discovery Ltd, to provide broker services directly to the consumer. The amounts were determined and paid based on the terms and conditions applicable to other brokers.

Discovery Life Limited, a wholly owned subsidiary of Discovery Ltd, provides broker services to consumers who holds policies in the name of Discovery Life Limited, as well as those with Discovery Health Medical Scheme. The amounts were determined and payable based on the signed instruction by the broker to offset the fees between the two entities.

CONTRACTUAL LEASE PAYMENTS

The Scheme has contracted with Discovery Central Services (Pty) Ltd, a wholly owned subsidiary of Discovery Ltd, to lease land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of five years. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred.

INTERNATIONAL TRAVEL SERVICES AGREEMENT

The Scheme contracted with Medical Services Organisation International (Pty) Ltd, a subsidiary of Discovery Health (Pty) Ltd, to deliver the following benefit offered by Discovery Health Medical Scheme to its members who are working or travelling outside the borders of the Republic of South Africa (RSA):

- **The International Travel Benefit**

  Members are covered for emergency medical assistance outside of the RSA for a period of 90 (ninety) days from date of departure from the RSA. This cover includes in-hospital treatment, repatriation and out-of-hospital treatment above a US$150 or €100 (One Hundred and Fifty US Dollars or One Hundred Euros) excess payment by the Member. This benefit is available to all members, except members on KeyCare plans.

- **The Africa Evacuation Benefit**

  Members are covered for emergency medical assistance with or without evacuation to the Republic of South Africa and pre-authorised in-hospital elective procedures at the South African Rand equivalent in accordance with their respective health plans. Cover commences on the Member's date of departure from the RSA and continues for an unlimited period in those specified African countries. This benefit is available to all members, except members on KeyCare plans.

This agreement is in accordance with instructions given by the Trustees. The agreement is effective from 1 October 2020. The Scheme and Medical Services Organisation International (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 90 days written notice.

NEGOTIABLE CERTIFICATES OF DEPOSITS AND FLOATING RATE NOTES

As part of the Scheme's investment policy and investment diversification strategy the Board of Trustees approved a Strategic Asset Allocation. The Scheme implements the investment strategy by appointing independent asset managers to manage the respective portfolios through discretionary mandates with no influence by the Scheme and its officers over the selection of underlying instruments in the respective portfolios.

The Scheme's cash and bond asset managers have included negotiable certificates of deposits issued by Discovery Bank Ltd and floating rate notes issued by Discovery Ltd in certain fixed income portfolios.

29. Surplus/(deficit) from operations per benefit plan

2022	Executive	Classic Comp	Classic Smart Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**906 628**	**9 799 720**	**43 568**	**2 494 396**	**16 624 946**	**4 693 515**	**971 489**	**6 771 873**	**2 171 297**
Net claims incurred	(1 163 341)	(10 508 282)	(24 990)	(2 183 493)	(13 980 671)	(4 303 664)	(1 011 139)	(4 826 840)	(1 737 788)
Risk claims incurred	(1 166 143)	(10 534 498)	(25 053)	(2 188 366)	(14 012 192)	(4 313 620)	(1 013 635)	(4 838 013)	(1 741 923)
Third-party claim recoveries	2 802	26 216	63	4 873	31 521	9 956	2 496	11 173	4 135
Accredited managed healthcare services (no risk transfer)	(12 272)	(165 580)	(751)	(71 686)	(506 333)	(114 471)	(19 120)	(250 098)	(78 555)
Net income/(expense) on risk transfer arrangements	(246)	(3 311)	(2)	740	(1 038)	(552)	(292)	(1 271)	(119)
Risk transfer arrangement fees paid	(1 919)	(29 254)	(89)	(3 223)	(22 818)	(8 371)	(2 583)	(7 572)	(2 954)
Recoveries from risk transfer arrangements	1 673	25 943	87	3 963	21 780	7 819	2 291	6 301	2 835
Relevant healthcare expenditure	**(1 175 859)**	**(10 677 173)**	**(25 743)**	**(2 254 439)**	**(14 488 042)**	**(4 418 687)**	**(1 030 551)**	**(5 078 209)**	**(1 816 462)**
Gross healthcare result	**(269 231)**	**(877 453)**	**17 825**	**239 957**	**2 136 904**	**274 828**	**(59 062)**	**1 693 664**	**354 835**
Broker service fees	(10 519)	(143 111)	(616)	(54 846)	(439 042)	(101 093)	(16 782)	(194 096)	(56 650)
Expenses for administration	(36 932)	(495 773)	(2 273)	(220 909)	(1 559 937)	(350 462)	(57 781)	(773 125)	(242 417)
Other operating expenses	(1 158)	(15 814)	(72)	(6 939)	(50 035)	(11 168)	(1 904)	(24 915)	(7 630)
Net impairment losses on healthcare receivables	(613)	(8 229)	(38)	(3 666)	(25 812)	(5 814)	(959)	(12 762)	(4 019)
NET HEALTHCARE RESULT	**(318 453)**	**(1 540 380)**	**14 826**	**(46 403)**	**62 078**	**(193 709)**	**(136 488)**	**688 766**	**44 119**
Investment income	12 546	168 430	773	75 100	530 158	119 109	19 631	262 874	82 443
Net gains/(losses) on financial instruments	(3)	(792)	(5)	(472)	1 634	(1 029)	(92)	3 276	211
Sundry income	175	2 347	11	1 048	7 425	1 659	274	3 698	1 155
Other income	**12 718**	**169 985**	**779**	**75 676**	**539 217**	**119 739**	**19 813**	**269 848**	**83 809**
Asset management fees	(582)	(7 804)	(36)	(3 481)	(24 609)	(5 518)	(910)	(12 226)	(3 828)
Interest paid	(7)	(99)	–	(43)	(302)	(68)	(11)	(149)	(47)
Interest paid on savings accounts	(3 236)	(43 438)	–	–	(136 695)	(30 707)	(5 063)	(67 756)	–
Other expenditure	**(3 825)**	**(51 341)**	**(36)**	**(3 524)**	**(161 606)**	**(36 293)**	**(5 984)**	**(80 131)**	**(3 875)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**(309 560)**	**(1 421 736)**	**15 569**	**25 749**	**439 689**	**(110 263)**	**(122 659)**	**878 483**	**124 053**

29. Surplus/(deficit) from operations per benefit plan continued

2022	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Smart	Essential Smart	TOTAL
Risk contribution income	**289 029**	**7 848 619**	**3 295 867**	**5 789 569**	**376 748**	**106 442**	**2 416 201**	**1 031 020**	**65 630 927**
Net claims incurred	(192 650)	(7 053 075)	(3 096 293)	(6 052 861)	(317 256)	(55 824)	(1 829 816)	(583 683)	(58 921 666)
Risk claims incurred	(193 025)	(7 069 073)	(3 103 565)	(6 067 334)	(318 094)	(55 971)	(1 834 219)	(585 242)	(59 059 966)
Third-party claim recoveries	375	15 998	7 272	14 473	838	147	4 403	1 559	138 300
Accredited managed healthcare services (no risk transfer)	(7 873)	(263 209)	(110 935)	(318 804)	(24 865)	(9 078)	(92 565)	(74 013)	(2 120 208)
Net income/(expense) on risk transfer arrangements	(18)	(128)	(121)	74 423	–	2 141	(46)	11	70 171
Risk transfer arrangement fees paid	(355)	(13 229)	(5 395)	(207 503)	–	(4 340)	(1 933)	(683)	(312 221)
Recoveries from risk transfer arrangements	337	13 101	5 274	281 926	–	6 481	1 887	694	382 392
Relevant healthcare expenditure	**(200 541)**	**(7 316 412)**	**(3 207 349)**	**(6 297 242)**	**(342 121)**	**(62 761)**	**(1 922 427)**	**(657 685)**	**(60 971 703)**
Gross healthcare result	**88 488**	**532 207**	**88 518**	**(507 673)**	**34 627**	**43 681**	**493 774**	**373 335**	**4 659 224**
Broker service fees	(6 822)	(218 625)	(83 411)	(174 930)	(11 598)	(3 392)	(64 733)	(32 189)	(1 612 455)
Expenses for administration	(24 262)	(809 491)	(341 339)	(541 184)	(22 652)	(15 410)	(286 761)	(229 903)	(6 010 611)
Other operating expenses	(774)	(25 720)	(10 691)	(31 848)	(2 470)	(913)	(9 152)	(7 424)	(208 627)
Net impairment losses on healthcare receivables	(402)	(13 407)	(5 666)	(16 546)	(1 292)	(470)	(4 733)	(3 787)	(108 215)
NET HEALTHCARE RESULT	**56 228**	**(535 036)**	**(352 589)**	**(1 272 181)**	**(3 385)**	**23 496**	**128 395**	**100 032**	**(3 280 684)**
Investment income	8 249	275 122	116 036	339 575	26 506	9 685	97 488	78 262	2 221 987
Net gains/(losses) on financial instruments	(67)	(855)	(1 021)	(99)	(97)	113	1 296	1 119	3 117
Sundry income	115	3 843	1 617	4 750	370	136	1 372	1 103	31 098
Other income	**8 297**	**278 110**	**116 632**	**344 226**	**26 779**	**9 934**	**100 156**	**80 484**	**2 256 202**
Asset management fees	(382)	(12 759)	(5 376)	(15 758)	(1 230)	(451)	(4 534)	(3 646)	(103 130)
Interest paid	(5)	(157)	(66)	(193)	(15)	(5)	(55)	(44)	(1 266)
Interest paid on savings accounts	(2 126)	(70 931)	–	–	–	–	–	–	(359 952)
Other expenditure	**(2 513)**	**(83 847)**	**(5 442)**	**(15 951)**	**(1 245)**	**(456)**	**(4 589)**	**(3 690)**	**(464 348)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**62 012**	**(340 773)**	**(241 399)**	**(943 906)**	**22 149**	**32 974**	**223 962**	**176 826**	**(1 488 830)**

29. Surplus/(deficit) from operations per benefit plan continued

2021	Executive	Classic Comp	Classic Smart Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**907 510**	**9 860 527**	**40 946**	**2 452 506**	**15 477 187**	**4 685 786**	**960 787**	**6 003 771**	**2 024 618**
Net claims incurred	(1 066 031)	(10 015 807)	(23 084)	(1 977 562)	(12 805 099)	(4 230 624)	(897 653)	(4 220 987)	(1 563 043)
Risk claims incurred	(1 067 200)	(10 028 838)	(23 130)	(1 980 038)	(12 819 985)	(4 235 929)	(898 795)	(4 226 260)	(1 565 027)
Third-party claim recoveries	1 169	13 031	46	2 476	14 886	5 305	1 142	5 273	1 984
Accredited managed healthcare services (no risk transfer)	(12 000)	(163 035)	(668)	(68 935)	(461 339)	(112 053)	(18 459)	(216 403)	(71 885)
Net income/(expense) on risk transfer arrangements	47	972	2	302	1 625	539	102	391	189
Risk transfer arrangement fees paid	(1 712)	(23 907)	(93)	(2 118)	(14 635)	(5 749)	(2 058)	(4 205)	(1 736)
Recoveries from risk transfer arrangements	1 759	24 879	95	2 420	16 260	6 288	2 160	4 596	1 925
Relevant healthcare expenditure	**(1 077 984)**	**(10 177 870)**	**(23 750)**	**(2 046 195)**	**(13 264 813)**	**(4 342 138)**	**(916 010)**	**(4 436 999)**	**(1 634 739)**
Gross healthcare result	**(170 474)**	**(317 343)**	**17 196**	**406 311**	**2 212 374**	**343 648**	**44 777**	**1 566 772**	**389 879**
Broker service fees	(9 855)	(136 507)	(548)	(50 308)	(386 336)	(96 160)	(15 770)	(161 843)	(48 957)
Expenses for administration	(36 127)	(487 971)	(2 014)	(212 811)	(1 423 474)	(343 855)	(55 729)	(670 059)	(222 280)
Other operating expenses	(1 253)	(17 968)	(75)	(7 366)	(53 963)	(12 567)	(2 310)	(26 128)	(7 790)
Net impairment losses on healthcare receivables	(808)	(10 887)	(45)	(4 758)	(31 856)	(7 679)	(1 246)	(15 069)	(4 988)
NET HEALTHCARE RESULT	**(218 517)**	**(970 676)**	**14 514**	**131 068**	**316 745**	**(116 613)**	**(30 278)**	**693 673**	**105 864**
Investment income	10 559	142 771	588	62 257	416 790	100 592	16 311	196 446	65 061
Net gains/(losses) on financial instruments	11 013	147 850	615	64 578	432 148	104 245	16 898	203 993	67 666
Sundry income	170	2 287	10	1 002	6 725	1 614	262	3 204	1 057
Other income	**21 742**	**292 908**	**1 213**	**127 837**	**855 663**	**206 451**	**33 471**	**403 643**	**133 784**
Asset management fees	(555)	(7 485)	(31)	(3 272)	(21 918)	(5 280)	(857)	(10 367)	(3 430)
Interest paid	(7)	(101)	–	(44)	(292)	(71)	(11)	(137)	(46)
Interest paid on savings accounts	(3 169)	(42 794)	–	–	(124 904)	(30 160)	(4 889)	(58 836)	–
Other expenditure	**(3 731)**	**(50 380)**	**(31)**	**(3 316)**	**(147 114)**	**(35 511)**	**(5 757)**	**(69 340)**	**(3 476)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**(200 506)**	**(728 148)**	**15 697**	**255 589**	**1 025 294**	**54 327**	**(2 564)**	**1 027 976**	**236 172**

29. Surplus/(deficit) from operations per benefit plan continued

2021	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Smart	Essential Smart	TOTAL
Risk contribution income	**280 455**	**7 616 121**	**3 265 278**	**5 558 879**	**357 212**	**98 515**	**2 019 763**	**849 436**	**62 459 297**
Net claims incurred	(199 384)	(6 599 167)	(2 891 647)	(5 520 497)	(285 216)	(58 847)	(1 537 765)	(507 467)	(54 399 878)
Risk claims incurred	(199 614)	(6 607 260)	(2 895 174)	(5 527 534)	(285 602)	(58 925)	(1 539 792)	(508 237)	(54 467 338)
Third-party claim recoveries	230	8 093	3 527	7 037	386	78	2 027	770	67 460
Accredited managed healthcare services (no risk transfer)	(7 403)	(249 898)	(108 109)	(301 916)	(23 287)	(8 382)	(76 502)	(60 142)	(1 960 416)
Net income/(expense) on risk transfer arrangements	25	1 243	476	80 373	1	2 726	157	50	89 220
Risk transfer arrangement fees paid	(265)	(6 913)	(2 857)	(200 077)	1	(4 071)	(1 061)	(357)	(271 813)
Recoveries from risk transfer arrangements	290	8 156	3 333	280 450	–	6 797	1 218	407	361 033
Relevant healthcare expenditure	**(206 762)**	**(6 847 822)**	**(2 999 280)**	**(5 742 040)**	**(308 502)**	**(64 503)**	**(1 614 110)**	**(567 559)**	**(56 271 074)**
Gross healthcare result	**73 693**	**768 299**	**265 998**	**(183 161)**	**48 710**	**34 012**	**405 653**	**281 877**	**6 188 223**
Broker service fees	(6 225)	(201 608)	(77 752)	(158 460)	(10 219)	(2 927)	(50 632)	(24 809)	(1 438 916)
Expenses for administration	(22 816)	(771 434)	(333 887)	(512 636)	(21 220)	(14 233)	(237 244)	(186 958)	(5 554 748)
Other operating expenses	(834)	(28 007)	(11 417)	(35 042)	(2 629)	(1 015)	(8 944)	(7 369)	(224 677)
Net impairment losses on healthcare receivables	(511)	(17 249)	(7 461)	(21 172)	(1 640)	(590)	(5 338)	(4 227)	(135 524)
NET HEALTHCARE RESULT	**43 307**	**(249 999)**	**(164 519)**	**(910 471)**	**13 002**	**15 247**	**103 495**	**58 514**	**(1 165 642)**
Investment income	6 678	225 799	97 652	276 726	21 350	7 673	69 561	54 795	1 771 609
Net gains/(losses) on financial instruments	6 934	234 027	101 274	287 438	22 200	8 015	72 385	57 274	1 838 553
Sundry income	108	3 635	1 569	4 467	348	125	1 137	906	28 626
Other income	**13 720**	**463 461**	**200 495**	**568 631**	**43 898**	**15 813**	**143 083**	**112 975**	**3 638 788**
Asset management fees	(351)	(11 865)	(5 129)	(14 559)	(1 128)	(405)	(3 675)	(2 906)	(93 213)
Interest paid	(5)	(158)	(69)	(194)	(15)	(5)	(49)	(38)	(1 242)
Interest paid on savings accounts	(2 002)	(67 679)	–	–	–	–	–	–	(334 433)
Other expenditure	**(2 358)**	**(79 702)**	**(5 198)**	**(14 753)**	**(1 143)**	**(410)**	**(3 724)**	**(2 944)**	**(428 888)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**54 669**	**133 760**	**30 778**	**(356 593)**	**55 757**	**30 650**	**242 854**	**168 545**	**2 044 258**

30. Reconciliation of movements in the statement of cash flows

R'000	2022	2021
Cash received from members – contributions	**79 514 258**	75 876 638
Gross contribution income	**79 542 906**	75 816 287
Transfers received from other medical schemes	**39 561**	30 778
Movement in contribution receivable	**(274 762)**	(148 395)
Movement in provision of contributions that are not recoverable	**6 472**	(9 303)
Transfer of accounts receivable due to amalgamation	**–**	8 705
Transfers received due to amalgamation	**–**	(1 266)
Contributions received in advance	**193 801**	179 707
Contribution refunds due to employers	**6 280**	218
COVID-19 Support: Contributions funded from PMSA	**–**	(93)
Cash received from members and providers – other	**9 300**	3 726
Movement in sundry accounts receivable	**9 300**	3 726
Cash paid to providers and members – claims	**(74 927 970)**	(68 679 150)
Relevant healthcare expenditure	**(60 971 703)**	(56 271 073)
Claims charged to members' Personal Medical Savings Accounts	**(13 592 080)**	(12 823 099)
Movement in outstanding claims	**(412 688)**	488 046
Movement in member and service provider claims	**(12 627)**	679
Movement in provision of members' and service providers' portions that are not recoverable	**(101 939)**	(111 873)
Receivables written off directly to the Statement of Comprehensive Income	**(13 608)**	(10 283)
Movement in risk transfer arrangements	**(1 118)**	2 323
Movement in other insurance receivables	**35 469**	(22 045)
Movement in third party receivables	**(12 106)**	630
Movement in forensic receivables	**16 198**	59 093
Movement in provision of forensic debtors that are not recoverable	**(1 848)**	(1 048)
Transfer of outstanding claims due to amalgamation	**–**	(5 767)
Movement in reported claims not yet paid	**140 080**	15 267
Cash paid to providers and employees – non-healthcare expenditure	**(7 915 944)**	(7 438 509)
Broker service fees	**(1 612 455)**	(1 438 916)
Movement in broker fees	**93**	(216)
Movement in provision of amounts due by brokers that are not recoverable	**2 708**	(3 017)
Expenses for administration	**(6 010 611)**	(5 554 748)
Other operating expenses	**(208 627)**	(224 677)
Depreciation	**1 486**	1 486
Unvested long-term employee benefit	**5 453**	3 790
Sundry income	**31 101**	28 625
Movement in accounts payable	**215 069**	(51 466)
Transfer of accounts payable due to amalgamation	**–**	(4 178)
Contributions received in advance	**(193 801)**	(179 707)
Contribution refunds due to employers	**(6 280)**	(218)
Movement in reported claims not yet paid	**(140 080)**	(15 267)
Purchases of financial assets	**(7 774 847)**	(8 738 440)
Financial assets at fair value through profit or loss (Note 3)	**(7 930 674)**	(8 841 598)
Capitalised interest	**155 827**	103 158
Proceeds from sale of financial assets	**9 410 317**	7 735 859
Financial assets at fair value through profit or loss (Note 3)	**9 410 317**	7 582 315
Derivative financial instruments (Note 8)	**–**	153 544
Interest received	**1 588 234**	1 345 399
Interest income (Note 23)	**1 748 669**	1 448 795
Movement in interest receivable	**(4 608)**	(238)
Capitalised interest	**(155 827)**	(103 158)

30. Reconciliation of movements in the statement of cash flows continued

During the preparation of the current year financial statements, various misallocations were identified relating to prior year cash movements which were incorrectly classified between various line items in the statement of cash flows. These errors have been corrected retrospectively and the affected individual line items presented in the table below:

R'000	2021 Previously presented	Adjustment	2021 Restated
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers*	**75 929 680**	**(49 316)**	**75 880 364**
Cash received from members – contributions*	75 929 680	(53 042)	75 876 638
Cash received from members and providers – other*		3 726	3 726
Cash paid to providers, employees and members*	**(76 660 618)**	**49 550**	**(76 611 068)**
Cash paid to providers and members – claims*	(68 596 626)	(82 524)	(68 679 150)
Cash paid to providers and employees – non-healthcare expenditure*	(7 570 583)	132 074	(7 438 509)
Cash paid to members – savings plan refunds	(493 409)	–	(493 409)
CASH USED IN OPERATIONS*	**(730 938)**	**234**	**(730 704)**
Purchase of financial assets	(8 738 440)	–	(8 738 440)
Proceeds from disposal of financial assets	7 735 859	–	7 735 859
Increase in long-term employee plan asset	(5 360)	–	(5 360)
Interest received*	1 345 637	(238)	1 345 399
Dividend income	322 814	–	322 814
Interest paid	(4)	–	(4)
Asset manager fees paid*	(93 217)	4	(93 213)
NET CASH OUTFLOW FROM OPERATING ACTIVITIES	**(163 649)**	**–**	**(163 649)**

31. Events after the reporting period

During 2022, the CMS initiated a routine inspection of DHMS in terms of Section 44 (4) (b) of the Act. On 4 April 2023, the CMS issued a draft report to the Scheme. The Scheme is in the process of responding to the draft report and at the date of reporting this process had not been finalised.

No other significant events occurred between the reporting date and the date the financial statements were authorised for issue.

32. Amalgamations

ACCOUNTING POLICY:

Scheme amalgamations are accounted for by applying the acquisition method.

The cost of an amalgamation is measured as the fair value of the assets transferred and liabilities incurred or assumed at the date of exchange.

When an entity is amalgamated into the Scheme, all identifiable assets, liabilities and members' funds are accounted for at their fair values at the acquisition date. No consideration is paid for these transactions, and they are recognised as from the transaction date, being the date confirmed by the Registrar of the CMS.

The Scheme recognises the net assets from amalgamated schemes as a direct addition to reserves in its Statement of Financial Position.

Section 63 (14) of the Act prescribes those relevant assets and liabilities of the party effecting the transfer shall vest in and become binding upon the party to which transfer is effected.

No goodwill is recognised on the amalgamation of schemes.

32. **Amalgamations** continued

QUANTUM MEDICAL AID SOCIETY

An amalgamation between the Scheme and Quantum Medical Aid Society (QMAS) was confirmed and effective from 1 August 2021. The disclosures provided below have been provided to enable users to evaluate the nature and financial effect of the amalgamation.

QMAS was a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme was open to all current and retired employees of Bidvest Group Limited and Sun International Group Limited, or any associated company. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Act, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and QMAS voted that the amalgamation of QMAS with the Scheme would be in the best interest of the QMAS members.

The Scheme obtained control of QMAS by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 2 886 principal members and 5 753 beneficiaries joined the Scheme.

No goodwill is recognised as a result of this transaction.

The acquisition date fair value of the QMAS members interest transferred, and the acquisition date fair value of each major class of assets and liabilities was:

R'000	2022	2021
Quantum Medical Aid Society		
Reserves effectively transferred:	–	160 456
(Acquisition date fair value of QMAS members' interest)		
Net recognised values of QMAS identifiable assets and liabilities:	–	160 456
Current assets	–	181 587
Financial assets at fair value through profit or loss	–	166 850
Cash and cash equivalents	–	5 987
Member and service provider claims receivables	–	2 506
Provision for impairment	–	(1 985)
Interest receivable	–	19
Other accounts receivable	–	8 190
Current liabilities	–	(21 111)
Outstanding claims provision	–	(5 767)
Reported claims not yet paid	–	(2 686)
Members' savings account trust liability	–	(11 165)
Unallocated funds	–	(11)
Discovery Health (Pty) Ltd	–	(1 051)
General accruals	–	(431)
Movement subsequent to amalgamation	–	(1 344)
CLOSING BALANCE	–	**159 112**

32. **Amalgamations** continued

As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below.

R'000	2022	2021
Fair value of receivables acquired:	–	8 730
Insurance receivables	–	8 711
Members claim debtors	–	116
Service provider claim debtors	–	2 390
Other accounts receivable	–	8 190
Provision for impairment	–	(1 985)
Loans and receivables	–	19
Interest receivable	–	19
Gross contractual amounts receivable:	–	10 715
Insurance receivables	–	10 696
Member claim debtors	–	116
Service provider claim debtors	–	2 390
Other accounts receivable	–	8 190
Loans and receivables	–	19
Interest receivable	–	19
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	–	(1 985)
Member claim debtors	–	(61)
Service provider claim debtors	–	(1 924)

The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.

R'000	2022	2021
Current assets	–	181 567
Financial assets at fair value through profit or loss	–	166 850
Cash and cash equivalents	–	5 987
Member claim debtors	–	55
Service provider claim debtors	–	466
Interest receivable	–	19
Other accounts receivable	–	8 190
Current liabilities	–	(21 111)
Outstanding claims provision	–	(5 767)
Reported claims not yet paid	–	(2 686)
Contribution in advance	–	(11 165)
Unallocated funds	–	(11)
Discovery Health (Pty) Ltd	–	(1 051)
General accruals	–	(431)
	–	**160 456**

33. Insurance risk management report

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and the requirements of legislation.

This section summarises these risks and the way in which they are managed.

INSURANCE RISK

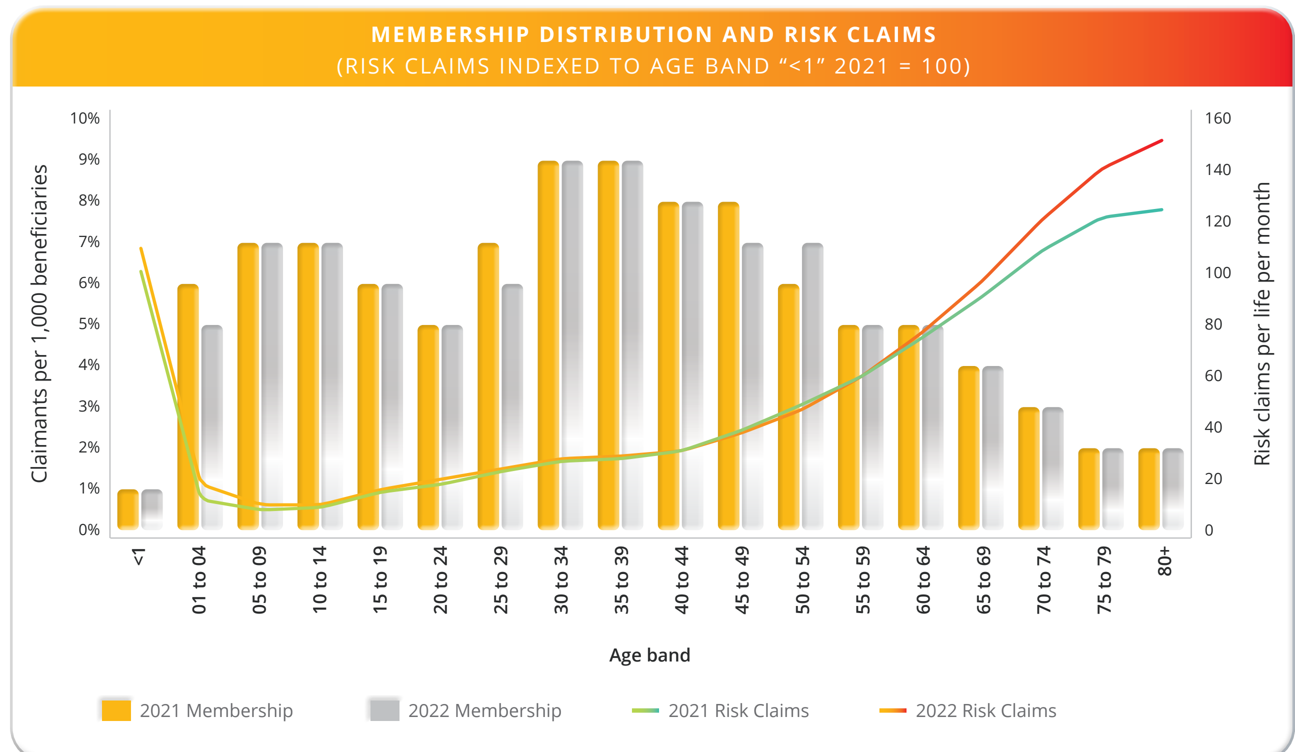
The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and/or severity of claims are greater than estimated.

A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier induced demand and the cost of new technologies or drugs.

As the following graph illustrates, claims are expected to increase with age. In the absence of mandatory membership and a continuous inflow of young, healthy lives, the average age of lives covered by the medical scheme is expected to increase year-on-year. The increases expected from demographic changes are allowed for in the annual benefit and contribution reviews, but if this differs from the expected it may result in higher than expected inflationary increases in claims.

The following graph indicates the distribution of beneficiaries by age band for 2021 and 2022, as well as the risk claims paid. The risk claims are indexed to a value of 100 for the "<1" age band in 2021. There has been an increase in the proportion of beneficiaries older than 40 over the past year.



The risks that the Scheme faces can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

33. Insurance risk management report continued

INSURANCE RISK continued

HOSPITAL BENEFITS

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional fees, medication, equipment and consumables.

DAY-TO-DAY BENEFITS

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the PMSA and an insurance risk element. This includes the Day-to-day Extender Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits.

CHRONIC BENEFITS

The Chronic Illness Benefit covers approved medication and treatment for up to 50 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

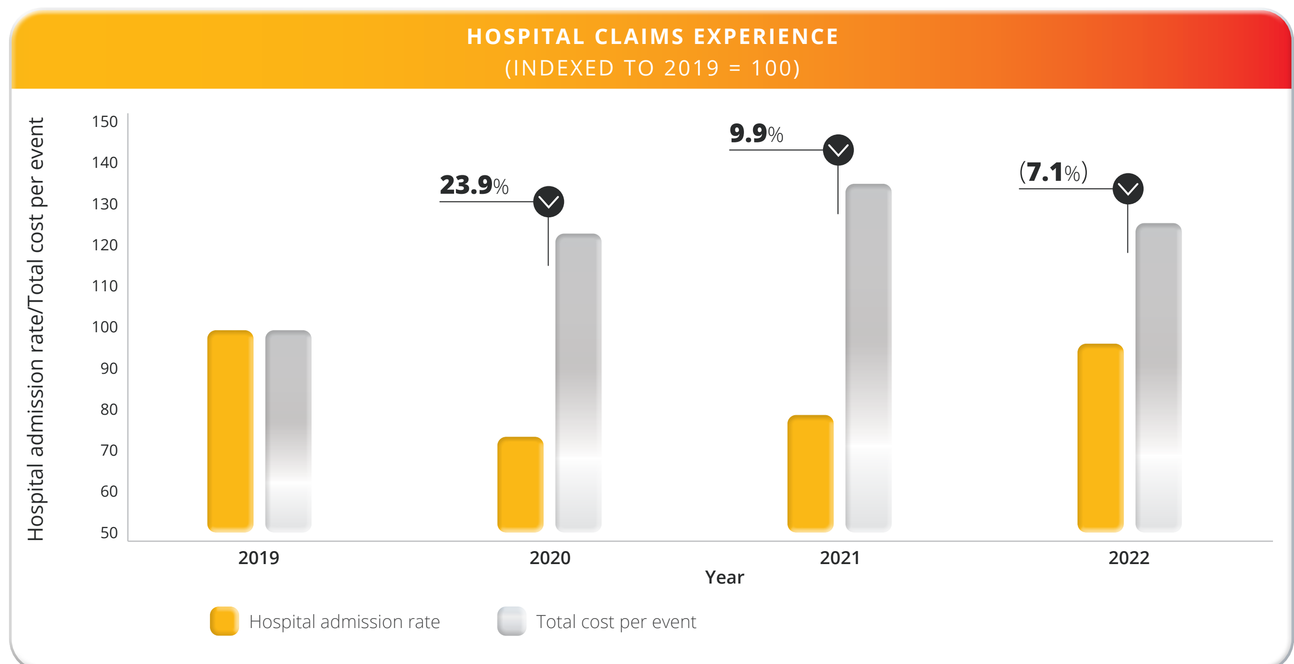
The risks associated to the Scheme with the types of benefits offered to members are addressed below.

HOSPITAL BENEFIT RISK

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims results in an increase in the cost of claims.

An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The following graph indicates the change in the admission rate over the past four years as well as the impact on the costs per event (which have not been case-mix adjusted). This graph is indexed to a value of 100 as at 2019.



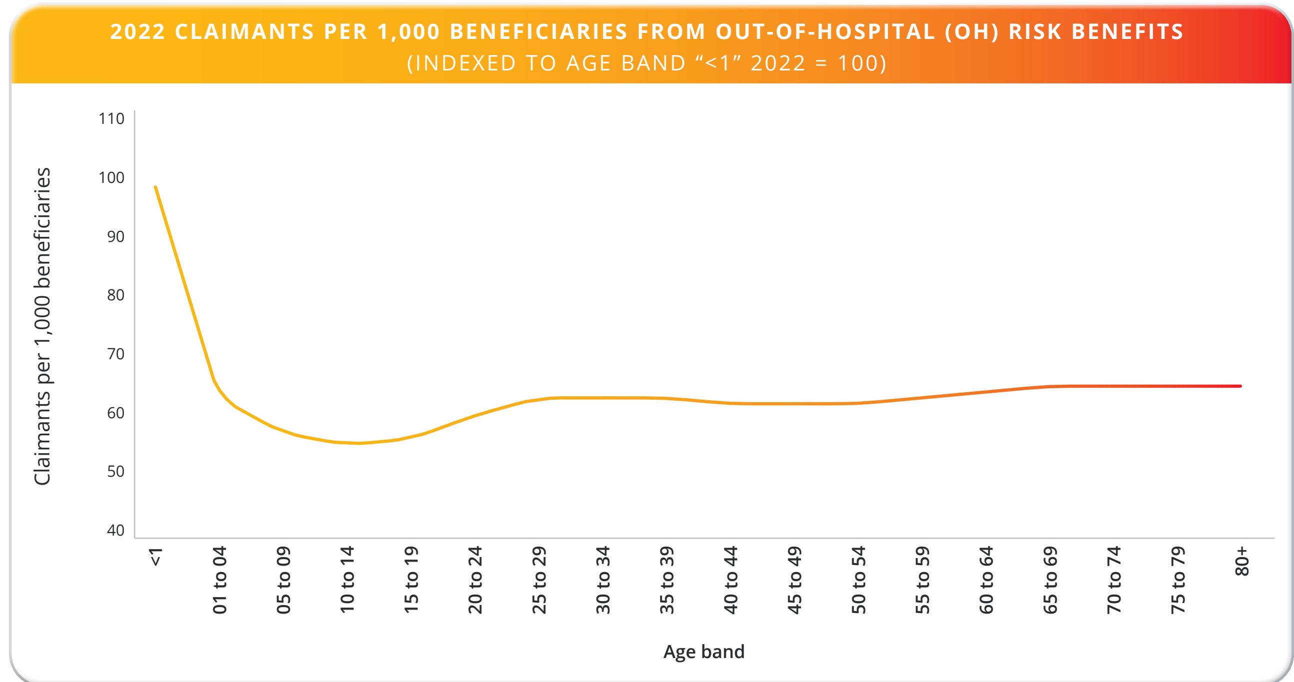
The number of hospital admissions reduced significantly from April 2020. This was due to the 5-stage lockdown imposed by the South African Government in response to the COVID-19 pandemic. This meant that there were minimal elective procedures, and only emergency and high-risk cases were admitted. The number of admissions has increased from 2020 to 2022 but were on average in 2022 still at a slightly lower level than in 2019. Given that the type of admissions that did occur in 2020 were higher-risk and more complex, the cost per event (CPE) increased significantly from 2019 to 2020 and continued to increase in 2021. This is largely due to the impact of COVID-19. COVID-19 did not have such a significant impact on 2022 as depicted in the graph above with the admission rate increasing further in 2022 while the total cost per event decreased. The decrease in cost per event in 2022 is mainly due to the increase in the number of lower-cost admissions, indicating to some extent a reversion to the pre-COVID-19 experience.

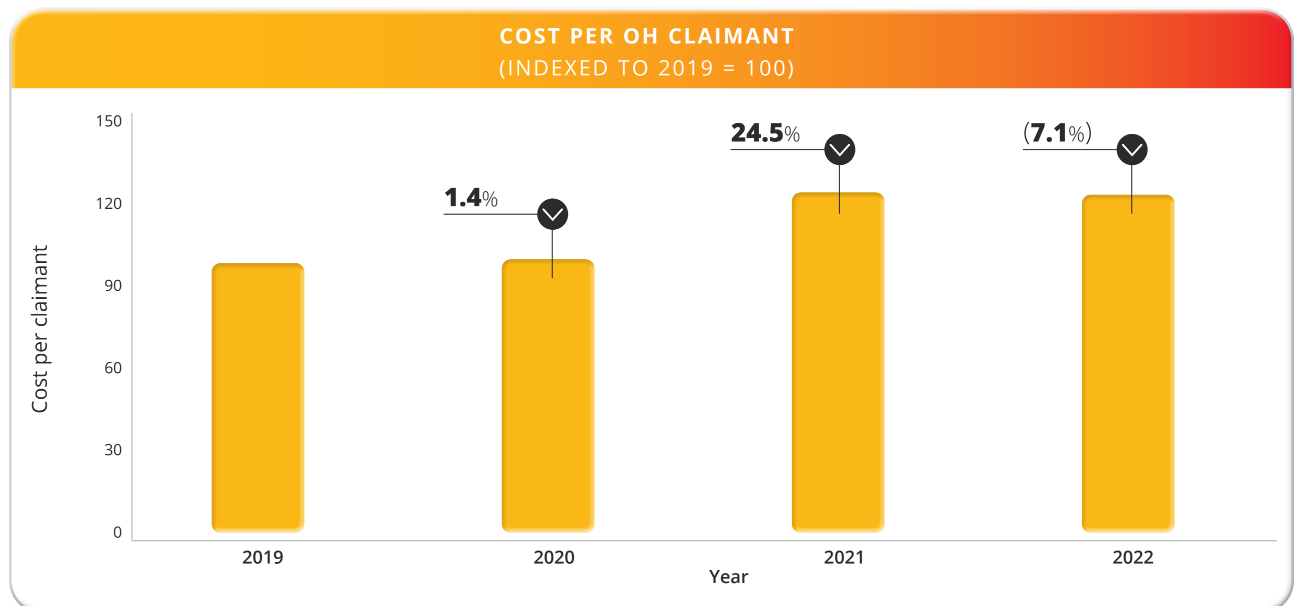
33. Insurance risk management report continued

INSURANCE RISK continued

DAY-TO-DAY BENEFITS RISK

The frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options, as well as an increase in the number of claims categorised as prescribed minimum benefit claims, will also have an impact on the claims. The frequency of the ATB claims increases throughout the year as an increased number of members run out of their medical savings.





The out-of-hospital (OH) benefits for 2020 did not increase by as much as expected. This was largely due to the Government imposed lockdowns limiting access to healthcare services from April 2020. There was however a significant increase in pathology spend due to claims paid for polymerase chain reaction (PCR) testing, which is the means used to identify positive COVID-19 cases. These PCR test costs offset some of the reduction seen in other OH claim categories for 2020.

There was a significant increase in OH claims from 2020 to 2021. Additional COVID-related costs such as COVID-19 vaccinations have contributed to these higher OH costs, together with less stringent lockdown restrictions and contributed to the higher cost per claimant in 2021 compared to 2020. The high OH claims continued in 2022 with OH claims only decreasing slightly from 2021 to 2022. The 2022 cost per claimant is in line with expected inflationary increases from pre-COVID levels in 2019.

33. **Insurance risk management report** continued

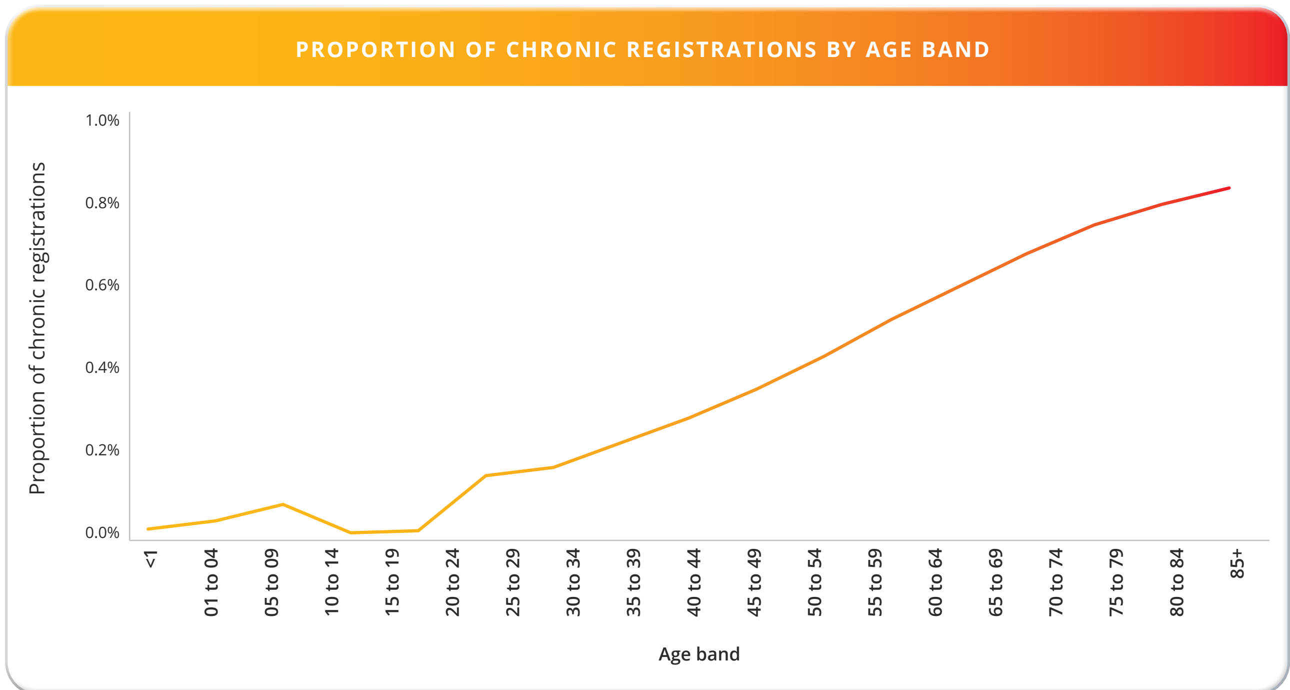
INSURANCE RISK continued

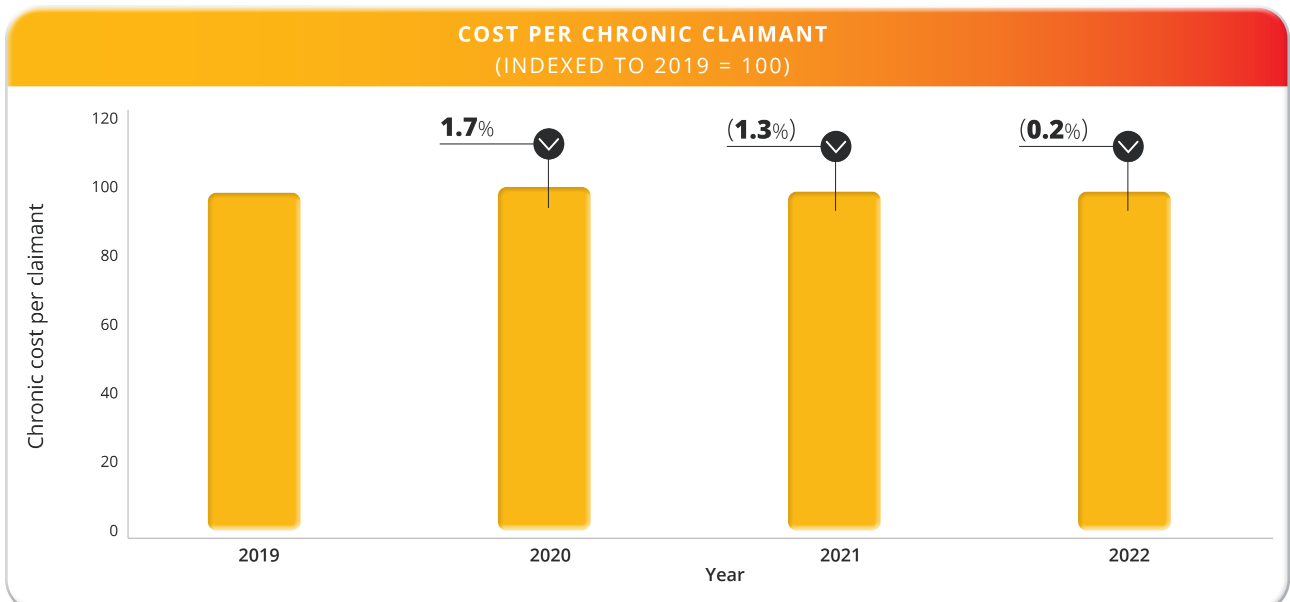
CHRONIC BENEFITS RISK

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and the presence of multiple chronic conditions per person will have an impact on the severity of the claims.

The following graphs indicate the percentage of chronic registrations by age band for 2022, as well as the change in the cost per claimant over the past four years. The cost per claimant graph is indexed to a value of 100 as at 2019.





33. **Insurance risk management report** continued

RISK MANAGEMENT

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include:

- Members have to be referred by a doctor prior to an elective admission.
- All hospital admissions have to be pre-authorised.
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times.
- The Centre for Clinical Excellence evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these.
- The development of protocols around various high-cost conditions, such as lower back surgery.
- The establishment of a unit to focus on reducing surgical consumable spend.
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.
- The establishment of the Coordinated Care Programme. This is a dedicated unit to ensure direct co-ordination of care from medical providers to high-risk beneficiaries that are exposed to conditions that would generate multiple admissions if not managed.
- The establishment of an Advanced Illness Benefit Programme dedicated to managing care during the end-of-life stage for patients that are terminally ill.
- The establishment of a disease management unit dedicated to managing high-risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Centre for Clinical Excellence is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

CONCENTRATION OF INSURANCE RISK

As the largest open medical scheme by membership in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme also offers a wide range of benefit plans which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

An annual actuarial valuation is performed, which specifies the contributions to be charged in return for the benefits to be provided given the expected demographic profile of each benefit option.

RISK TRANSFER ARRANGEMENTS

The Scheme has three risk transfer agreements in which suppliers are paid a capitation fee to provide certain minimum benefits to Scheme members, as and when they are required by the members. Capitation arrangements fix the cost to the Scheme of providing these benefits.

The first two risk transfer arrangements cover out-of-hospital optometry and dentistry benefits for members on the KeyCare Plus and KeyCare Start plans. The third arrangement covers the treatment for members diagnosed with diabetes (type I and II) on all plans excluding KeyCare plans.

RISK IN TERMS OF RISK TRANSFER ARRANGEMENTS

The Scheme does, however, remain liable to its members to provide these benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the costs of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. This is to mitigate against the reputational and operational risks that the Scheme faces should a supplier not meet its obligations. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims which are included in the arrangement.

ASSESSMENT OF CONTRIBUTION INCREASES:

In 2022, a 0.0% increase was implemented across all options from 1 January 2022 with a contribution increase of 7.9% implemented effective 1 October 2022. This translated to an effective average increase of below 2% for 2022 off the December 2021 contributions.

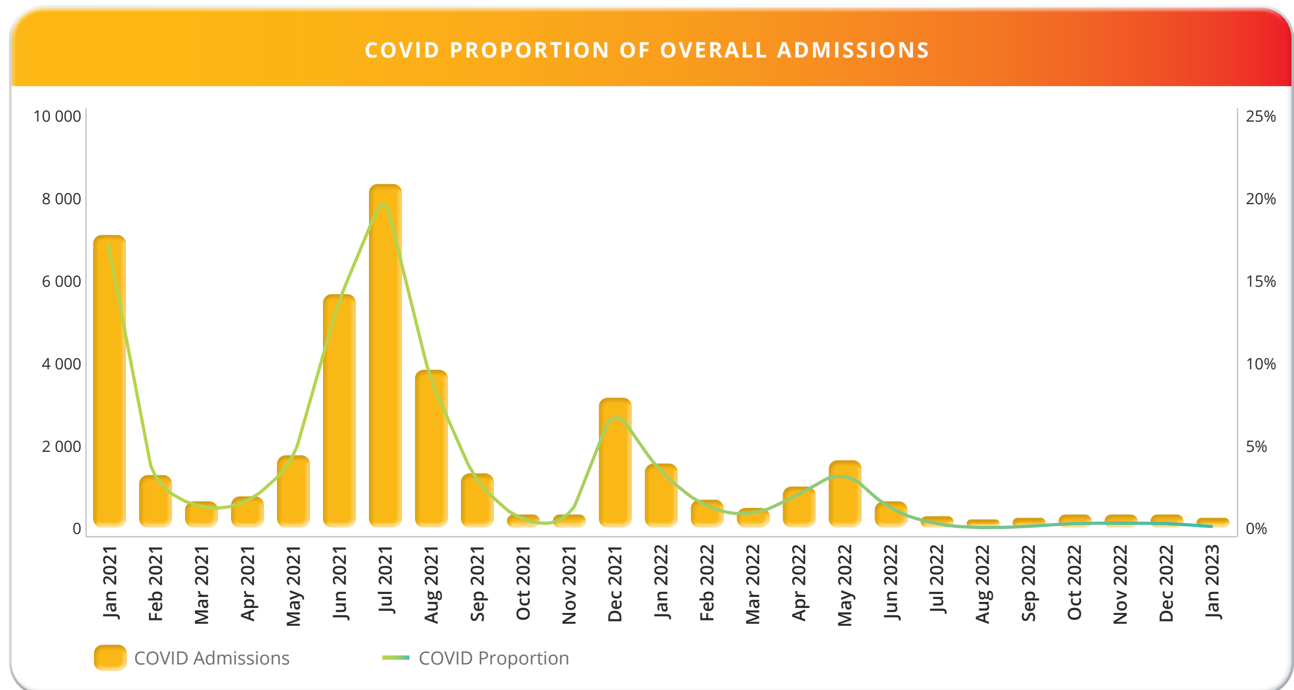
In order to balance the economic pressures faced by members and the longevity of the Scheme, it was decided once again to implement a 0.0% increase across all options from 1 January 2023 with a proposed contribution increase of 9.9% for Executive, Comprehensive and Priority benefit options and 7.9% increase for all other benefit options from 1 April 2023. This translates to an effective average increase of below 6.2% for 2023 off the December 2022 contributions. A lower increase would require a large increase in 2024 for the solvency of the Scheme to remain above 25%, and this level of increase was considered to not be viable.

33. Insurance risk management report continued

CONCENTRATION OF INSURANCE RISK continued

COVID-19 EXPERIENCE:

COVID-19 claims experience has stabilised at much lower levels than were seen during the peak of the pandemic, as can be seen in the following graph, and now form part of the base claims experience used for future projections. The number of COVID admissions by month, along with the proportion of overall admissions that it constitutes, is provided in the graph below.



By the middle of February 2023, 76.0% of adults on DHMS have been vaccinated for COVID-19.

CLAIMS DEVELOPMENT

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments are typically resolved within one year and in the majority of cases within three months. At year-end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chain ladder method and another method using the estimated cost per event and pre-authorised admissions is also followed.

The estimation of the December 2022 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this guidance note, the following factors are considered to determine whether they would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

33. Insurance risk management report continued

CONCENTRATION OF INSURANCE RISK continued

Based on the processing patterns and claims development up to the end of December 2022 in respect of treatment dates during 2022, the recommended provision for outstanding claims as at December 2022 is R1 843 million (2021: R2 257 million). Note that any changes in case mix are automatically accounted for in the methodology. A sensitivity test is shown further below.

R'000	2022	2021
The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**43 634 520**	38 717 881
Chronic claims incurred	**3 161 541**	3 031 099
Out-of-hospital risk claims incurred	**12 165 065**	12 489 624

The table below outlines the sensitivity of insured liability estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables.

		Impact on outstanding claims provision	
R'000	Change in variable (%)	2022	2021
In-hospital claims incurred	1% slower claims processing	**517 894**	377 985
Chronic claims incurred	1% slower claims processing	**8 064**	7 451
Out-of-hospital risk claims incurred	1% slower claims processing	**184 187**	137 062

LIQUIDITY RISK

The main component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time, approximately 98% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Liquidity risk can also arise when the Scheme's investment mix does not match the nature of the liabilities. However, investments are managed by professional asset managers and finance professionals who ensure that investments, including cash and cash equivalents, are always sufficiently liquid to meet current liabilities while excess reserves are invested to maximise investment return within the scope of Regulations to the Medical Schemes Act.

ASSUMPTION RISK

The Scheme's reserves and therefore solvency is most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include assumptions regarding utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

34. Financial risk management report

OVERVIEW

The Scheme is exposed to financial risk through its financial assets, insurance assets, financial liabilities and insurance liabilities. In particular, the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

The Trustees have overall responsibility for establishing and overseeing the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

The Scheme manages financial risks as follows:

- The Investment Committee, a Committee of the Board of Trustees, recommends the Scheme's Investment Policy to the Trustees for approval. The Investment Committee meets at least quarterly and reports back to the Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company, RisCura, has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- Independent valuation of the Scheme's investments is performed by a third party.

MARKET RISK

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

R'000	Total	Currency risk	Price risk	Interest rate risk
2022				
Investments	**33 173 672**			
Offshore cash and bonds	**2 196 242**	✓		✓
Equities	**8 937 682**		✓	
Short duration bonds	**5 488 733**			✓
Flexible fixed income bonds	**8 639 881**			✓
Money market instruments	**7 313 485**			✓
Property	**597 649**		✓	
2021				
Investments	34 688 723			
Offshore cash and bonds	2 299 286	✓		✓
Equities	7 578 533		✓	
Short duration bonds	10 604 304			✓
Flexible fixed income bonds	5 229 271			✓
Money market instruments	8 367 829			✓
Property	609 500		✓	

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently, changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

34. Financial risk management report continued

CURRENCY RISK

The majority of the Scheme's benefits are rand-denominated and therefore the Scheme does not have significant net currency risk relating to benefits.

For the purpose of seeking investment diversification, the Scheme continued to invest in offshore bond portfolios (reference currency is the US Dollar). Derivative financial instruments are utilised by the independent bond managers within these portfolios for risk mitigation and efficient portfolio construction and grouped in the respective portfolio. At 31 December 2022, R2.2 billion (2021: R2.3 billion) (Note 3) was invested in these portfolios.

- **CURRENCY DERIVATIVES FINANCIAL INSTRUMENT (SYNTHETIC FORWARDS)**

During 2021, a decision was taken to exit the currency hedges with the final contract being closed out during June 2021. The weakening of the Rand against the US Dollar in 2022 provided an opportunity for the Scheme to directly enter into new contracts to expand the level of exposure hedged.

After considering the current market conditions, the preferred protection structure to provide protection from the Rand appreciating against the US Dollar has been reassessed and the structure changed from using zero-cost currency collars to synthetic forwards.

The Scheme entered into synthetic forward arrangements with South African banks to hedge exposure to changes in the ZAR/US Dollar exchange rate with respect to its offshore bond portfolios. The following table provides details of the open contracts at year-end.

			2022		
Contract	Expiry date	Nominal USD value $'000	USD put (floor)	USD call (cap)	% above floor
1	21/08/2023	$32 000	**R16.94**	**R17.52**	**3.48%**
2	08/09/2023	$16 000	**R17.48**	**R18.07**	**3.38%**
3	06/10/2023	$16 000	**R18.08**	**R18.61**	**2.93%**

The synthetic forwards are categorised as at fair value through profit or loss.

At the time of expiry of the synthetic forwards the following transactions could occur depending on the rate at which the Rand is trading against the US Dollar:

- If the spot rate is higher than the cap, the Scheme would be required to pay the difference between the cap and the spot rate to the counterparty.
- If the spot rate is trading lower than the cap but higher than the floor, no action would take place.
- If the spot rate is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the spot rate to the Scheme.

The fair value of these contracts has been included in financial assets. Gains and losses on these arrangements are included in the "Net surplus" (Note 8).

34. Financial risk management report continued

CURRENCY RISK continued

CURRENCY RISK SENSITIVITY ANALYSIS

The sensitivity of the Rand appreciating and depreciating against the US Dollar is presented below. This impact would be recognised in the "Net Surplus". The potential outcomes of the sensitivity are based on the assumption that the Rand has strengthened or weakened against the US Dollar by 5% (increase or decrease of R0.85) or 15% (increase or decrease of R2.55) from a spot level of R17.02 to the US Dollar, with all other variables held constant. The analysis is presented including and excluding the impact of the synthetic forwards, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the synthetic forwards would be based on the exchange rate at the date of expiry of the respective contracts.

R'000	15% appreciation of ZAR against USD	5% appreciation of ZAR against USD	5% depreciation of ZAR against USD	15% depreciation of ZAR against USD
2022				
(Loss)/gain arising from currency appreciation/ depreciation before synthetic forwards	**(329 436)**	**(109 812)**	**109 812**	**329 436**
(Loss)/gain arising from currency appreciation/ depreciation after synthetic forwards	**(118 320)**	**(13 756)**	**90 807**	**195 371**
2021				
(Loss)/gain arising from currency appreciation/ depreciation	(344 893)	(114 964)	114 964	344 893

PRICE RISK

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as at fair value through profit or loss. The value of the Scheme's equity and property investments amounted to R9.5 billion (2021: R8.2 billion) (Note 3).

The Scheme manages the price risk arising from investments in equity securities through the diversification of its investment portfolios. Diversification of the portfolios is performed by independent asset managers in accordance with the mandate set by the Scheme. The strategy to manage price risk, by limiting exposure to any constituent of the benchmark to a maximum weight of 15%, remains in place.

No direct derivative contracts have been entered into related to the equity holdings during the current financial year.

EQUITY PRICE RISK SENSITIVITY ANALYSIS

The analysis reflecting the impact of increases or decreases in equity prices has been presented below. This impact would be recognised in the "Net Surplus". The potential outcomes of the sensitivity are based on the assumption that equity prices had increased or decreased by 5% or 15%, with all other variables held constant. The Scheme has not hedged this portfolio.

The following table indicates the 5% or 15% change in the respective index.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
2022				
(Loss)/gain arising from price decrease/increase	**(1 340 652)**	**(446 884)**	**446 884**	**1 340 652**
2021				
(Loss)/gain arising from price decrease/increase	(1 149 486)	(383 162)	383 162	1 149 486

The analysis reflecting the impact of increases or decreases in prices of the property portfolio has been presented below. This impact would be recognised in the "Net Surplus". The potential outcomes of the sensitivity are based on the assumption that prices had increased or decreased by 5% or 15%, with all other variables held constant. The Scheme has not hedged this portfolio.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
2022				
(Loss)/gain arising from price decrease/increase	**(89 647)**	**(29 882)**	**29 882**	**89 647**
2021				
(Loss)/gain arising from price decrease/increase	(93 295)	(31 098)	31 098	93 295

34. Financial risk management report continued

INTEREST RATE RISK

The Scheme is exposed to interest rate risk as it places funds in short-dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk with the contracts being grouped into the respective portfolio.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

R'000	0 – 3 Months	3 – 12 Months	>12 Months	Total
At 31 December 2022				
Cash and cash equivalents	**3 624 134**	**–**	**–**	**3 624 134**
Money market instruments carried at fair value through profit or loss	**–**	**7 313 485**	**–**	**7 313 485**
Short duration bonds carried at fair value through profit or loss	**–**	**1 045 096**	**4 443 637**	**5 488 733**
Flexible fixed income bonds carried at fair value through profit or loss	**–**	**483 651**	**8 156 230**	**8 639 881**
Offshore bonds carried at fair value through profit or loss	**–**	**–**	**2 196 242**	**2 196 242**
At 31 December 2021				
Cash and cash equivalents	3 838 314	–	–	3 838 314
Money market instruments carried at fair value through profit or loss	–	8 367 829	–	8 367 829
Short duration bonds carried at fair value through profit or loss	–	10 604 304	–	10 604 304
Flexible fixed income bonds carried at fair value through profit or loss	–	–	5 229 271	5 229 271
Offshore bonds carried at fair value through profit or loss	–	2 299 286	–	2 299 286

▪ INTEREST RATE RISK SENSITIVITY ANALYSIS

A sensitivity analysis indicating results of increases/decreases in interest rates has been presented below. This impact would be recognised in the "Net Surplus". The sensitivity is based on the assumption that local or foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

Gains/(losses) arising from change in:

R'000	2% interest rate decrease	1% interest rate decrease	1% interest rate increase	2% interest rate increase
2022				
Local portfolios	**1 229 652**	**614 826**	**(614 826)**	**(1 229 652)**
Foreign portfolios	**203 830**	**101 915**	**(101 915)**	**(203 830)**
2021				
Local portfolios	880 831	440 415	(440 415)	(880 831)
Foreign portfolios	151 426	75 713	(75 713)	(151 426)

The majority of the Scheme's assets are invested in variable interest rate instruments with a significant portion of the fixed rate instruments maturing in the short term. At 31 December 2022 56% of the investments were invested in variable interest rate instruments, 19% in fixed rate instruments, and the remaining 26% in non-interest bearing instruments. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets due to the short duration thereof.

LEGAL RISK

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. All Scheme agreements are reviewed by the legal team to ensure that contractual obligations are clearly defined and not ambiguous. At 31 December 2022, the Scheme considered there to be no significant concentration of legal risk and no provision has been raised.

34. Financial risk management report continued

INVESTMENT RISK

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities.

The Scheme's Investment Committee oversees investments, ensuring that funds are invested in line with the Act.

The investment philosophy is to hold a diversified pool of assets. The assets are selected as being most appropriate given the liquidity and solvency requirements of the Scheme. In contemplating solvency, the return goals of the Scheme, as well as the risk associated with all assets and asset classes are considered. Diversification is across securities, issuers, asset classes, geographic regions as well as managers within asset classes where practical. The Scheme diversifies its investment portfolio by investing in short-term deposits, money market, bond, property and equity portfolios managed by reputable asset managers.

The Scheme's investment objective statement is:

- Maximise targeted investment returns, which is dependent on contribution increases implemented over the next year and the evaluation of the solvency level above the statutory minimum requirement from time to time.
- The return target will be reviewed at the end of every year taking into account the actual returns achieved, projected operating surplus and finalised contribution increases.
- The return target is subject to a low-risk appetite for:
  - Solvency reducing below 25% due to poor investment returns; or
  - Achieving returns in any year that are lower than the return assumed by the actuary in the pricing budget.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure performance in accordance with the agreed mandates.

BREAKDOWN OF INVESTMENTS

The investments are split between the following in the Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

R'000	Segregated Funds	Collective Investment Schemes	Policy of Insurance	Total
2022				
Investments	**29 565 443**	**2 196 242**	**1 411 987**	**33 173 672**
Offshore cash and bonds	**–**	**2 196 242**	**–**	**2 196 242**
Equities	**8 937 682**	**–**	**–**	**8 937 682**
Short duration bonds	**4 076 746**	**–**	**1 411 987**	**5 488 733**
Flexible fixed income bonds	**8 639 881**	**–**	**–**	**8 639 881**
Property	**597 649**	**–**	**–**	**597 649**
Money market instruments	**7 313 485**	**–**	**–**	**7 313 485**
Cash and cash equivalents	**3 022 200**	**601 934**	**–**	**3 624 134**
	32 587 643	**2 798 176**	**1 411 987**	**36 797 806**
2021				
Investments	31 083 524	2 299 286	1 305 913	34 688 723
Offshore bonds	–	2 299 286	–	2 299 286
Equities	7 578 533	–	–	7 578 533
Yield-enhanced bonds	9 298 391	–	1 305 913	10 604 304
Inflation-linked bonds	5 229 271	–	–	5 229 271
Property	609 500	–	–	609 500
Money market instruments	8 367 829	–	–	8 367 829
Cash and cash equivalents	901 508	2 936 806	–	3 838 314
	31 985 032	**5 236 092**	**1 305 913**	**38 527 037**

34. Financial risk management report continued

BREAKDOWN OF INVESTMENTS continued

MONEY MARKET PORTFOLIOS:

LOCAL PORTFOLIOS:

These money market portfolios are managed by independent asset managers. The investment mandates are for actively managed portfolios of financial instruments aimed at maximising return on the investments, on a long-term basis, with due regard to the relevant risks and the constraints imposed by the mandates.

For the first portfolio, the mandate stipulates liquidity requirements that 5% of the assets must be available within 24 hours' and 15% within five working days. The weighted modified duration of the portfolio may not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed two years. The term of each individual instrument is also limited. The average weighted credit rating of this portfolio will not be less than A+.

The liquidity requirements of the second portfolio also stipulate that 5% of the assets must be available on 24 hours' notice and an additional 15% within five working days. The average portfolio duration is limited to 180 days. There are a number of additional liquidity requirements included in the mandate, such as requiring that all investments with a maturity longer than 18 months must be of a negotiable nature. The key feature of being of a negotiable nature is that the instrument can be sold by the holder of that instrument to another party without requiring explicit consent from the issuer of the instrument.

The performance benchmark for these portfolios is measured against STeFI plus 130 basis points per annum over rolling one-year periods.

The local money market portfolios comprise approximately 22% (2021: 23%) of the Scheme's financial assets at fair value through profit or loss.

SHORT DURATION BOND PORTFOLIOS:

LOCAL PORTFOLIOS:

The Scheme has three short duration bond portfolios managed by independent asset managers.

The first portfolio uses a specialist fixed income strategy with South African exposure and invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include, but are not limited to, listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is STeFI three-month index plus 150 basis points per annum. To manage liquidity, the asset manager endeavours to invest in securities such that the repayment of capital in relation to securities matches the Scheme's liabilities, as communicated to the asset manager from time to time.

The second portfolio is a specialist low interest rate yield enhanced portfolio with moderate risk limits that seeks diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions. This is achieved by investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is the STeFI Composite Index. The weighted average credit quality is A+ with a weighted average term to maturity of less than five years. A minimum of 10% of the portfolio will be held in money market instruments with an expected term to maturity of less than 91 days. A minimum of 20% of the portfolio must be held in money market instruments.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty and sets exposure limits to unrated investments.

The third portfolio is a duration constrained mandate that seeks yield enhancement through responsible credit allocation as well as harvesting a liquidity premium. The maximum term to maturity of any instrument may be no longer than seven years. Notice of three calendar months is required for a full withdrawal from the portfolio.

These portfolios comprise approximately 17% (2021: 31%) of the Scheme's financial assets at fair value through profit or loss.

OFFSHORE PORTFOLIOS:

The Scheme has two offshore portfolios managed by independent asset managers.

The first portfolio is a multi-asset credit strategy invested in an open-ended specialised investment fund on a non-discretionary basis. The fund is benchmarked against the Secured Overnight Funding Rate plus 400 basis points.

The second portfolio is actively managed on a discretionary basis and is invested in a portfolio of foreign offshore fixed income instruments. The primary objective is the long-term growth of capital and income. The benchmark for this portfolio is the FTSE World Government Bond Index (USD).

These portfolios comprise approximately 7% (2021: 7%) of the Scheme's financial assets at fair value through profit or loss.

34. **Financial risk management report** continued

BREAKDOWN OF INVESTMENTS continued

FLEXIBLE FIXED INCOME PORTFOLIOS:

The Scheme has two flexible fixed income portfolios, each managed by an independent asset manager.

Both portfolios have a composite benchmark of 50% FTSE/JSE All Bond Index ("ALBI") and 50% FTSE/JSE Inflation Linked Bond Index ("CILI"). The mandates allow manages to switch between cash, nominal bonds and inflation linked bonds based on their investment view. The managers seek to outperform the benchmark through a combination of asset allocation as well as yield enhancement from security selection. The portfolios have no modified duration limits, but average weighted credit quality should be at least A+.

To limit concentration risk, limits are in place for both issuer and credit quality category.

These portfolios comprise approximately 26% (2021: 15%) of the Scheme's financial assets at fair value through profit or loss.

EQUITY PORTFOLIOS:

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. These risks are mitigated by blending investment mandates across different manager styles and sectors.

The portfolios may only be invested in South African equities and are to be as fully invested as can practically be achieved at all times. One portfolio has a maximum cash allocation of 2% and the remaining portfolios a maximum allocation of 5%. The portfolios must comply with the Act and are prohibited from investing in Discovery Ltd. The Scheme has mitigated exposure to any single benchmark constituent by limiting investment in any single benchmark constituent to a maximum of 15%.

The Scheme considers responsible investing in all its investments. Managers are required to exclude tobacco manufacturers and related exposures by utilising negative screening. This includes all direct investments and indirect investments greater than 5%.

The performance of the actively managed portfolios is measured against the benchmark, which is the FTSE/JSE Capped Shareholder weighted index (SWIX) adjusted to exclude tobacco (as per the Scheme's Responsible Investment Policy) and capping the combined exposure to Naspers and Prosus to a maximum of 15%. The performance of the passive portfolio is measured against the same benchmark.

These portfolios comprise approximately 27% (2021: 22%) of the Scheme's financial assets at fair value through profit or loss.

34. **Financial risk management report** continued

BREAKDOWN OF INVESTMENTS continued

PROPERTY PORTFOLIOS:

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. The benchmark for this mandate is the FTSE/JSE SA All Property Index.

The mandate does not permit investment in foreign listed shares or direct property investments and requires that there will always be more than six holdings in the portfolio.

This portfolio comprises approximately 2% (2021: 2%) of the Scheme's financial assets at fair value through profit or loss.

The following table compares the fair value and carrying amounts of assets and liabilities per class of assets and liabilities.

R'000	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
2022						
Investments						
– Offshore bond portfolio	**2 196 242**	**–**	**–**	**–**	**2 196 242**	**2 196 242**
– Equities	**8 937 682**	**–**	**–**	**–**	**8 937 682**	**8 937 682**
– Short duration bond portfolio	**5 488 733**	**–**	**–**	**–**	**5 488 733**	**5 488 733**
– Flexible fixed income bond portfolio	**8 639 881**	**–**	**–**	**–**	**8 639 881**	**8 639 881**
– Property	**597 649**	**–**	**–**	**–**	**597 649**	**597 649**
– Money market portfolios	**7 313 485**	**–**	**–**	**–**	**7 313 485**	**7 313 485**
Cash and cash equivalents	**–**	**3 624 134**	**–**	**–**	**3 624 134**	**3 624 134**
Trade and other receivables	**–**	**6 040**	**2 967 973**	**–**	**2 974 013**	**2 974 013**
Leases	**–**	**–**	**–**	**(9 832)**	**(9 832)**	**(9 832)**
Personal Medical Savings Accounts	**–**	**–**	**–**	**(7 310 364)**	**(7 310 364)**	**(7 310 364)**
Trade and other payables	**–**	**–**	**(1 010 272)**	**(722 126)**	**(1 732 398)**	**(1 732 398)**
Derivative financial instruments	**38 525**	**–**	**–**	**–**	**38 525**	**38 525**
Outstanding claims provision	**–**	**–**	**(1 844 365)**	**–**	**(1 844 365)**	**(1 844 365)**
	33 212 197	**3 630 174**	**113 336**	**(8 042 322)**	**28 913 385**	**28 913 385**
2021						
Investments						
– Offshore bond portfolio	2 299 286	–	–	–	2 299 286	2 299 286
– Equities	7 578 533	–	–	–	7 578 533	7 578 533
– Short duration bond portfolio	10 604 304	–	–	–	10 604 304	10 604 304
– Flexible fixed income bond portfolio	5 229 271	–	–	–	5 229 271	5 229 271
– Property	609 500	–	–	–	609 500	609 500
– Money market portfolios	8 367 829	–	–	–	8 367 829	8 367 829
Cash and cash equivalents	–	–	–	–	–	–
– Medical Scheme assets	–	3 838 314	–	–	3 838 314	3 838 314
– Personal Medical Scheme assets	–	10 860	–	–	10 860	10 860
Trade and other receivables	–	10 728	2 719 122	–	2 729 850	2 729 850
Personal Medical Savings Accounts	–	–	–	(7 081 549)	(7 081 549)	(7 081 549)
Trade and other payables	–	–	(851 215)	(666 108)	(1 517 323)	(1 517 323)
Outstanding claims provision	–	–	(2 257 054)	–	(2 257 054)	(2 257 054)
	34 688 723	**3 859 902**	**(389 147)**	**(7 747 657)**	**30 411 821**	**30 411 821**

34. **Financial risk management report** continued

CREDIT RISK

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are through its trade and other receivables, investments and cash.

TRADE AND OTHER RECEIVABLES

Trade and other receivables comprise of insurance receivables and other receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt.

EXPOSURE TO CREDIT RISK

The carrying amount of trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis, as set out in the approved Debt Management Policy. The tables below highlight "Trade and other receivables" which are due and past due (by number of days).

Based on past experience, the Scheme believes that no provision for impairment is required in respect of contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. For forensic debtors that are past due and outstanding for less than three years, past experience has indicated that no provision is required. The Scheme has not re-negotiated the terms of receivables and does not hold any collateral or guarantees as security.

PROVISION FOR IMPAIRMENT

INSURANCE RECEIVABLES

For insurance receivables, the Scheme establishes an allowance for impairment that represents its estimate of incurred losses. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparty.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures; and
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified.

The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

OTHER RECEIVABLES

The Scheme applies the IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for other receivables.

To measure the expected credit losses associated with other receivables, these have been grouped based on shared credit risk characteristics and the days past due. Other receivables comprise sundry accounts receivable and interest receivable and are all current and not in a past due status. An immaterial expected loss rate is assigned to receivables that are not past due. Any loss associated to these receivables is negligible and no provision raised. No further analysis is presented.

CASH AND CASH EQUIVALENTS

For cash and cash equivalents, these amounts are short-dated/on-demand deposits with highly rated banks and money market funds and as a result there is no expectation of any credit losses as the probability of default is remote. As a result the amount at risk would be immaterial and no further analysis presented.

34. Financial risk management report continued

CREDIT RISK continued

R'000	Current	Total
2022		
Expected loss rate	**0%**	
Gross carrying amount – other receivables	**6 040**	**6 040**
Sundry accounts receivable	**271**	**271**
Interest receivable	**5 769**	**5 769**
Gross carrying amount – cash and cash equivalents	**3 624 134**	**3 624 134**
2021		
Expected loss rate	0%	
Gross carrying amount – other receivables	10 728	10 728
Sundry accounts receivable	9 567	9 567
Interest receivable	1 161	1 161
Gross carrying amount – cash and cash equivalents	3 838 314	3 838 314

The movement in the provision for impairment, for each component of insurance receivables has been presented below:

R'000	Contribution receivables	Member and service provider claims receivables	Other risk transfer arrangements	Broker fee receivables	Forensics receivables	Total
Balance at 1 January 2021	22 471	322 924	–	1 896	11 779	359 070
Increase in provision for impairment	9 303	111 873	–	3 017	1 048	125 240
Amounts utilised during the year		(127 667)				(127 667)
BALANCE AT 31 DECEMBER 2021	**31 774**	**307 130**	**–**	**4 913**	**12 826**	**356 643**
Balance at 1 January 2022	**31 774**	**307 130**	**–**	**4 913**	**12 826**	**356 643**
Increase in provision for impairment	**(6 472)**	**101 939**	**–**	**(2 708)**	**1 850**	**94 609**
Amounts utilised during the year		**(79 093)**				**(79 093)**
BALANCE AT 31 DECEMBER 2022	**25 302**	**329 976**	**–**	**2 205**	**14 676**	**372 159**

34. **Financial risk management report** continued

CREDIT RISK continued

	Total member and service provider claims receivables											
R'000	Active member claims receivables	Withdrawn member claims receivables	Service provider claims receivables	Total	Contri-bution receivables	Other risk transfer arrange-ments	Broker fee receivables	Other insurance receivables	Forensics receivables	Related party	Other receivables	Total
31 December 2022												
Not past due	**4 507**	**13 199**	**2 908**	**20 614**	**2 562 004**	**1 490**	**311**	**27 915**	**49 257**	**25 164**	**6 040**	**2 692 795**
Past due 30 – 60 days	**5 782**	**16 779**	**772**	**23 333**	**41 853**	**–**	**47**	**–**	**2 275**	**–**	**–**	**67 508**
Past due 61 – 90 days	**5 431**	**11 769**	**1 334**	**18 534**	**17 802**	**–**	**22**	**–**	**1 226**	**–**	**–**	**37 584**
Past due 91 – 120 days	**5 519**	**8 766**	**452**	**14 737**	**14 459**	**–**	**195**	**–**	**4 139**	**–**	**–**	**33 530**
Past due 121 – 150 days	**3 994**	**10 151**	**916**	**15 061**	**13 132**	**–**	**3**	**–**	**2 477**	**–**	**–**	**30 673**
Past due 151 – 180 days	**3 233**	**13 744**	**1 417**	**18 394**	**–**	**–**	**14**	**–**	**1 543**	**–**	**–**	**19 951**
181 days to more than one year	**35 674**	**265 646**	**28 656**	**329 976**	**–**	**–**	**2 205**	**–**	**131 950**	**–**	**–**	**464 131**
Gross Receivables	**64 140**	**340 054**	**36 455**	**440 649**	**2 649 250**	**1 490**	**2 797**	**27 915**	**192 867**	**25 164**	**6 040**	**3 346 172**
Provision for impairments	**(35 674)**	**(265 646)**	**(28 656)**	**(329 976)**	**(25 302)**	**–**	**(2 205)**	**–**	**(14 676)**	**–**	**–**	**(372 159)**
Trade and other receivables neither past due nor impaired	**28 466**	**74 408**	**7 799**	**110 673**	**2 623 948**	**1 490**	**592**	**27 915**	**178 191**	**25 164**	**6 040**	**2 974 013**
31 December 2021												
Not past due	5 497	7 395	1 721	14 613	2 322 213	372	493	63 385	45 500	13 058	10 728	2 470 362
Past due 30 – 60 days	9 140	9 666	315	19 121	69 544	–	51	–	1 726	–	–	90 442
Past due 61 – 90 days	4 626	8 261	220	13 107	(14 400)	–	35	–	1 215	–	–	(43)
Past due 91 – 120 days	5 281	12 137	498	17 916	(421)	–	60	–	780	–	–	18 335
Past due 121 – 150 days	4 399	10 454	418	15 271	4 024	–	23	–	1 238	–	–	20 556
Past due 151 – 180 days	5 028	11 307	1 683	18 018	–	–	23	–	1 379	–	–	19 420
181 days to more than one year	31 620	236 917	38 593	307 130	–	–	4 913	–	155 378	–	–	467 421
Gross Receivables	65 591	296 137	43 448	405 176	2 380 960	372	5 598	63 385	207 216	13 058	10 728	3 086 493
Provision for impairments	(31 620)	(236 917)	(38 593)	(307 130)	(31 774)	–	(4 913)	–	(12 826)	–	–	(356 643)
Trade and other receivables neither past due nor impaired	33 971	59 220	4 855	98 046	2 349 186	372	685	63 385	194 390	13 058	10 728	2 729 850

34. **Financial risk management report** continued

CREDIT QUALITY

The credit quality of trade and other receivables that are neither past due nor impaired as presented on page 169 can be assessed by reference to historical information about counterparty default.

CONTRIBUTIONS DEBTORS

On average, the Scheme collects over 99% (2021: 93%) of outstanding contributions in the month following the contributions being due. Therefore, we can establish that the credit quality of contribution debtors is high and no additional disclosure of the credit quality is provided.

ACTIVE MEMBER CLAIMS DEBTORS

A provision for impairment covering 56% (2021: 48%) of the debtors has been raised and the Trustees are satisfied that this is adequate.

WITHDRAWN MEMBER CLAIMS DEBTORS

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 78% (2021: 80%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

SERVICE PROVIDER CLAIMS DEBTORS

A provision for impairment covering 79% (2021: 89%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

BROKER DEBTORS

A provision for impairment covering 79% (2021: 88%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

FORENSIC DEBTORS

Forensic debt is recovered through Acknowledgement of Debts (AOD's), reversals and cost adjustments. AOD amounts are recovered through debit orders, Electronic Fund Transfers (EFT's) or direct deposits into the bank account, which are monitored on a continuous basis. Forensic debt is only written off in the event of death or insolvency of the debtor. A provision for impairment covering 8% (2021: 6%) of the total amount due has been raised. This provision is applicable to forensic debt where there have not been any recoveries over a three-year period. The Trustees are satisfied that this is adequate.

OTHER INSURANCE RECEIVABLES AND OTHER RECEIVABLES

These debtors mainly comprise of amounts due by hospitals, which are inherently of high quality. As agreed with the providers, the majority of these receivables are recovered by reducing future provider payments thereby providing a high certainty of recoverability, thus no further analysis has been performed on these receivables.

34. Financial risk management report continued

CREDIT QUALITY continued

FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS, CASH AND CASH EQUIVALENTS AND DERIVATIVE FINANCIAL INSTRUMENTS

The Scheme's credit risk exposures at 31 December for the respective years were as follows:

R'000	2022	2021
– Offshore cash and bonds	**2 196 242**	2 299 286
– Short duration bonds	**5 488 733**	10 604 304
– Flexible fixed income bonds	**8 639 881**	5 229 271
– Money market instruments	**7 313 485**	8 367 829
– Cash and cash equivalents	**3 624 134**	3 838 314
– Derivative financial instruments	**38 525**	–
	27 301 000	**30 339 004**

The Scheme manages credit risk on its investment portfolios through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Cash and cash equivalents comprise cash deposits and money market funds with financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 173.

Counterparties of derivatives disclosed in Note 8 are limited to high credit quality financial institutions.

The Scheme's credit risk policy guides the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure;
- Industry exposure; and
- Expected loss.

Compliance with the limits are regularly monitored with quarterly feedback provided to the Scheme's Investment Committee.

The Scheme has assessed whether the above financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market values stated above.

34. Financial risk management report continued

CREDIT QUALITY continued

CREDIT RATING SCALES

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indicators of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

LONG-TERM RATING SCALES

AAA: HIGHEST CREDIT QUALITY
AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: VERY HIGH CREDIT QUALITY
AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: HIGH CREDIT QUALITY
A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: GOOD CREDIT QUALITY
BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

BB: SPECULATIVE
BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time, however business or financial flexibility exists which supports the servicing of financial commitments.

B: HIGHLY SPECULATIVE
B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met, however capacity for continued payment is vulnerable to deterioration in the business and economic environment.

CCC: POSSIBILITY OF DEFAULT
Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

CC: VERY HIGH LEVELS OF CREDIT RISK
Default of some kind appears probable.

NR: NOT RATED
NR ratings indicate that the issuer has not been rated.

34. **Financial risk management report** continued

EXPOSURE TO CREDIT RISK

The following table discloses the Scheme's asset credit ratings using official credit ratings where available, or the asset manager's rating and is presented using a Fitch national scale rating. The credit risk policy limits investments in non-investment grade instruments to a maximum of 10% after considering official credit ratings and asset manager assigned internal credit ratings where official ratings are not available. Less than 5% (2021: Less than 6%) of the instruments are invested in non-investment grade instruments after consideration of internally assigned credit ratings.

		Long-term rating						
R'000	Total	Govt	AAA	AA+ to AA-	A+ to A-	BBB- to BBB+	BB- to BB+	Not rated
2022								
At fair value through profit or loss:	**23 638 341**	**5 960 939**	**1 135 636**	**13 281 854**	**500 365**	**11 181**	**1 454 127**	**1 294 239**
Offshore bond portfolio	**2 196 242**	**–**	**–**	**781 750**	**–**	**–**	**1 414 492**	**–**
Short duration bond portfolio	**5 488 733**	**8 598**	**563 937**	**3 847 654**	**322 660**	**10 276**	**34 567**	**701 041**
Flexible fixed income bond portfolio	**8 639 881**	**5 952 341**	**496 154**	**1 534 076**	**113 551**	**905**	**5 068**	**537 786**
Money market portfolios	**7 313 485**	**–**	**75 545**	**7 118 375**	**64 154**	**–**	**–**	**55 411**
Cash and cash equivalents	**3 624 134**	**–**	**–**	**3 624 134**	**–**	**–**	**–**	**–**
Derivatives	**38 525**						**38 525**	
TOTAL	**27 301 000**	**5 960 939**	**1 135 636**	**16 905 988**	**500 365**	**11 181**	**1 492 652**	**1 294 239**
% per rating band		21.83%	4.16%	61.92%	1.83%	0.04%	5.47%	4.74%
2021								
At fair value through profit or loss:	26 500 690	5 095 129	1 744 493	15 348 115	1 035 005	6 465	1 461 966	1 809 517
Offshore bond portfolio	2 299 286	–	–	848 820	–	–	1 450 466	–
Short duration bond portfolio	10 604 304	394 842	1 270 488	6 645 738	600 069	6 465	11 500	1 675 202
Flexible fixed income bond portfolio	5 229 271	4 700 287	93 012	558 832	36 203	–	–	(159 063)
Money market portfolios	8 367 829	–	380 993	7 294 725	398 733	–	–	293 378
Cash and cash equivalents	3 838 314	–	–	3 838 314	–	–	–	–
TOTAL	**30 339 004**	**5 095 129**	**1 744 493**	**19 186 429**	**1 035 005**	**6 465**	**1 461 966**	**1 809 517**
% per rating band		16.79%	5.75%	63.24%	3.41%	0.02%	4.82%	5.96%

34. **Financial risk management report** continued

EXPOSURE TO CREDIT RISK continued

The Scheme's asset credit ratings have been disclosed at portfolio level, where the portfolio is classified as collective investment schemes or policy of insurance. This reclassification has been updated retrospectively. The restated items are as follows:

		Long-term rating									
R'000	Total	Govt	AAA	AA+ to AA-	A+ to A-	BBB- to BBB+	BB- to BB+	B- to B+	CCC+ to CCC-	CC+	Not rated
2021 Restated											
At fair value through profit or loss:	26 500 690	5 095 129	1 744 493	15 348 115	1 035 005	6 465	1 461 966	–	–	–	1 809 517
– Offshore bond portfolio	2 299 286	–	–	848 820	–	–	1 450 466	–	–	–	–
– Short duration bond portfolio	10 604 304	394 842	1 270 488	6 645 738	600 069	6 465	11 500	–	–	–	1 675 202
Cash and cash equivalents	3 838 314	–	–	3 838 314	–	–	–	–	–	–	–
TOTAL	**30 339 004**	**5 095 129**	**1 744 493**	**19 186 429**	**1 035 005**	**6 465**	**1 461 966**	**–**	**–**	**–**	**1 809 517**
% per rating band		16.79%	5.75%	63.24%	3.41%	0.02%	4.82%	–	–	–	5.96%
2021 Previously presented											
At fair value through profit or loss:	26 500 690	5 129 539	2 016 854	14 154 769	1 322 117	361 251	447 767	789 894	55 729	1 650	2 221 120
– Offshore bond portfolio	2 299 286	34 410	261 227	47 498	182 156	330 465	436 267	789 894	55 729	1 650	159 990
– Short duration bond portfolio	10 604 304	394 842	1 281 622	6 253 714	705 025	30 786	11 500	–	–	–	1 926 815
Cash and cash equivalents	3 838 314	302 840	238 313	2 254 960	–	–	–	–	–	–	1 042 201
TOTAL	**30 339 004**	**5 432 379**	**2 255 167**	**16 409 729**	**1 322 117**	**361 251**	**447 767**	**789 894**	**55 729**	**1 650**	**3 263 321**
% per rating band		17.91%	7.43%	54.09%	4.36%	1.19%	1.48%	2.60%	0.18%	0.01%	10.76%

34. Financial risk management report continued

EXPOSURE TO CREDIT RISK continued

The Scheme's investments in securitisations and collective investment schemes (funds) are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers. The Scheme does not control these funds as it has no voting rights, is not able to call meetings and in addition, has no ability to direct the relevant activities of these funds. As the Scheme does not control these funds, its investments in these structured entities are not consolidated in the Scheme's Financial Statements.

All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the Statement of Financial Position and no other material risks relating to these investments have been identified other than those already disclosed in previous sections of this Report.

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and Description	2022 R'000	Authorised programme size	% of Authorised programme size	Fair Value Hierarchy		Debt Ranking		Credit Rating		Underlying assets	
				Level	%	Ranking	%	Rating	%	Asset	%
Residential mortgage-backed securitisations	**216 937**	R125 billion	0.17%	Level 1	72%	Senior secured	32%	AAA	67%	Residential mortgages	100%
				Level 2	28%	Secured	68%	NR	22%		
Asset-backed securitisations	**62 133**	R20 billion	0.31%	Level 1	100%	Senior secured	73%	AAA	94%	Vehicle loans	94%
						Secured	27%	AA- to AA+	6%	Unsecured loans	6%
Commercial mortgage-backed securitisations	**23 840**	R2 billion	1.19%	Level 1	100%	Secured	100%	AA- to AA+	100.00%	Commercial mortgage loans	100.00%

Name and Description	2022 R'000	Portfolio size R'000	% of Portfolio size	Fair Value Hierarchy	Credit Rating	Fund
Collective investment schemes	**288 367**	21 862 219	1.32%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	98 108	40 028 710	0.25%	Level 2	AA+	Nedgroup Investments Corporate Money Market F. C2
	207 076	44 613 482	0.46%	Level 1	AA	Nedgroup Investments Core Income Fund Class C2
	2 592	24 324 828	0.01%	Level 2	AA+	Ninety One Corporate Money Market Class A
	4 215	43 114 236	0.01%	Level 2	AA+	Ninety One Money Market Fund Class A
	1 560	69 211 828	0.00%	Level 2	AA+	STANLIB Corporate Money Market Fund Class B5
	759 004	202 800 000	0.37%	Level 2	AA+	Legg Mason Brandywine Global Opportunistic Fixed Income Fund
	1 414 491	12 307 780	11.49%	Level 2	BB	Ninety One ga Multi-asset Credit

34. **Financial risk management report** continued

EXPOSURE TO CREDIT RISK continued

Name and Description	2021 R'000	Authorised programme size	% of Authorised programme size	Fair Value Hierarchy Level	Fair Value Hierarchy %	Debt Ranking	Debt Ranking %	Credit Rating	Credit Rating %	Underlying assets Asset	Underlying assets %
Residential mortgage-backed securitisations	458 151	R125 billion	0.37%	Level 1	78%	Senior secured	35%	AAA	55%	Residential mortgages	100%
				Level 2	22%	Secured	65%	AA- to AA+	23%		
								A+	0%		
								NR	22%		
Asset-backed securitisations	175 739	R25 billion	0.70%	Level 1	100%	Senior secured	73%	AAA	85%	Equipment leases	6%
				Level 2	0%	Secured	20%	AA- to AA+	15%	Unsecured loans	14%
						Senior Unsecured	7%	NR	0%	Vehicle loans	80%
Commercial mortgage-backed securitisations	4 490	R3 billion	0.15%	Level 1	100%	Secured	100%	AAA	100.00%	Commercial mortgage loans	100.00%

Name and Description	2021 R'000	Portfolio size R'000	% of Portfolio size	Fair Value Hierarchy	Credit Rating	Fund
Collective investment schemes	1 923 943	18 768 004	10.25%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	84 217	41 512 945	0.20%	Level 2	AA+	Nedgroup Investments Corporate Money Market F. C2
	919 825	58 744 352	1.57%	Level 1	AA	Nedgroup Investments Core Income Fund Class C2
	2 232	30 377 128	0.01%	Level 2	AA+	Ninety One Corporate Money Market Class A
	3 059	39 773 785	0.01%	Level 2	AA+	Ninety One Money Market Fund Class A
	3 529	68 013 787	0.01%	Level 2	AA+	Stanlib Corporate Money Market Fund Class B5
	857 082	250 500 000	0.34%	Level 2	AA+	Legg Mason Brandywine Global Opportunistic Fixed Income Fund
	1 442 244	8 032 754	18.06%	Level 2	BB	Ninety One Global Alternative Multi-asset Credit

34. **Financial risk management report** continued

LIQUIDITY RISK

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. To meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 92% (R2.4 billion) (2021: 98%, R2.4 billion) of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

A maturity analysis for financial liabilities carried at amortised cost, excluding liabilities arising from insurance contracts is provided below:

R'000	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
At 2022			
Personal Medical Savings Accounts (Note 9)	**7 310 364**	**–**	**–**
Trade and other payables (Note10)	**722 126**	**–**	**–**
Derivative financial liabilities (Note 8)	**38 525**	**–**	**–**
Leases (Note 2)	**2 098**	**2 245**	**5 490**
	8 073 113	**2 245**	**5 490**
At 2021			
Personal Medical Savings Accounts (Note 9)	7 081 549	–	–
Trade and other payables (Note 10)	666 108	–	–
Leases (Note 2)	1 961	2 098	6 573
	7 749 618	**2 098**	**6 573**

FAIR VALUE ESTIMATION

FINANCIAL INSTRUMENTS

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short-term nature.

PERSONAL MEDICAL SAVINGS ACCOUNTS

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore, the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

34. Financial risk management report continued

FAIR VALUE HIERARCHY FOR FINANCIAL ASSETS MEASURED AT FAIR VALUE

ASSETS MEASURED AT FAIR VALUE

	Fair value measurement at end of the year using:			
R'000	Total	Level 1	Level 2	Level 3
2022				
Current assets				
– Offshore cash and bonds	**2 196 242**	**–**	**2 196 242**	**–**
– Equities	**8 937 682**	**8 882 943**	**54 739**	**–**
– Short duration bonds	**5 488 733**	**3 499 272**	**1 989 461**	**–**
– Flexible fixed income bonds	**8 639 881**	**7 815 253**	**824 628**	**–**
– Property	**597 649**	**589 151**	**8 498**	**–**
– Money market instruments	**7 313 485**	**2 606 224**	**4 707 261**	**–**
– Derivative financial instruments	**38 525**	**–**	**38 525**	**–**
	33 212 197	**23 392 843**	**9 819 354**	**–**
2021				
Current assets				
– Offshore cash and bonds	2 299 286	–	2 299 286	–
– Equities	7 578 533	7 552 725	25 808	–
– Short duration bonds	10 604 304	6 096 091	4 508 213	–
– Flexible fixed income bonds	5 229 271	5 027 723	201 548	–
– Property	609 500	603 580	5 920	–
– Money market instruments	8 367 829	4 773 528	3 594 301	–
	34 688 723	**24 053 647**	**10 635 076**	**–**

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market.

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable.

Level 3 – These are assets measured using inputs that are not based on observable market data.

34. **Financial risk management report** continued

FAIR VALUE HIERARCHY FOR FINANCIAL ASSETS MEASURED AT FAIR VALUE continued

The table below details the valuation techniques and observable inputs for assets falling under Level 2:

Description R'000	Fair value at 2022	Fair value at 2021	**Valuation techniques**	**Observable Input**
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**5 010 331**	7 009 047	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**4 707 261**	3 594 301	Discounted cash flow valuation, Black-Scholes model	Published exchange swap curve, published interest rate curve, published credit spread curve/implied credit spread curve, risk free yield to maturity curve, risk free zero curve, swap yield to maturity curve, swap zero curve
Unlisted equity	**63 237**	31 728	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
Derivative financial instruments	**38 525**	–	Discounted cash flow valuation, Black-Scholes model	Published index levels, published exchange swap curve, published interest rate curve, published credit spread curve, implied volatilities
	9 819 354	**10 635 076**		

CAPITAL MANAGEMENT

The Scheme is subject to the capital requirement imposed by Regulation 29 (2) of the Act, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross annual contributions of 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Act, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

The calculation of the regulatory capital requirement is set out below.

R'000	2022	2021
Total members' funds per Statement of Financial Position	**28 930 015**	30 418 845
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(1 002 934)**	(1 603 656)
Accumulated funds per Regulation 29	**27 927 081**	28 815 189
Gross annual contribution income	**79 542 906**	75 816 287
Solvency margin		
= Accumulated funds / gross annual contribution income x 100	**35.11%**	38 01%

At 2022, the Scheme's regulatory capital level of 35.11% (2021: 38.01%) was R8 billion (2021: R9.9 billion) more than the statutory capital requirement of 25%.

35. Critical accounting estimates and judgements

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

OUTSTANDING CLAIMS PROVISION

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 33.

OTHER RISK TRANSFER ARRANGEMENTS

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 14.

IMPAIRMENT OF ASSETS

The critical estimates made by the Scheme are set out under Note 34 and judgements relating to the impairment of assets are set out under Note 4.

CLASSIFICATION OF INVESTMENTS AS CURRENT AND NON-CURRENT

The critical estimates and judgements relating to the classification of investments are set out under Note 3.

CLASSIFICATION OF MONEY MARKET FUNDS AS CASH AND CASH EQUIVALENTS

The critical estimates and judgements relating to the classification of money market funds are set out under Note 6.

VALUATION OF UNLISTED INVESTMENTS

The estimates relating to the valuation of level 2 investments are set out under Note 34.

36. Non-compliance matters

Circular 11 of 2006 issued by the CMS deals with issues to be addressed in the audited financial statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them material or not.

During 2022, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

SUSTAINABILITY OF BENEFIT PLANS

In terms of Section 33 (2) of the Act, each benefit plan is required to be self-supporting in terms of membership and financial performance and be financially sound.

For the year ended 2022 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/surplus (R'000)
Executive	(318 453)	(309 560)
Classic Comprehensive	(1 540 380)	(1 421 736)
Classic Core	(46 403)	25 749
Classic Priority	(193 709)	(110 263)
Essential Comprehensive	(136 488)	(122 659)
Coastal Core	(352 589)	(241 399)
Coastal Saver	(535 036)	(340 773)
KeyCare Plus	(1 272 181)	(943 906)
KeyCare Core	(3 385)	22 149

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes. Different strategies are continually evaluated to address the deficit in these plans while considering the overall financial stability of the Scheme.

When structuring benefit options, the financial sustainability of all the options and the requirements of the CMS are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy for plans' sustainability must balance short- and long-term financial considerations, fairness to both healthy and sick members, and continued affordability of cover for members with different levels of income and healthcare needs. While the Scheme is committed to complying wherever possible with applicable legislation, it also focuses intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

DHMS continually provides the CMS with updates on both the Scheme and individual benefit option performance through monthly management accounts and quarterly monitoring meetings.

INVESTMENTS IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide and the CMS has granted DHMS exemption for a three-year period effective from 1 December 2022.

INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE THE REPUBLIC OF SOUTH AFRICA

The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by international swaps and derivatives association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied.

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS exemption for a three-year period effective from 1 December 2022.

CONTRIBUTIONS RECEIVED AFTER DUE DATE

Section 26 (7) of the Act states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment becomes due. There are instances where the Scheme received contributions after the three-day period, however, there are no contracts in place agreeing to this practice. It is important to note that the Scheme has no control over the timely payment of contributions. The legal obligation resides with the members/employers to pay contributions within the prescribed period. The Scheme employs robust credit control processes dealing with the collection of outstanding contributions, including suspending membership for non-payment.

36. Non-compliance matters continued

CLAIMS PAID IN EXCESS OF 30 DAYS

Section 59 (2) of the Act states that: "A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme".

During the year, there were instances where claims were not paid within 30 days. These represent a negligible amount of total claims paid for the year. There is a defined process to identify claims that have not been paid within 30 days to ensure that these claims are paid expeditiously.

BROKER FEES PAID

In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis on receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2), limited to one broker as required by Regulation 28 (8).

In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible. The exceptions relate to transactions that do not occur frequently and the administrator has developed exception reporting to identify and correct these transactions and has a well-established claw-back system to rectify commission overpayments.

PRESCRIBED MINIMUM BENEFITS

Section 29 (1) (o) and Regulation 8 provide the scope and level of minimum benefits that the Scheme must provide to members and dependants. During the year under review there were isolated instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims are being reprocessed to ensure that they are correctly paid.

DIRECT OR INDIRECT BORROWING OF MONEY

In terms of Section 35 (6) (c) of the Act, a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were instances during the year where the Scheme inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of re-occurrence.

AMOUNTS DEBITED TO SCHEME BANK ACCOUNT

Section 26 (4) (b) provides that no amount may be debited to a scheme bank account other than costs incurred by the medical scheme in the carrying on of the business as a medical scheme. During the year under review, a total of R212 808 was debited to the Scheme's bank account that was not related to the Scheme. This debit arose from the incorrect allocation of bank accounts for certain payments. The amount and related interest have subsequently been refunded to the Scheme and additional quality assurance processes have been implemented to mitigate this occurring again.

NON-COMPLIANCE TO THE CMS DIRECTIVE ISSUED IN CIRCULAR 26 OF 2022 – BROKERS MAY NOT RECEIVE BROKER COMMISSION ON OWN POLICIES

During 2022 CMS published Circular 26 of 2022: Brokers and Brokerages who earn commission in respect of their own health or medical scheme policies. The CMS directive stated that all arrangements in terms of which any broker is receiving broker commission, whether directly or indirectly, related to their own health or medical scheme policy, must be terminated by 30 June 2022.

During the year, there were two identified instances where brokers earned commission on their own health policies amounting to R840 after 30 June 2022. These represent less than 0.001% of total broker fees paid for the year. The identified policies have been moved to non-commissionable status.

Resources

Contact details

Principal Officer

Email **principalofficer@discovery.co.za** or call +27 11 529 2888 and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

Council for Medical Schemes (CMS)

DHMS is regulated by the CMS. The CMS can be contacted by telephone on 0861 123 267 or via email on **information@medicalschemes.co.za.** The CMS is located at Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157.

COMPLAINTS, COMPLIMENTS OR DISPUTES

DHMS is committed to providing you with the highest standard of service and your feedback is important to us. To submit a complaint, compliment or dispute:

MEMBER SUPPORT

Important sources of information

We include various useful links below. You may need to log into the website to view some information.

OTHER INFORMATION

FEEDBACK ON THE SCHEME'S INTEGRATED REPORT

We welcome any comments you may have, and would value specific feedback on the following:

- Was the Integrated Report (this Report) understandable to you?
- Were you able to find the information you were looking for, and if not, what were you looking for?
- Did this Report cover all the information relevant to your relationship with the Scheme?
- Did it help in your understanding of the Scheme and its performance, and if not, how could we improve?

Email your feedback to **dhms_stakeholders@discovery.co.za**

REPORTING FRAUD OR UNETHICAL BEHAVIOUR

We provide a fraud hotline and investigate possible instances of fraud. If you even slightly suspect someone of committing fraud or behaving unethically, please report all information to the fraud hotline on the number below. This facility is independently managed by Deloitte and you may remain anonymous if you prefer:

- Toll-free call: 0800 0045 00
- Email: discovery@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks, 4320

You can also email us directly at **forensics@discovery.co.za** to investigate your concerns.

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TAQUANTA ASSET MANAGERS (PTY) LTD
7th Floor, Newlands Terraces, Boundary Road, Newlands, 7700

ACRONYMS AND ABBREVIATIONS USED IN THIS REPORT

AGM	Annual General Meeting
AOD	Acknowledgement of Debt
ATB	Above Threshold Benefit
ATC	Africa Telehealth Collaboration
BUSA	Business Unity South Africa
CaT	Compatibility and Trust
CCMG	Contact Centre Management Group
CIB	Chronic Illness Benefits
CMS	The Council for Medical Schemes
CPI	Consumer price index
Deloitte	Deloitte Touche Tohmatsu Limited
DHMS/the Scheme	Discovery Health Medical Scheme
Discovery Health	Discovery Health (Pty) Ltd
DoH	Department of Health
DSP	Designated service provider
EDO	Efficiency discounted option
EFT	Electronic Funds Transfer
EID	Employee intelligence dashboard
ESG	Environmental, social and governance
ERSGI	ER Specialist Governance Incorporated
FIA	Financial Intermediaries Association
FOSHI	Future of SA Healthcare Incorporated
FWA	Fraud, waste and abuse
GCI	Gross contribution income
HFA	Health Funders Association
HPCSA	Health Professions Council of South Africa
HPRG	Health Professional Reference Group
HQA	Health Quality Assessment
HSMS	Health Squared Medical Scheme
IAS	International Accounting Standards
IASB	International Accounting Standards Board
IFRS	International Financial Reporting Standards
IoDSA	Institute of Directors in South Africa
IRBA	Independent Regulatory Board for Auditors
IVLP	International Visitors Leadership Programme
King IV	The King IV™ Report on Corporate Governance for South Africa 2016
LCBO	Low-Cost Benefit Option
MAFR	Mandatory Audit Firm Rotation
NGOs	Non-Government/al Organisations
NHI	National Health Insurance
NHI Bill	National Health Insurance Bill
OH	Out-of-hospital
PCH	Parliamentary Committee on Health
PCR	polymerase chain reaction (test)
PMBs	Prescribed minimum benefits
PMSA	Personal Medical Savings Account
PwC	PricewaterhouseCoopers Incorporated
QMAS	Quantum Medical Aid Society
RAF	Road Accident Fund
RSA	Republic of South Africa
SAICA	South African Institute of Chartered Accountants
SCA	Supreme Court of Appeal
STeFI	Short-Term Fixed Interest
SREC	Stakeholder Relations and Ethics Committee
TCF	Treating Customers Fairly
The Act	The Medical Schemes Act
The year	The financial year
The Trustees/Board	The DHMS Board of Trustees
UHC	Universal Health Coverage
VBC	Value-based care
WHO	World Health Organisation

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