Discovery
Health Medical Scheme

INTEGRATED REPORT 2023

Discovery Health Medical Scheme registration number 1125

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Discovery Health Medical Scheme registration number 1125

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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 2 788 242 beneficiaries at 31 December 2023, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.8%[2].

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

In the work we do alongside our service providers, we aspire to fulfil our purpose of providing our members with quality, value-based healthcare that is affordable and equitable, now and into the future. Our approach to everything we do is rooted in our ethics and 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 2022 (https://www.medicalschemes.co.za/publications/#2009-3696-wpfd-2022-23-annual-report). At the end of 2022, 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 2.1 million beneficiaries. Source: Annexures to the CMS Annual Report 2022-2023.*

Why join DHMS?

Quality of care is key to our membership proposition

Our members are at the core of what we do, and the Scheme continually strives to ensure that they have access to the most safe, efficient and effective healthcare in South Africa.

Through our partnerships with Discovery Health and other healthcare providers, we enable access to quality of care initiatives and innovations, programmes, professionals, and member-centric care. These are monitored closely and continuously by the Scheme. We drive value-based healthcare, an approach based on placing importance on and reimbursing for better health outcomes for patients rather than only the volume of services delivered. Additionally, we empower our members with information that is current and relevant to their needs.

Value provided by Discovery Health *pg 94*

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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.

FOR OUR MEMBERS >

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We'll be here for you

Financial strength and sustainability are key factors 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.

KEY OUTCOMES MEASURES FOR ENSURING THE SCHEME'S SUSTAINABILITY >

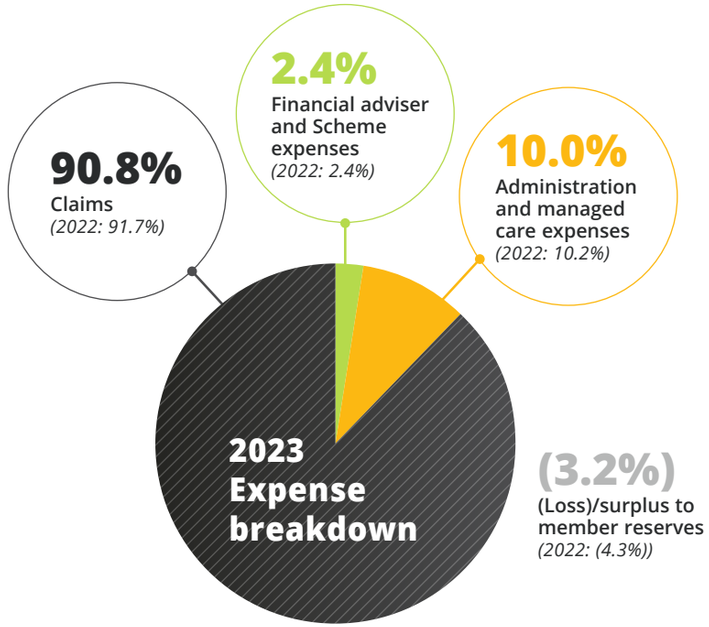
We make sure your investment in membership takes care of you

The Scheme's income is derived only from member contributions and investment returns. All contributions are pooled to fund members' claims, and surplus funds are transferred to Scheme reserves for the security and benefit of members. These reserves are invested to earn returns to bolster the Scheme's financial position.

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 alongside) 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.

Healthcare inflation and utilisation *pg 84*



We provide excellent cover to our members and compare well to other schemes

AVERAGE CONTRIBUTIONS FOR 2024

11.1% lower[2]

than the next seven largest open medical schemes

(2023: 12.3%)[3].

IN 2022, WE PAID

96%

of in-hospital claims, vs 91% for all other open schemes[4].

Our performance *pg 77*

1 *These may relate to various sources of healthcare inflation, and include uncertainty about the timing and severity of burden of disease.*

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, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans on other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

3 *The differential reported for 2023 has been updated from 12.2% to 12.3% to reflect the interim contribution increase effective 01 May 2023 by Sizwe-Hosmed.*

4 *Based on claimed amounts. Source: CMS Annual Report 2022-2023. Comparative data not yet available for the 2023 year.*

SECTION 2

About **our report**

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

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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, material matters, 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.

The **IFRS 17 accounting standard** is now applicable to the Scheme, and changes have therefore been made to the **terminology and presentation** of our Financial Statements. This introduces some **new terms into the main body of this Report as well as the Financial Statements**.

More about IFRS 17 and how it affects this Report *pg 98*

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 30 April 2024

MICHELLE NORTON
Chairperson

MARIUS DU TOIT
Trustee

CHARLOTTE MBEWU
Principal Officer

Scope and boundary

This Report covers the benefit year from 01 January 2023 to 31 December 2023, also referred to as the 2023 financial year (the year). In addition, it discusses material developments in early 2024, up to the date of approval of this Report by the Trustees.

The boundary of this Report includes an assessment of our offerings, 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.

How Discovery Health supports the Scheme's value creation *pg 93*

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) (IIRF) 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 2023 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 the material matters, 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 and constraints, 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 material matters are identified from these discussions, and 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.

Auditor independence

PricewaterhouseCoopers Inc. has audited the Scheme's Financial Statements (comprising the Statement of Financial Position at 31 December 2023, 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 2023.

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 must 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 2023.

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

Process disclosures *continued*

Mandatory audit firm rotation

On 01 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 01 April 2023.

The rule on mandatory audit firm rotation was however set aside by the Supreme Court of Appeal on 31 May 2023. Despite the rule being set aside, the Trustees determined that from a good governance perspective the Scheme should, nevertheless, rotate its auditor, as PricewaterhouseCoopers Inc. has been the Scheme's auditor for 22 years.

The appointment of Deloitte[1] as the Scheme's auditor for the financial year beginning 01 January 2024 was approved at the 2023 Annual General Meeting.

Report preparation and approval

Under the direction and oversight of an experienced and expert executive, Scheme management prepares 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 responsible executive 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.
- The Scheme's external auditors provide independent assurance of the Financial Statements.
- Finally, the Trustees approve the report for publication and submission to the CMS.

1 *Deloitte Touche Tohmatsu Limited*

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.

The model is based on three lines of defence. The first line consists of functions that own and manage risks; the second line consists of functions that oversee or who specialise in compliance or the management of risk; and the third line consists of functions that provide independent assurance.

FIRST LINE	**Scheme management provides the Trustees with assurance that internal control and risk management are integrated into the day-to-day running of the Scheme and monitored on an ongoing basis.**
SECOND LINE	**The outsourced Group Risk Management, Forensics and Compliance functions assess the effectiveness of the Scheme's internal control and risk management processes.**
THIRD LINE	**Management and the Trustees obtain external assurance on the Scheme's financial performance and internal control frameworks from the Internal Audit function, the appointed external auditor, appointed independent actuary and other independent assurance providers.**

SECTION 3

Our value story

Medical schemes must continually balance affordability, sustainability and enhancement of benefits.

OUR OPERATING CONTEXT

What schemes are and how they work

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

Medical schemes must accept all prospective members under the principles of social solidarity, coupled with community risk rating, ensuring standardised pricing, with no differentiation based on, for example, the status of an individual's health or age. Members' funds[1] are pooled to provide healthcare funding in an equitable manner, thereby providing our members access to healthcare services. In accordance with community risk rating, schemes must charge the same contribution rate for a specific benefit plan to all members on that plan and can differentiate between benefit plans based on benefits and benefit limits, albeit that Prescribed Minimum Benefits (PMBs) apply equally across all benefit plans.

Scheme income and pricing

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

Schemes derive income only from member contributions and investment returns earned on members' funds[1]. Contributions are priced to match expected claims for the forthcoming year based on healthcare inflation (tariff increases and the impact of supply and demand, including the utilisation of healthcare services), the demographic profile of the membership base and the operational expenses of the scheme.

Medical schemes must hold sufficient reserves, in the form of a regulated solvency of not less than 25% of gross annual member contributions. This is to ensure that schemes can weather times of economic difficulty and unexpected claims, provide for variations in utilisation and escalation in the cost of treatment, optimise benefits according to appropriateness, costs and the health needs of scheme membership, and treat all scheme members equitably.

The pricing of contributions is a function of balancing utilisation, scheme sustainability and affordability for members, with other imperatives such as adapting to changing healthcare needs.

As the demographic characteristics[2] members, for example the proportion of members suffering from chronic conditions, differ between schemes, each scheme has unique pricing needs and constraints.

1 Now referred to as insurance contract liabilities in the Financial Statements.
2 Health status is influenced by several factors including age, gender, socio-economic status, ethnicity, chronicity etc.

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Barriers to lower contribution rates

As membership of medical schemes is voluntary, medical schemes are vulnerable to anti-selection, where members may choose to join and leave schemes based on their healthcare needs. This affects 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 distanced from the pricing of healthcare services as schemes fund these on their behalf. The market therefore does not self-regulate pricing. As such, in an environment of mostly unregulated healthcare pricing in the private sector (with the exception of medicines pricing), the role of schemes in constantly negotiating prices on behalf of their members is vital in mitigating healthcare inflation.

Medicine prices are regulated by the National Department of Health. Medicine prices and price inflation are of concern to schemes as, together with an increasing new high-cost medicine demand, they contribute to healthcare inflation. Healthcare inflation is expected to be significantly higher than ordinary inflation every year due to tariff increases and increased utilisation, driven by the expansion of available healthcare services and changing demographic profiles. In 2023, Discovery Health Medical Scheme (DHMS or the Scheme) paid R13.4 billion for medicine claims, including approximately R3.2 billion for chronic conditions and R1.6 billion for oncology.

More about healthcare inflation *pg 84*

More about medicine pricing *pg 76*

Risk management interventions are implemented to achieve better access and pricing for members, for example, through the creation of designated service provider (DSP) networks, which achieve lower prices based on the volume of members making use of the DSP network. Schemes may impose a co-payment on members who choose to utilise non-DSP healthcare providers, as the lower pricing is dependent on members making use of the network.

Better health outcomes as well as lower prices can be achieved by negotiating agreements for the treatment of populations of members, for example in caring for members with specific diseases. Providers engaged in this type of work monitor their patients' adherence to medicine and testing requirements, thereby preventing their disease from worsening and keeping claims lower.

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.*

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

Medical scheme governance and regulation

SECTION 7 OF THE MEDICAL SCHEMES ACT (THE ACT) DESCRIBES THE COUNCIL FOR MEDICAL SCHEME'S (CMS') 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 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[2] 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 thereof. The Act requires that at least half of the trustees must be scheme members.

More about how we are governed *pg 48*

The industry landscape

At the end of 2022 there were 72 medical schemes registered with the CMS, consisting of 17 open schemes and 55 restricted schemes, covering over 9 039 000 beneficiaries (2021: 8 945 000)[1]. These schemes paid out approximately R218 billion in total healthcare benefits[2] in 2022 (2021: R205 billion). The average age of total registered scheme members in 2022 increased by 0.2 years to 33.9 from 33.7 in 2021, and the proportion of pensioners increased to 9.3% from 9.1%[3].

More about why these metrics are important *pg 78*

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The outlook for medical schemes

The rising prevalence of chronic disease is a worldwide healthcare concern. Mental health is one of the largest contributors to scheme expenditure and has strong linkages to other chronic conditions. Cancer, diabetes and cardio-metabolic syndrome also contribute to an escalating burden of disease in scheme populations, and the effect of these diseases on schemes is exacerbated by an aging scheme membership and stagnant membership growth. This drives contribution increases and impacts schemes' risk pool cross-subsidisation as the young and healthy subsidise an older population.

In South Africa, 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[4]. Parliament has recently passed legislation to implement a system of National Health Insurance (NHI) aimed at achieving Universal Health Coverage (UHC) in South Africa. The NHI Bill, however, is based on a flawed funding model that is unlikely to achieve UHC, and has constitutional flaws that are likely to be the subject of extensive constitutional challenges. The CMS, together with medical schemes, has produced a framework for Low-Cost Benefit Options (LCBOs) within schemes, which would allow them to compete with similar insurance products currently operating under CMS exemptions, while also offering members of these options the benefit of tax credits to mitigate the cost of membership, thereby expanding access and care in the next few years in parallel to developments in the establishment of the NHI. The framework is currently with the Minister of Health for approval.

Schemes must work to be responsive to healthcare needs as well as changes in technology and society. Rapidly-improving artificial intelligence tools have many applications for healthcare, including diagnosis, patient-guided use, administration, education and research. In schemes, these tools offer great opportunities to enhance member support and healthcare journeys, allowing for greater personalisation, access and convenience. These tools need to be carefully monitored and governed, taking into consideration ethical risks while ensuring that members can access human touchpoints, especially given the highly personal and emotive nature of healthcare.

The impact of decreasing gross domestic product, high inflation and high unemployment on current and prospective scheme members results in a reduced ability to afford scheme membership, a factor that the industry is highly cognisant of and works hard to counter. The CMS has a vital part to play in supporting and facilitating access to schemes through optimising the regulatory environment.

Key drivers for medical schemes include cost containment and improved member health by using new technology, screening, implementation of value-based disease prevention and management programmes, reducing the fragmented nature of care, and implementing effective measures against fraud, waste and abuse. An increasing focus on quality of care – through better understanding and measurement of process and outcomes and developing industrywide reporting – provides opportunities to support healthcare providers in achieving better health for members.

To achieve better healthcare for our members and an improved healthcare system for South Africa, it is vital for the industry to collaborate with government, business, labour and civil society. This will ensure the continued existence of our healthcare system, and equitable access to it, for the benefit of all citizens.

Our strategic themes *pg 13*

Regulatory and industry matters dealt with in 2023 *pg 73*

1 *Based on beneficiaries, according to the CMS Annual Report for the year ended December 2022 (https://www.medicalschemes.co.za/publications/#2009-3696-wpfd-2022-23-annual-report).*
2 *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.*
3 *Source: Annexures to the CMS Annual Report 2022–2023. Data includes both open and restricted schemes but does not include data for 2023 (https://www.medicalschemes.co.za/publications/#2009-3696-wpfd-2022-23-annual-report).*
4 *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 that affect our ability to create sustainable value for our members, and they underpin 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.

We determine our material matters by assessing emerging events, risks and opportunities in our operating context, and the needs and concerns of our members and other stakeholders. Reflecting factors both outside of and within our control, careful responses and management present 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 (Pty) Ltd (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
- Ethical business and stakeholder partnerships
- Scheme sustainability and lack of growth in our current economy
- Health system transformation and sustainability

- Our strategic themes *pg 13*
- Our residual risks *pg 17*
- Performance *pg 77*
- How Discovery Health supports the Scheme's value creation *pg 93*

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Caring for our members

Our members need affordable medical scheme membership, to access quality care that is cost-effective and promotes good health outcomes, and assistance in navigating the complex healthcare system. They are also facing increasing risks of chronic non-communicable diseases, including cancer, mental health conditions and related complications, which are associated with lower quality of life and reduced life span.

Affordability constraints, driven by unabating healthcare inflation which leads to anti-selection, add to the average age of the Scheme's membership, and therefore healthcare costs increasing. The healthcare landscape will continue to change over the short and long term, with factors like the long-term effects of COVID-19[1] and the health impacts of climate change and pollution needing to be monitored and responded to. Additionally, the ongoing advancement of medical technology and individualised treatments results in increased healthcare expenditure.

In responding to these needs, DHMS works to appropriately tailor benefits to our members' demographics and healthcare needs, support members at all stages of their lives, and to be responsive to increasing consumer preferences. This includes the promotion of digital health capabilities and platforms that optimise access, wellbeing and efficiencies. In our aim to be a trusted partner to our members, we provide member education and empowerment to assist their healthcare journeys, to counter health information asymmetry, and to work with them for their holistic better health outcomes. Further, we promote co-ordinated disease prevention and healthy living, and aim to limit the progression of existing disease across broad at-risk groups. We safeguard our members' data and privacy and strive to provide reliable and easy interaction with the Scheme.

We continually balance Scheme sustainability – so that we are there for our members into the future – with affordability and equitable treatment of all members.

1 *Based on Discovery Health's analysis of the Scheme's claims experience, infections, driven by COVID-19, have increased and add 1% to the Scheme's overall claims cost.*

Our material matters *continued*

Scheme sustainability and lack of growth in our current economy

South Africa's ongoing low economic growth, high interest rates and cost of living, and infrastructure challenges are all factors that influence our sustainability. South Africa is also affected by the external forces of geo-political tensions, economic uncertainty and the impact of global conflicts. The resulting shifting trade dynamics, with increasing input costs of imported products and the delays in obtaining them, constrain economic improvements and local development.

These internal and external forces place pressure on job growth and social cohesion, impacting household income and reducing scheme affordability. This has the potential to drive members to alternative products outside medical schemes and results in the continued low growth of scheme membership. Medical scheme affordability and membership growth are vital for the continued viability of scheme social solidarity-based healthcare access for South Africans, as they bring young healthy lives into the system and enable cross-subsidisation, thus protecting all members. Schemes compete for new members and members who change schemes for various reasons, and must also compete against insurance products, which may be more affordable but do not offer the same extent of cover as schemes do.

Ethical business and stakeholder partnerships

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. The lack of these elements, in embedded corruption and fraudulent behaviour, ultimately affects our members through constraints on access to healthcare, the design of benefits, and the overall sustainability of healthcare funding.

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 through improved healthcare funding models and benefit design, amongst others. Barriers include inadequate governance, controls and capacity in the broader business and political environments.

Health system transformation and sustainability

The stabilisation of national healthcare policy through a revised NHI Bill in support of the national good, and the reduction of attendant economic uncertainty, is essential before a clear way forward can be mapped. The policy decisions as articulated in the current formulation of the NHI Bill are a cause of concern for the long-term sustainability of medical schemes and the entire South African healthcare system, including both public and private sectors.

The deterioration and possible collapse of structures contributing to healthcare funding and access, such as the Road Accident Fund, needs to be prevented and managed, and regulatory reforms to broaden healthcare access need to be actioned. Policy reform is essential to unlock broader and equitable access, funding, and improved delivery of healthcare.

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 fraud, waste and abuse, and corruption; uncertain quality of care; shortage of nurse, doctor and allied professional skills; and affordability and access. Innovation, competition and collaborative partnerships are essential to address these challenges, and to achieve effective levels of care for all South Africans in the spirit of social solidarity.

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 sustainability of the Scheme and the affordability needs of members.

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OUR FIVE STRATEGIC THEMES

- Caring for our members
- Sustainability and membership growth
- Regulatory and policy developments
- Governance excellence
- People management and development

Our purpose and our vision guide our strategy, which remains adaptive and responsive to our operating context, future developments, 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 achieving related objectives mitigates our residual risks.

Each year, the Scheme Office reviews the prior year's objectives and our performance against them, and develops strategy for the coming year. The Trustees and Independent Committee Members provide input at an annual strategy discussion, with insights from external advisers, stakeholders and Discovery Health also taken into account.

High-level objectives are disaggregated into specific strategic initiatives and 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[1] interfaces with these Committees and the Board, and reports regularly on performance, operational oversight, monitoring, and mitigating emerging risks.

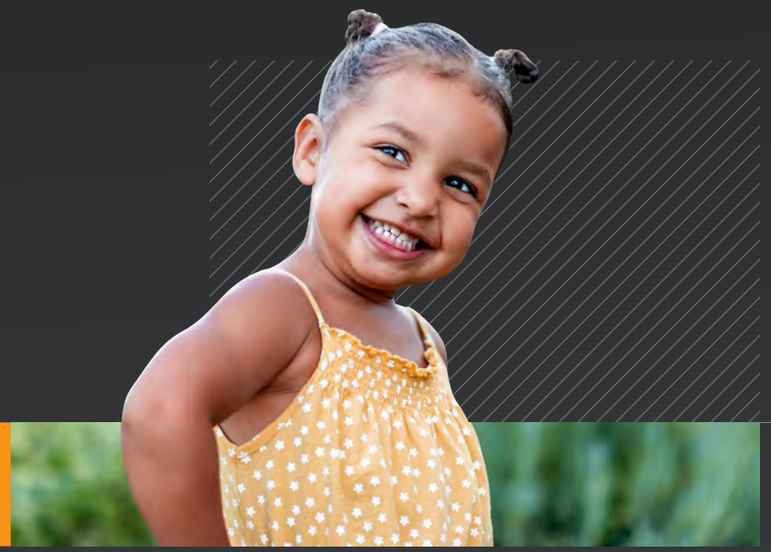
The Scheme's objectives and work streams are closely tied to our performance management methodology, designed to reward our employees for excellence and foster a culture of continuous improvement, learning and development.

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.

See our business model for more information *pg 25*

1 *The Scheme Office consists of the Principal Officer, executive team and administration staff. The Principal Officer is accountable for the day-to-day management of the Scheme.*

Performance against our **strategic themes in 2023**



Over 2024, we will continue to develop opportunities for members to access affordable and appropriate, high-quality care.

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 the needs of our members.

The Scheme membership's burden of disease is driven by chronic diseases including mental health and cancer, with approximately one in three of our members living with a chronic disease. During 2023, the Scheme continued to enhance efforts to manage these conditions, through specific disease management programmes such as DiabetesCare, CardioCare and the Mental Health Programme, while also enabling access to health technology therapies indicated in the treatment of cancer. The fruits of these efforts are evident in the improvement in process indicators related to health outcomes in members who are enrolled on the disease management programmes, compared to the non-enrolled members.

In recognition of the evidence that patients who are managed by one healthcare professional have better health outcomes, the Scheme implemented a requirement that members enrolled on the Chronic Illness Benefit should nominate one Primary Care Provider (PCP) to co-ordinate their care needs, accompanied by campaigns encouraging members to do so and for PCPs to support patients in doing so. This initiative continues in 2024, with nomination rates as of February 2024 at close to 50% of these members.

During the pandemic, the Scheme became concerned by member's lower utilisation of healthcare, screenings and health checks, increasing the likelihood of only detecting diseases at a later and more serious stage. In 2023 the Scheme implemented the WELLTH Fund to encourage screening and checks, and to provide access to some general primary healthcare benefits to complement the screening. Over 570 000[1] health checks have been done from the inception of the WELLTH Fund.

In continuation of the strategic deployment of innovative digital solutions to expand access to cost-effective healthcare, the Scheme expanded the Hospital at Home programme through partnership with other providers, including one hospital group. Towards the end of 2023 the Scheme launched three other digital innovations:

- Virtual Urgent Care gives members immediate access to a panel of expert emergency care doctors when they are not able to access their primary care providers for urgent care.
- Virtual Physical Therapy gives members access to AI-guided physical therapy as prescribed by their therapists, and for times when members need to complete their therapy without the therapist being present.
- Internet-based Cognitive Behavioural Therapy for members diagnosed with depression supports and complements our drive to make mental health benefits more widely accessible.

Over 2024, we will continue to develop opportunities for members to access affordable and appropriate, high-quality care. The Scheme is increasing its efforts to promote disease prevention, screening, early diagnosis and management, and is currently developing innovative science-based programmes to mitigate cardio-metabolic disease risk by focusing on lifestyle and health-seeking behaviours. We hope, through these various programmes and initiatives, to help our members to live healthier and better lives.

The Scheme is also exploring opportunities to leverage the success and appreciation of the WELLTH Fund by both members and healthcare providers.

Some other care programmes and benefits for our members *pg 37*

Resources, support and information for our members *pg 186*

1 *As of 20 February 2024.*

Performance against our strategic themes in 2023 *continued*

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.

In 2023, the Scheme experienced a marginal decrease in membership of 1 680 principal members (2022: 22 532 increase), which is in line with stagnation of overall growth in the medical schemes industry, indicative of the challenging economic environment. We continue to focus on Scheme growth and member retention strategies to ensure long-term stability and sustainability of the Scheme.

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.

Opportunities to support growth may include amalgamations with other schemes, engaging with regulators on policy reform that may affect membership, and ensuring that our plans and benefits appeal to the full range of potential members, as well as reaching them through effective marketing and distribution strategies with a focus on member retention. 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 the medical schemes environment, as these assist the uncovered population of our country to access private healthcare in a highly affordable price range.

Our investment strategy receives ongoing close attention due to the continued high level of economic and geo-political risk in the environment, with the aim of maximising returns within specified risk margins, while maintaining statutory solvency at the required levels. Our asset managers, with consideration of responsible investing practices, integrate environmental, social and governance (ESG) factors into their investment strategies, 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 2024, we will continue to ensure the Scheme's strength and sustainability by pursuing further growth and amalgamation opportunities; we have seen that organic growth in Scheme membership leads to significant reduction in claims[1], 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.

1 *As new members tend to have a better demographic profile than the average of existing Scheme members and may have waiting periods. Growth due to amalgamations with other schemes may not include this effect.*

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 reducing benefits or implementing larger contribution increases in the future. Higher increases mitigate the risk of 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.

More about how medical schemes price contributions *pg 8*

Performance against our strategic themes in 2023
continued

Regulatory and policy developments

The Scheme continues to monitor the progress of the NHI Bill and conducts the extensive and detailed analysis required to respond 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 the Health Policy Subcommittee of Business Unity South Africa (BUSA). We are committed to maintaining and enhancing our relationships and working collaboratively with regulatory authorities and industry stakeholders, as we believe this is key to ensuring beneficial outcomes for all.

In 2023 and early 2024, the Scheme continued to engage with the CMS on several regulatory and policy matters, including LCBOs and the PMB review. Subsequent to the publication of the Section 59 Investigation Interim Report, which found no evidence of intentional or explicit racial bias in any of the processes or methodologies carried out on the Scheme's 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, the Scheme also considered responses by Discovery Health to an additional report by the Section 59 Investigation Panel. Discovery Health, with the support of independent experts, had found a number of errors in the additional report, and made a submission to the Panel detailing these.

In 2024, the Scheme will continue to engage in initiatives to drive medical scheme industry reform for the benefit of DHMS and the industry; work to enhance stakeholder relationships that promote outcomes which support the success and sustainability of the industry, with a focus on promoting wider access through such mechanisms as optimised PMBs, LCBOs and funding mechanisms for high-cost medications; and will consider appropriate steps in response to further NHI developments.

More about our engagement with regulatory matters *pg 73*

Governance excellence

To fulfil their accountability to our members, the Trustees closely monitor the work of the Scheme Office and Discovery Health in its capacity as the Scheme's administration and managed care provider. This includes ensuring that the Scheme's outsourcing and procurement arrangements and processes support independence, good governance and business decisions and assist the Trustees in executing their fiduciary duties. 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 and frameworks from across the world as well as the King IV Report on Corporate Governance for South Africa 2016. 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.

We held a physical Annual General Meeting (AGM) in 2023 and worked with a new independent electoral body to prevent any conflict of interest.

In 2024 we plan to hold a hybrid AGM where members can choose to join the AGM either virtually or in person at a physical venue, enabling members to participate and vote regardless of where they are.

More about how we are governed *pg 48*

People management and development

The Scheme Office is staffed by a small but highly capable and knowledgeable team, focused on the business activities of the Scheme Office as a centre of governance excellence. These activities follow a cycle of setting strategy and standards; overseeing implementation and delivery; monitoring, adapting and improving processes; and executing day-to-day work. Daily management of the Scheme includes investment and operations management, stakeholder engagement and responsible corporate citizenship, regulatory engagement, advocacy and compliance, finance, procurement, legal and dispute management, strategic planning and implementation, and talent, culture and leadership management. The expertise and capability required means that people management and development is a core enabler of the Scheme's success.

Subsequent to the pandemic, the Scheme carefully considered and implemented a hybrid working model designed to optimise productivity while supporting our culture, and giving employees some much-needed flexibility and access to better work-life balance. Regular culture assessments and interventions take place to monitor and promote desired culture, values and behaviours, and to equip employees to manage adversity and challenges while developing their capabilities.

In 2023, a role benchmarking exercise was completed, and appropriate recommendations were implemented to ensure the Scheme's continued ability to attract and retain the required level of employee. Employees have access to a wide range of development opportunities; two employees who received bursaries completed their respective MBA and LLB studies, and bespoke courses aimed at enhancing the soft skills and leadership of our people were conducted. The Scheme Office's culture of development and learning in a values-driven environment continues to be highly effective in the hybrid work model that the Scheme utilises.

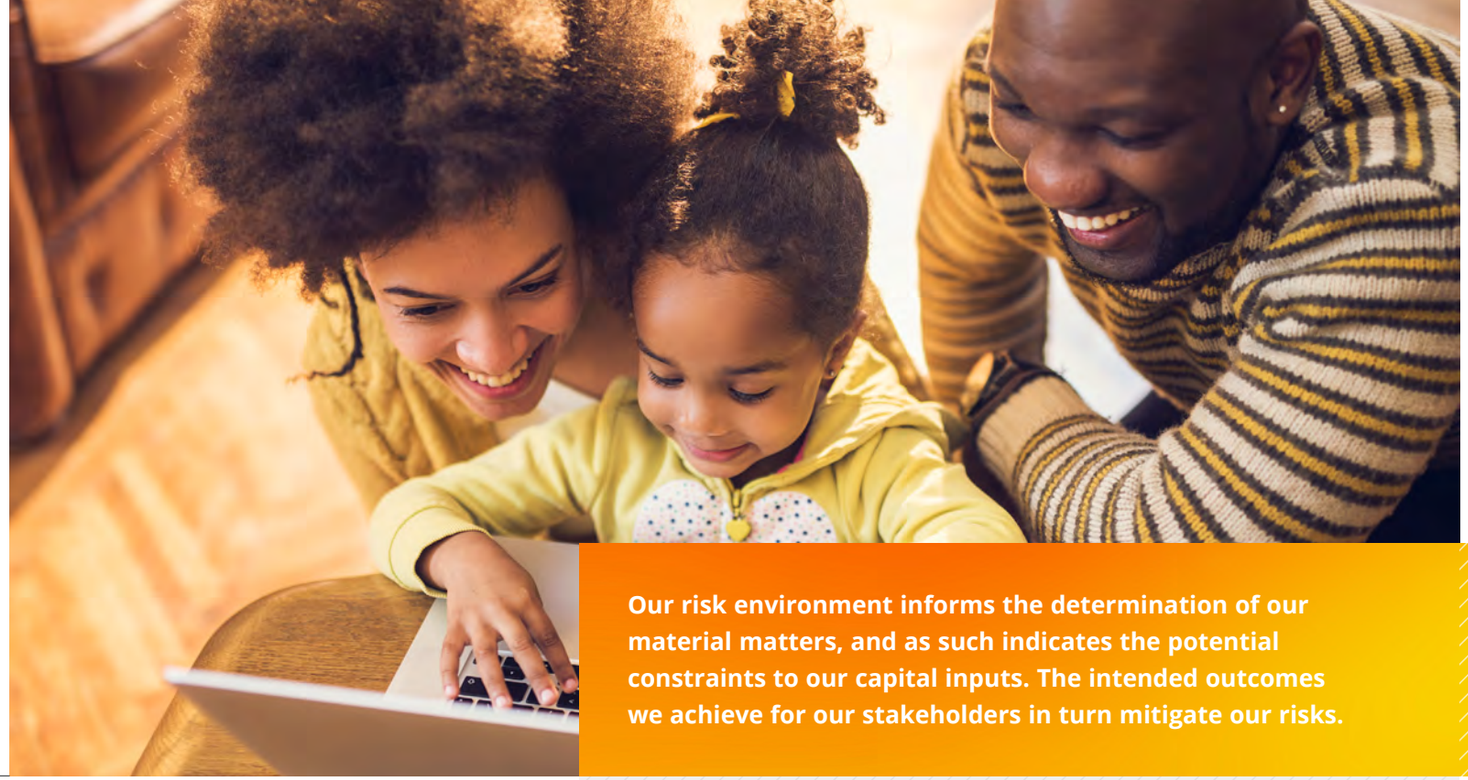
In 2024, DHMS will continue to focus on development, ensuring that our people are capable of effectively implementing the Scheme's strategic objectives, ensuring our continuing operations and sustainability, for the benefit of our members.

Our business model *pg 25*

Our values *pg 32*

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.



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.

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 are 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 that pertain directly to our core service to our members and to our business activities, as well as more broadly. This ensures that emerging risks are included in the scope of assessment. 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 associated mitigation strategies follows.

- SCHEME SUSTAINABILITY, AFFORDABILITY OF CONTRIBUTIONS AND MEDICAL INFLATION
- GOVERNANCE, POLICY, REGULATORY AND COMPLIANCE
- TECHNOLOGY AND INFORMATION
- STAKEHOLDER MANAGEMENT

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, the absence or limitation of regulatory tools to manage anti-selection (where members may select not to be on medical schemes or buy into lower contribution plans until they need high-cost medical cover) and some aspects of the PMB regulations, particularly in the context of unregulated medical tariffs.

Mitigating actions

- Each year, the Trustees carefully assess utilisation forecasts, solvency requirements, membership growth, the membership's demographic and disease profile, and the benefit plans offered by the Scheme to ensure the sustainability of the Scheme for the following and forthcoming years, while considering the healthcare needs and affordability constraints of members. In this regard, the Scheme continuously considers product and benefit differentiation and optimisation to meet different member's needs.
- Risk management interventions are implemented 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. This includes consideration of innovations that may lower healthcare costs, while ensuring members have access to quality healthcare, through negotiated tariffs with major healthcare professionals such as hospital groups, radiology and pathology providers, corporate pharmacies and others, direct payment arrangements, and DSP networks to mitigate PMB exposure.
  Value-based contracting, while still not covering the majority of healthcare expenses, is increasingly being implemented through working closely with healthcare professionals. The Scheme is continuously developing and enhancing managed care programmes underpinned by a population health management approach, focused on the prevention and management of non-communicable diseases and conditions, to support co-ordinated care and better quality outcomes.
- Continuous healthcare innovation, including customer-centric digital healthcare solutions that can improve efficiency and lower healthcare costs.
- Developing science-based programmes to focus on disease prevention, and physical and mental wellbeing to stem the trends in chronic diseases of lifestyle and mental disorders.
- 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.
- 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 and other health technologies including medical devices, treatments and services offered to members. This includes health technology assessments, evaluating supply chain dynamics and sourcing alternatives where appropriate. Discovery Health also actively monitors utilisation for the Scheme to enable agile responses to changes.
- Engagements with regulators take place to address concerns and propose appropriate guardrails in regulatory amendments to help protect the sustainability of the Scheme.
- Advocating for the introduction of Low-Cost Benefit Options within schemes to promote accessibility, membership growth and a healthier population.
- 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 LCBOs, the PMB review, and DSP networks, and utilising these to benefit members through new efficiency discount options.

GOVERNANCE, POLICY, REGULATORY AND COMPLIANCE

Risk description and impact

Changes in the regulatory environment and the requirement to manage these changes present challenges to not only the healthcare industry, but our business model as well. These changes may have operational, compliance, governance, 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 legislation, Scheme 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 can introduce 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.

Mitigating actions

- Regular, detailed and proactive engagement with relevant stakeholders and 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 regulatory 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 monitoring 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 enable 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.
- A focus on proactive, robust governance and the implementation of frameworks to safeguard and promote organisational knowledge supports risk mitigation.
- 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.

TECHNOLOGY AND INFORMATION

Risk description and impact

The Scheme's environment 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, financial loss and business disruption, all of which can impact the integrity and availability of information assets and the security of personal information. This may also have 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 controls and standards, including infrastructure and security measures, offering improved risk mitigation are continually assessed and implemented where appropriate.
- Reports are obtained from independent assurance providers regarding key risks and the associated controls.

STAKEHOLDER MANAGEMENT

Risk description and impact

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 may impact the Scheme's sustainability. Conversely, 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.
- Even though not legally required, the Trustees embrace the Treating Customers Fairly (TCF) principles and framework prescribed for other financial institutions, 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 engagements, 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.
- Where specific stakeholder groups express dissatisfaction, frustration or a lack of understanding, engagement focus and communication strategies are implemented to hear and address, insofar as possible, the stakeholders' concerns.

Creating stakeholder value *pg 31*

Our Chairperson's statement

Discovery Health Medical Scheme registration number 1125

Economic uncertainty, geo-political instability, and the aftermath of COVID-19 continue to impact the global healthcare landscape. In South Africa, high unemployment levels, affordability constraints, healthcare cost inflation and increasing healthcare demands intensify the challenges. The Scheme continues to navigate these complex conditions with a steady focus on the best interests of our members.

MICHELLE NORTON, SC

Discovery Health continues to provide administration and managed healthcare services to the Scheme in accordance with the Vested outsourcing model that governs this relationship.

The Trustees consistently seek to balance providing access to an appropriate quality of care with managing costs and contribution increases to ensure the sustainability of the Scheme. The demise of Health Squared Medical Scheme in 2022 underscored the complex dynamics in which we operate and sharpened the Trustees' vigilance in addressing risks to the viability of the Scheme.

Governance excellence is central to the Scheme's operating model and we maintain the highest possible standards of corporate governance. The Scheme Office and the Trustees perform their duties within robust operating frameworks that govern key issues, including procurement and related party transactions. These frameworks provide clear and transparent guidelines for the strategic direction and operational outcomes of the Scheme, and support institutional memory in an environment where Trustees and Independent Committee Members serve limited terms of office.

Governance and leadership *pg 48*

In line with our governance objectives, the Trustees appointed The Ethics Institute to assess the Scheme's ethics culture. We were satisfied with the results of the assessment, which showed a benchmarked score in the 100th percentile, indicating a mature ethical culture.

The assessment identified only minor gaps in ethics awareness. An ethics management plan has been developed to ensure that these high standards are maintained, and the gaps addressed.

The Trustees also engaged PG Governance to conduct independent evaluations of the Board and Board Committees' performance against King IV corporate governance best practice and the Medical Schemes Act. The Board's overall evaluation score was 95%, and the Committees' scores ranged from 95% to 100%, all rated as excellent by PG Governance.

Discovery Health continues to provide administration and managed healthcare services to the Scheme in accordance with the Vested outsourcing model that governs this relationship. The Board continuously monitors the services rendered and outcomes achieved. A comprehensive peer-reviewed assessment of the value provided to the Scheme by Discovery Health is conducted every year (for the preceding year) and we are pleased to report that, for every R1.00 paid to Discovery Health by the Scheme in 2022, members received R2.08[1] worth of value.

More about the assessment of value *pg 94*

1 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2022, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.08 (2021: R2.02) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*

Our Chairperson's statement *continued*

The Trustees have been vigilant in addressing threats posed to the Scheme by fraudulent, wasteful or abusive practices or anti-competitive conduct by service providers. The Scheme is a party to the referral of a complaint to the Competition Commission regarding the overpricing of PCR tests by pathology laboratories. We anticipate that the outcome may enable us to recover member funds. We oversaw an investigation by our Administrator into allegations by an anonymous whistleblower of billing manipulation at six Mediclinic hospitals.

A consistent priority for the Trustees is the optimisation of benefits for our members while limiting contribution increases in response to healthcare cost inflation and increased utilisation of healthcare services. The supply-side component of healthcare cost inflation is strongly driven by the prevalence and growth of new medical and information technologies, which require careful consideration in a range of decisions of the Scheme and the Trustees.

The Trustees mandate Discovery Health to drive innovation in healthcare, particularly the implementation of value-based healthcare models. An important development here is a recent set of amendments to the ethical rules of the Health Professions Council of South Africa, which remove the previous barriers to multi-disciplinary practices. The amendments lay the foundation for more holistic healthcare and more efficient referral pathways, creating opportunities for innovative fee arrangements, supporting better health outcomes, and driving down costs. We are also exploring opportunities to leverage big data and ground-breaking analytics and algorithms to support members in making better, individualised decisions to optimise their health and prevent, reverse and manage disease.

From time to time, the Trustees are required to decide on benefit changes that create challenges for our members. These decisions are not taken lightly or without due consideration of how they may affect our members' financial planning and access to healthcare. Closing three Comprehensive Series plans in 2023 is an example; we needed to ensure that the exceptional benefits of the Comprehensive Series could be offered sustainably in the face of significant adverse loss ratios on specific plans. The Trustees appreciate the support of the Council for Medical Schemes in assessing and approving such proposed changes, towards an optimal balance between protecting our members and guarding the Scheme's sustainability.

Read more about the 2024 benefit and contribution changes *pg 24*

The Trustees are carefully following developments in respect of the National Health Insurance Bill that was passed by the National Assembly on 12 June 2023 and by the National Council of Provinces on 06 December 2023. The Scheme has petitioned the President not to sign the Bill in its current form, but rather to refer the Bill back to the National Assembly for reconsideration on constitutional grounds. While fully supporting the realisation of Universal Health Coverage in South Africa, the Board is concerned that key aspects of the Bill conflict with the Constitution and the constitutional standards governing legislation, and is engaging with external experts and key stakeholders to determine appropriate interventions.

The expertise and judgement of my fellow Trustees and the support of our Independent Committee Members have been crucial to the Board's effective decision-making in the face of complex challenges.

While our focus as Trustees is to ensure the ongoing sustainability and effective operation of the Scheme, we also recognise the importance of monitoring and accounting for our impact on the world around us. We include in this Report a sustainability position statement which articulates our approach and priorities. We have mandated the Scheme Office to conduct a formal evaluation of our current impact, which will enable us to develop a formal sustainability strategy aligned with the Scheme's overall objectives and operating imperatives.

Sustainability Position Statement *pg 33*

The Scheme's AGM and Trustee elections will take place on 27 June 2024. In accordance with a Council for Medical Schemes recommendation and in order to facilitate member participation and access, the Trustees have determined that the AGM and elections will be held in a hybrid format, permitting in-person or virtual attendance and participation.

I conclude by acknowledging the people who drive the work of the Board and the Scheme.

In June 2023 we took our leave of John Butler SC, who served two terms as a Trustee and chaired the Board from 01 January 2022 to 13 June 2023 with remarkable skill and steady guidance. We also bid farewell to Johan Human, who served two terms as a Trustee and enriched the Board with his actuarial expertise in the healthcare context. We thank them both for their longstanding commitment to the Board. We have welcomed in their places Dr Rendani Mbuvha and Dr Dhesan Moodley, whose respective actuarial and clinical expertise will be invaluable.

The expertise and judgement of my fellow Trustees and the support of our Independent Committee Members have been crucial to the Board's effective decision-making in the face of complex challenges. Our Principal Officer, Charlotte Mbewu, provides exceptional leadership of the Scheme and the Scheme Office team has given consistently strong support to the Board.

M L Norton

MICHELLE NORTON, SC
Chairperson

Our Principal Officer's review

Discovery Health Medical Scheme registration number 1125

Our continued focus is to prioritise our members' health and wellness needs, in balance with the sustainability of the Scheme. We serve 2 788 242[1] beneficiaries, whose healthcare needs we must support in a manner that ensures quality of care.

MS CHARLOTTE MBEWU

In a complex environment spurred by economic volatility, changing demographics and affordability constraints, we have achieved the following on their behalf:

- Launched new benefits to increase health promotion and disease prevention, and to manage the reduced health-seeking behaviour emanating from the COVID-19 pandemic era.
- Enhanced benefits to assist members in funding their healthcare needs.
- Maintained the Scheme's strong solvency position.
- Maintained the Scheme's leading position and market share.

This has allowed the Scheme to maintain a strong operational performance, albeit in a complex operating environment.

1 *As at 31 December 2023.*

Our governance processes were enhanced and bedded down, and we continued to optimise our arrangements with Discovery Health.

The **IFRS 17 accounting standard** is now applicable to the Scheme, and changes have therefore been made to the **terminology and presentation** of our Financial Statements. This introduces some **new terms into the main body of this Report as well as the Financial Statements**.

IFRS statement in AFS chapter *pg 98*

For the period under review, the Scheme generated an insurance revenue (previously contribution income) of R73 328 million. Taking claims paid on behalf of members and other expenses directly attributable to membership into account, the Scheme generated an insurance service result before amounts attributable to future members of negative R2 252 million (2022: R2 493 million negative). This is a strong performance in the context of demographic risk and economic headwinds. In terms of our investment strategy, the Scheme generated investment income of R2 418 million (2022: R2 222 million), which strongly supported our financial position despite challenging and unpredictable market conditions.

As budgeted, insurance liability to future members (previously member funds) decreased to R28.7 billion (2022: R28.9 billion) with WELLTH Fund expenditure being funded through excess solvency, resulting in solvency of 30.60% (2022: 35.04%[2]) as at 31 December 2023. This is well above the 25% solvency level required by regulations. The Scheme is therefore in a strong position to meet members' needs, and to continue the WELLTH Fund that extends members' access to screening and additional day-to-day benefits.

Our performance *pg 77*

Our governance processes were enhanced and bedded down, and we continued to optimise our arrangements with Discovery Health. In particular, this relates to effectively assessing and adopting innovations by Discovery Health, and ensuring ongoing alignment with best practice governance and the fiduciary duties of our Trustees. The Scheme Office's culture of development and learning in a values-driven environment continues to be highly effective in the hybrid work model we have implemented.

2 *Previously reported as 35.11%, restated due to the implementation of IFRS 17.*

Our Principal Officer's review *continued*

Specific challenges we face include addressing the demographic profile of the Scheme, containing healthcare costs and ensuring membership growth, needed by the Scheme for cross-subsidisation between members and for Scheme sustainability; and policy and regulatory developments where the NHI Bill may still undergo constitutional review. Also due to regulatory barriers, medical schemes have been unable to implement low-cost, primary care-based benefit plans that would expand private healthcare access to many more South Africans.

Regulatory matters dealt with in 2023 *pg 73*

The demographic pressure on the Scheme, driven by an increasing burden of chronic disease together with membership affordability constraints in the current economic climate, shape our ongoing conversations about utilisation, membership growth, and strategies to better support the health and wellness needs of our members while enhancing healthcare expenses management. The ability to offer our members value for their contributions and be responsive to their changing needs is essential. Given healthcare inflation of 11.7% in 2023, and an expected range of consumer price index (CPI) + 4-7% in 2024, our challenge is to match contribution increases as closely as possible to utilisation, which is driven by supply- and demand-side factors, demographic risk, and tariff increases (which increase in line with healthcare inflation).

Healthcare inflation *pg 84*

Accordingly, for 2024 we have had to carefully consider and balance these aspects. The performance of the Delta and Essential Comprehensive plan options indicated a need to consolidate the Comprehensive series, leaving the Classic Comprehensive and Classic Smart Comprehensive as our two plans. Some non-emergency exclusions have been added to the KeyCare plans, as well as a requirement for KeyCare members and members registered on the Chronic Illness Benefit to nominate a single primary care provider for 2024. There is evidence showing that patients experience improved health outcomes when their primary care is co-ordinated through a single primary care GP, so this change is in line with the Scheme's focus of promoting value in healthcare.

The Scheme also reduced some Personal Medical Savings Account (PMSA) percentages to enable us to have a lower overall contribution increase, informed by the utilisation levels of the PMSAs, while simultaneously adding risk benefits to reduce the pressure on PMSAs for members. These additional benefits, previously frequently utilised through a PMSA, include mental health preventative screening and access to internet-based Cognitive Behavioural Therapy in support of and complimentary to benefits already in place within the Mental Health Programme. We have also added access to virtual urgent care. Access to these benefits and others is supported through the new member app, designed to offer a more personalised healthcare journey.

See your specific plan and contribution changes

We endeavour to continuously expand our members' access to programmes aimed at improving or maintaining their health and wellness. To this end, we are working with Discovery Health to utilise technology and data to build personalised health pathways for our members. These are grounded in credible research conducted in collaboration with the London School of Economics (LSE)[1]. These pathways will predict and encourage members to take steps that are most important to improving their current and future health. This ground-breaking innovation will help us to manage our demographics and burden of disease, as well as assist our members with individually tailored information.

We continue to engage closely with our regulator, the Council for Medical Schemes, and thank them for their ongoing drive to protect medical scheme members. We look forward to work underway to promote the improved functioning of the medical schemes industry through initiatives such as the review of Prescribed Minimum Benefits. We also closely monitor and, wherever possible, make submissions on policy changes such as the NHI Bill. We remain concerned that in its present form, it will not support sufficient reform and improvements to healthcare in South Africa. As such, we have proposed that proper consideration be given to a model allowing for multiple funders of healthcare, which is lower risk and more appropriate in the South African context. We have also asked for clarity on the intended role of medical schemes under the NHI Bill. While we do not anticipate any immediate changes for our members should the Bill be written into law, we will continue to support our government in moving towards universal health coverage, while advocating for the most constructive, appropriate and workable legislation to achieve this crucial national objective.

Finally, I thank our Trustees and Independent Committee Members for their thoughtful engagement in governing and overseeing the Scheme. Their support and guidance are invaluable to me and my team. The Scheme Office has again performed with dedication and excellence in an environment where carefully balancing operational and strategic objectives in the immediate and long-term interests of our members is essential.

C Mbewu

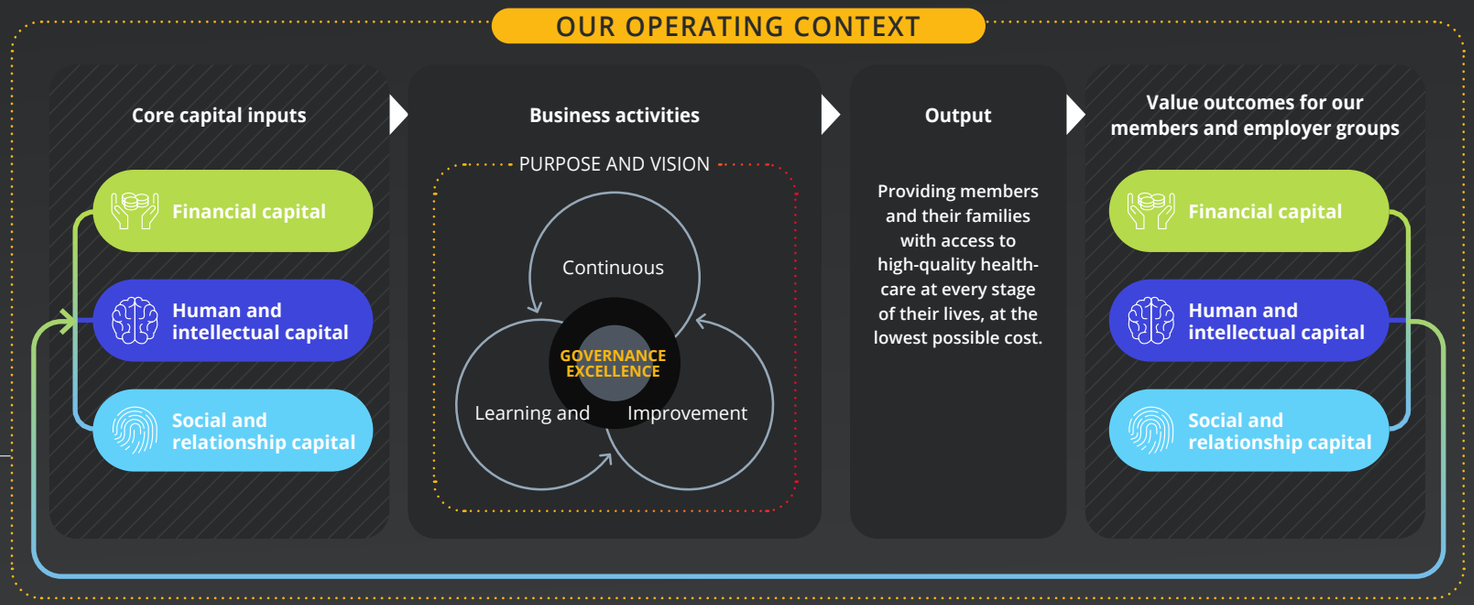
MS CHARLOTTE MBEWU
Principal Officer

We endeavour to continuously expand our members' access to programmes aimed at improving or maintaining their health and wellness.

1 *Work done with the LSE produced robust results on the reduction in the risk of developing type 2 diabetes and severe cancer through forming activity habits. https://www.dailymaverick.co.za/article/2024-03-12-get-moving-to-reduce-your-health-risks-and-cut-medical-costs-vitality-habit-index/.*

SECTION 4

Our business model



The primary need of our members is accessible and affordable healthcare now and in the future, and our business model is designed to fulfil that need through sustaining the financial, operational and relational wellbeing of Discovery Health Medical Scheme (DHMS or the Scheme).

We oversee a complex ecosystem of relationships with our members at the centre. Our business model centres on delivering excellence and innovation in our core service to our members through best practice governance and thought leadership in the medical schemes industry.

As a funder connecting our members to the private healthcare value chain, the Scheme's business model is people led, capability driven, and relationship based which is clearly reflected in our core capital inputs and our value outcomes.

The quality of our relationships with our stakeholders is essential to realising our vision and creating sustainable value outcomes for our members, employer groups and society, as well as supporting a better healthcare system, in line with our purpose.

Discovery Health Medical Scheme registration number 1125

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 our opportunities 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 and, in turn, 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.

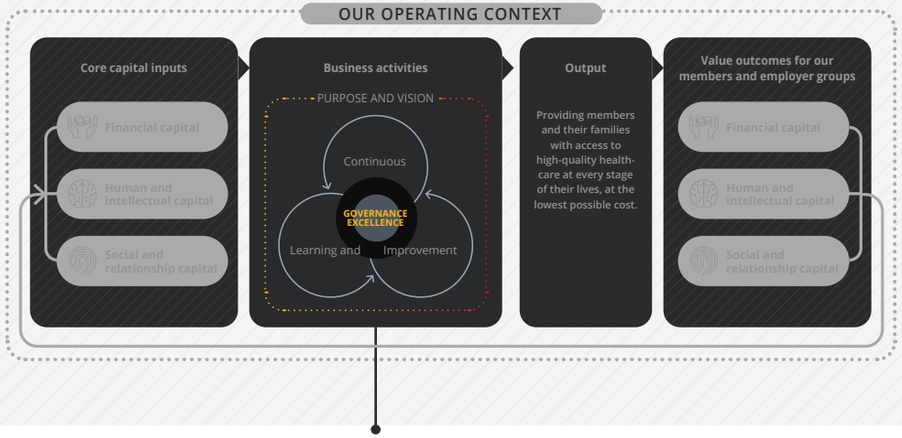
Vested outsourcing applies an outcomes-driven approach characterised by:

- 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. 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.

Key elements of our business model are discussed in:

Creating stakeholder value *pg 31*
Material matters *pg 11*
Our strategic themes *pg 13*
Our residual risks *pg 17*



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.

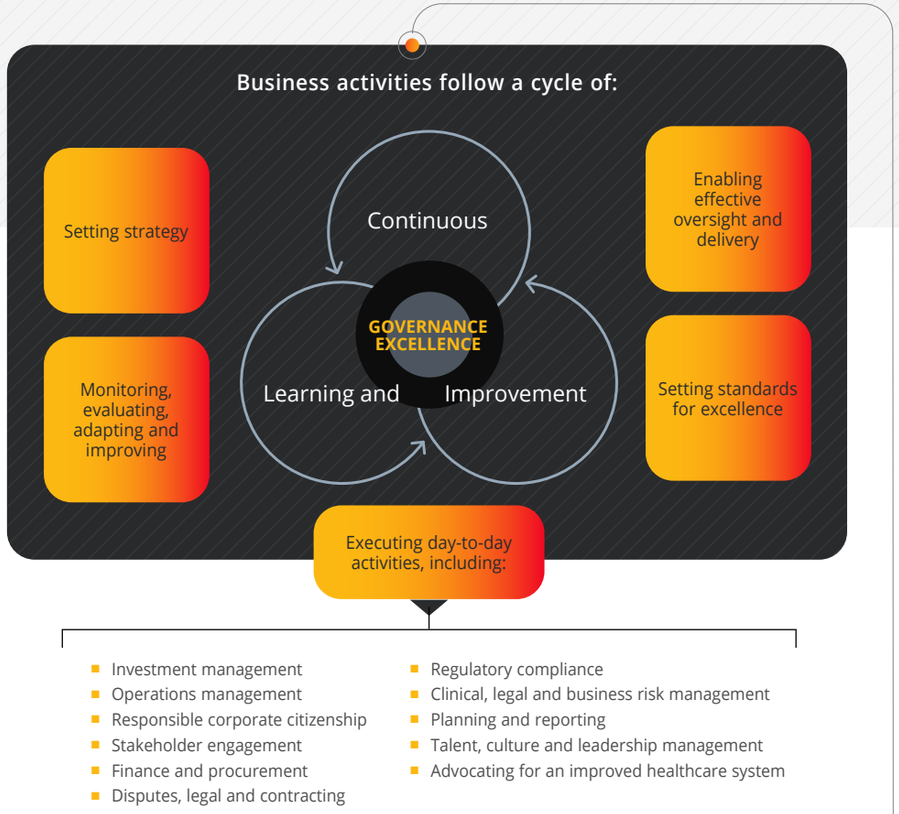
Our vision

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

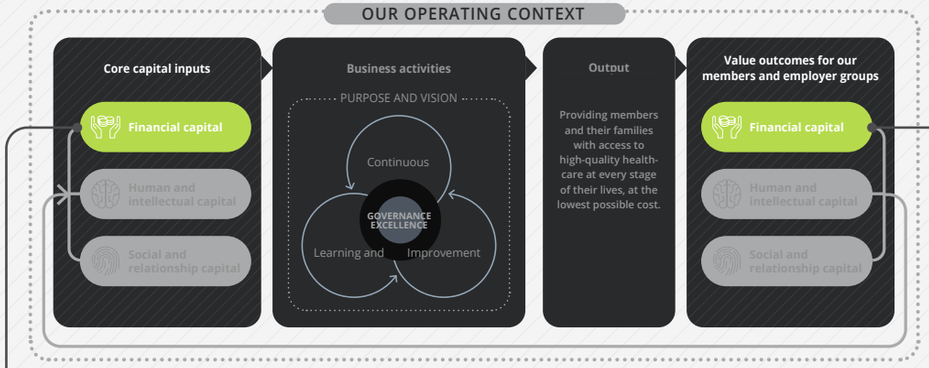
DHMS undertakes its business activities in line with its operating model, which defines the Scheme as a centre of governance excellence enabled by a culture of continuous learning and improvement and led by a capable, knowledgeable team. This means that the Scheme is focused on:

- **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.



Discovery Health Medical Scheme registration number 1125

Value snapshot for the year ended 31 December 2023



1 *At 31 December 2023.*
2 *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Annual Report for the year ended December 2022 (https://www.medicalschemes.co.za/publications/#2009-3696-wpfd-2022-23-annual-report). At the end of 2022 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 2.1 million beneficiaries. Source: Annexures to the CMS Annual Report 2022-2023.*
3 *Source for industry information: Annexures to the CMS Annual Report 2022–2023 (https://www.medicalschemes.co.za/publications/#2009-3696-wpfd-2022-23-annual-report). The average of all other open schemes excludes DHMS and has been calculated for 2022 since data for 2023 is not yet available. The average age and pensioner ratios from the CMS Annual Report may differ from those available in the DHMS Integrated Report due to a difference in the calculation methodology.*
4 *7.8% for 2022, vs the weighted average gross administration expenditure for open schemes as a proportion of GCI, which was 8.2% excluding the Scheme. Based on the CMS Annual Report 2022-2023.*

Core capital inputs

MATERIAL MATTERS RELEVANT TO THE CAPITAL indicating drivers and constraints of value – with potential for ⊘ positive, ⊖ neutral or ⊗ negative impact on the Scheme.

Financial capital

- **Gross member contributions** of R88.8 billion (2022: R79.5 billion).
- **Investment income** of R2.4 billion (2022: R2.2 billion), generated from Scheme assets.

Caring for our members
- ⊘ Affordable access to quality care in the face of compounding healthcare inflation and financial pressure.
- ⊗ Impact of burden of disease, climate change and pollution on healthcare landscape.
- ⊘ Scheme sustainability and equitable treatment of members.
- ⊖ Increased healthcare expenditure due to advancement of technology and individualised treatments.
- ⊘ Driving opportunities such as digital health capabilities and new delivery platforms to optimise access and efficiencies.

Scheme sustainability and lack of growth in our current economy
- ⊗ Low economic growth and affordability constraints causing muted or negative membership growth.
- ⊘ Driving membership growth, especially young healthy lives to enable cross-subsidisation.
- ⊗ Competition for new members and members who change schemes.
- ⊗ Geo-political tensions causing shifts in trade dynamics: increasing costs of imported products, delays, constraint of economic improvement and local development.

Ethical business and stakeholder partnerships
- ⊘ Partnerships to co-create a stronger, more affordable and accessible healthcare system.
- ⊘ Equitable access to high-cost health technologies and treatments, population care and wellness.
- ⊗ Corruption and fraudulent behaviour a constraint to healthcare access, design of benefits and sustainability of healthcare funding.

Health system transformation and sustainability
- ⊘ Social solidarity, innovation, competition and collaborative partnerships to meet healthcare challenges.
- ⊗ Deterioration of structures contributing to healthcare funding and access, stabilisation and implementation of policy and regulatory reform.
- ⊗ Prevalence of fraud, waste, abuse and corruption, uncertain quality of care, healthcare skills shortages.

Discovery Health Medical Scheme registration number 1125

Financial capital

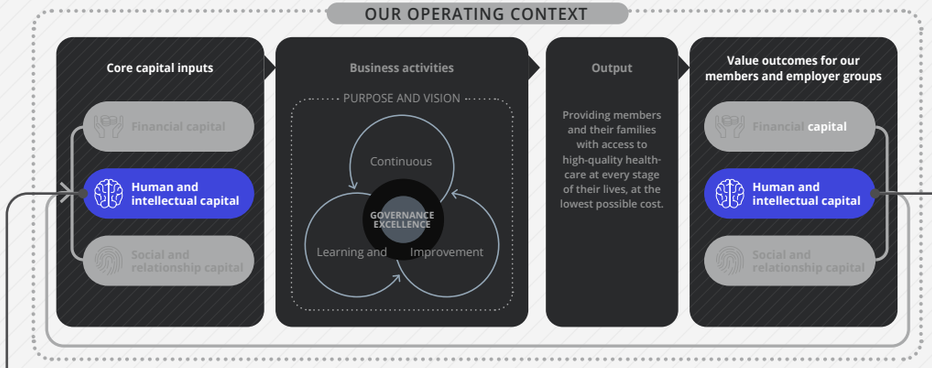
Outcomes achieved in relation to the capital in 2023, demonstrating the Scheme's response to these value drivers and constraints.

- Largest open medical scheme, with 2 788 242 beneficiaries[1] and 57.8%[2] market share.
- DHMS has good demographics when compared to the open medical scheme industry, with an average age of 35.6 and a pensioner ratio of 10.9% (versus 36.0 and 11.9% respectively across all other open medical schemes)[3].
- Financial strength, with R28.7 billion in member funds, a 30.60% solvency level, and an AAA credit rating confirming the Scheme's ability to meet large, unexpected claim variations.
- DHMS gross administration expenditure as a proportion of gross contribution income (GCI) is the fourth lowest out of 17 schemes in the open scheme market[4].

Other key stakeholder relationships relevant to our financial capital outcomes:

Our employees *pg 46*
Members *pg 37*
Discovery Health *pg 45*
Financial advisers *pg 44*
Regulatory bodies *pg 47*

Value snapshot for the year ended 31 December 2023 *continued*



Core capital inputs

MATERIAL MATTERS RELEVANT TO THE CAPITAL indicating drivers and constraints of value – with potential for ⊘ positive, ⊖ neutral or ⊗ negative impact on the Scheme.

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.

Caring for our members

⊘ Providing high-quality, value-based, member-centred healthcare journeys, at all stages of their lives.
⊘ Remaining responsive to increasing consumer preferences.
⊗ Participatory physical and mental healthcare and access to leading healthcare technology and treatments.
⊘ Scheme sustainability and equitable treatment of members.
⊘ Safeguarding of member's data and privacy.

Scheme sustainability and lack of growth in our current economy

⊘ Driving membership growth, especially young healthy lives to enable cross-subsidisation.
⊗ Preparation for 2024 elections further impacting infrastructure, change leadership capabilities, crime and management of public institutions.
⊗ Pressure on jobs growth and social cohesion impacting household income and scheme affordability constraints.

Ethical business and stakeholder partnerships

⊗ Inadequate governance, controls and capacity in the broader business and political environments.
⊘ Ethical leadership, best practice governance and social responsibility to society by all sectors.
⊖ Interdependent relationship with stakeholders provides regulatory and social licenses to operate enabling us to care for our members.

Health system transformation and sustainability

⊘ Social solidarity, innovation, competition and collaborative partnerships to meet healthcare challenges.
⊘ Driving opportunities such as digital health capabilities and new delivery platforms to optimise access and efficiencies.
⊗ Deterioration of structures contributing to healthcare funding and access, stabilisation and implementation of policy and regulatory reform.
⊗ Prevalence of fraud, waste, abuse and corruption, uncertain quality of care, healthcare skills shortages.

Discovery Health Medical Scheme registration number 1125

Human and intellectual capital

Outcomes achieved in relation to the capital in 2023, demonstrating the Scheme's response to these value drivers and constraints.

BOARD OF TRUSTEES AND BOARD COMMITTEES

In 2023, PG Governance evaluated the Board and Board Committees against the principles of the King IV Report on Corporate Governance for South Africa 2016, recognised as best governance practice, and the Medical Schemes Act. The Board's evaluation score was 95% and the Committees' score averaged 97%, both rated as excellent by PG Governance.

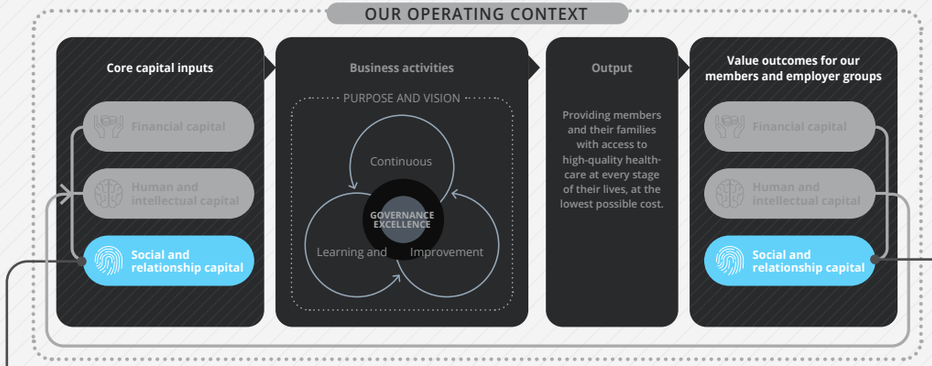
EMPLOYEES

- 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 Human and intellectual capital outcomes:

Members *pg 37*
Discovery Health *pg 45*
Providers *pg 40*
Regulatory bodies *pg 47*

Value snapshot for the year ended 31 December 2023 *continued*



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 potential for ⊘ positive, ⊖ neutral or ⊗ negative impact on the Scheme.

Caring for our members

⊗ Impact on healthcare landscape of burden of disease, climate change and pollution.
⊘ Providing high-quality, value-based, member-centred healthcare journeys.
⊘ Participatory physical and mental healthcare and access to leading healthcare technology and treatments.
⊘ Scheme sustainability and equitable treatment of members.
⊘ Providing member education and empowerment, and promoting co-ordinated disease prevention and healthy living to assist their healthcare journeys.
⊘ Providing reliable and easy interaction with the Scheme.

Scheme sustainability and lack of growth in our current economy

⊗ Low economic growth and affordability constraints causing muted or negative membership growth.

Ethical business and stakeholder partnerships

⊘ Partnerships to co-create a stronger, more affordable and accessible healthcare system.
⊗ Inadequate governance, controls and capacity in the broader business and political environments.
⊘ Ethical leadership, best practice governance and social responsibility to society by all sectors.

Health system transformation and sustainability

⊘ Social solidarity, innovation, competition and collaborative partnerships to meet healthcare challenges.
⊗ Lack of regulatory reform and incomplete implementation.
⊘ Driving opportunities such as digital health capabilities and new delivery platforms to optimise access and efficiencies.
⊗ Deterioration of structures contributing to healthcare funding and access, stabilisation and implementation of policy and regulatory reform.
⊗ Prevalence of fraud, waste, abuse and corruption, uncertain quality of care, healthcare skills shortages.

Discovery Health Medical Scheme registration number 1125

Social and relationship capital

Outcomes achieved in relation to the capital

in 2023, demonstrating the Scheme's response to these value drivers and constraints.

RESPONSIVE, HIGH-QUALITY, VALUE-BASED HEALTHCARE

- Driving access and 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 R8.5 billion[1] to our members.

Outcomes achieved in relation to the capital continues on the next page

1 *The estimated contribution savings provided to members across 2021, 2022 and 2023 has been updated to R8.5 billion (previously reported as R8.6 billion). At the time of calculation for the 2022 Integrated Report, the actual contribution income for the 2023 deferral period (January to March) had not yet been received, and so the savings were calculated based on the assumption that the plan distribution as at December 2022 would remain constant over the deferral period. This calculation has since been updated to reflect the actual contribution income received over January to March 2023, resulting in contribution relief for DHMS members of R8.5 billion through the 2021, 2022 and 2023 contribution increase deferrals.*

Value snapshot for the year ended 31 December 2023 *continued*

Social and relationship capital

Outcomes achieved in relation to the capital

in 2023, demonstrating the Scheme's response to these value drivers and constraints.

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 2023 would require 180 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 363 years of contributions based on the average risk contribution of R2 162 per beneficiary per month.
- For an average risk contribution of R2 162 per month, R79 billion was paid out for claims in 2023. Claims paid for the year included:
  - R5 430 per beneficiary with a chronic condition for out of hospital costs (800 610 beneficiaries);
  - R62 772 per admission (664 340 hospital admissions);
  - R126 627 per beneficiary undergoing oncology treatment (46 270 beneficiaries).
- 16.3% of beneficiaries claimed more than their contributions.

Plan choice

- Our full spectrum of 22 plan options for 2024 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 2023-January 2024, 94.67% of members did not change their plans.

Affordability[2]

- Average contributions for our members in 2024 are 11.1% lower than the next seven largest open medical schemes[3].
- The Scheme is more affordable than the next seven largest open schemes across most plan categories in 2024 (income capitated: -1.5%; hospital: 0.4%; limited day-to-day: -15.3%; extensive day-to-day: -7.5%).

Value for money

- The Trustees conduct a formal evaluation of the value for money Discovery Health (Pty) Ltd (Discovery Health) provides to the Scheme every year. In 2022, DHMS received R2.08 of value added by Discovery Health for each Rand paid to it[4].

More about the value provided by Discovery Health and how this is calculated *pg 94*

Digital capabilities and innovation[5]

- The new Discovery Health 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 2 410 doctors regularly used HealthID in treating our members during 2023, with 3.1 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.
- 183 600 virtual consultations were conducted during 2023, facilitating ease of access for members and convenience for providers, and enabling consultations under circumstances where patients are unable to attend a physical consultation.

Member satisfaction

- Member perception score of 8.81 out of 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:

Providers *pg 40*

Financial advisers *pg 44*

Discovery Health *pg 45*

Regulatory bodies *pg 47*

1 *All figures are for the period October 2022 to September 2023, 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 2023.*

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. Contribution rates on individual plans on other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

3 *The differential reported for 2023 has been updated from 12.2% to 12.3% to reflect the interim contribution increase effective 01 May 2023 by Sizwe-Hosmed.*

4 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2022, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.08 (2021: R2.02) 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 Touche Tohmatsu Limited (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 2021 to 2022 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.*

SECTION 5

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.

Discovery Health Medical Scheme registration number 1125

Responsible corporate citizenship

Discovery Health Medical Scheme (DHMS or the Scheme) engages continuously and extensively with our stakeholders. Our active engagement and 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 with our core intention of protecting our members while 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 fulfil this 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 the shared value model of Discovery Health – 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.

One of the Scheme's focus areas during 2023 was sustainability. Our Sustainability Position Statement has been developed to clearly communicate our current position as well as our future intent in this area.

Sustainability Position Statement *pg 33*

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. Ongoing focus on ethics in the Scheme Office is 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.

Reporting unethical behaviour *pg 187*

During 2023, The Ethics Institute conducted an ethical culture maturity assessment for the Scheme, which included both quantitative and qualitative elements. The results of the quantitative survey were benchmarked against 70 international organisations and the Scheme was placed in the 100th percentile for maturity of ethical culture. Benchmarked at the 96th percentile, ethics awareness was identified as an area of weakness, and the Scheme has developed an ethics management plan to address this through regular training, induction, and an ongoing communication strategy. Extending leadership behaviours to embed a culture of ethics talk and reinforcing the ethical behaviours expected at the Scheme will also be addressed.

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

Discovery Health Medical Scheme registration number 1125

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: an ethical culture, good performance, effective control and legitimacy. To achieve these outcomes, King IV recommends that Trustees cultivate integrity, competence, responsibility, accountability, fairness, and transparency, 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

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.

MUTUAL RESPECT

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.

ADAPTABILITY AND AGILITY

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.

TEAMWORK, SUPPORT AND CARE

We will support and care for ourselves and others. When working together, we will share the load and work interdependently.

PURSUIT OF EXCELLENCE

We will focus on continuous improvement, development and quality, with learning core to how we work.

RESILIENCE

We will remain resilient and persevere, with the ability to bounce back when required.

SOCIAL RESPONSIBILITY

We will act responsibly and in the best interest of our members and society.

Our Sustainability Position Statement

Who **we are**

Discovery Health Medical Scheme (DHMS or the Scheme) is a non-profit open[1] medical scheme operating under the Medical Schemes Act (the Act). The Scheme exists to fund the healthcare of its members in accordance with social solidarity principles.

These are:

- **cross-subsidisation** (members contribute to a shared pool of funds and sicker members can access funds from the pool when needed for their healthcare); and
- **community rating** (everyone contributes the same amount according to their chosen plan, without limitations for age or state of health[2]).

DHMS operates in the private healthcare sector[3] in South Africa, serving members who pay their contributions primarily from post-tax discretionary income.

DHMS has appointed Discovery Health to provide it with administration and managed care services. In practice, this means that a large proportion of the Scheme's operations are outsourced to Discovery Health which conducts activities on behalf of DHMS. The relationship between the two organisations is governed by a Vested® outsourcing arrangement which is based on prioritising outcomes through each organisation focusing on what it does best. Amongst its other priorities, the DHMS Scheme Office is focused on governance excellence and oversight of these outsourced operations.

Discovery Health Medical Scheme registration number 1125

1 *Anyone can join the Scheme, as opposed to closed schemes which have restricted membership based on, for example, employment.*
2 *Very limited waiting periods may be imposed in certain conditions, in accordance with the Act. This is to protect members who have already been contributing to the pool.*
3 *Versus the public sector, which is tax funded and is accessible by any South African who pays for care according to a means test.*
4 *For example the United Nation's Sustainable Development Goals; the Johannesburg Stock Exchange Sustainability Disclosure Guidance; Global Reporting Initiative Standards; International Financial Reporting Standards (IFRS) Sustainability Disclosure Standards; the various industry standards of the Sustainability Accounting Standards Board; the Integrated Reporting Framework; and various concern-focused frameworks such as the Task Force on Climate-related Financial Disclosures (TCFD).*
5 *IFRS is the accounting standard that is required by the Act to be utilised by the Scheme. Should specific sustainability disclosures be required by IFRS, they will be incorporated.*

How we **govern sustainability**

The DHMS Board of Trustees has adopted a responsible corporate citizenship framework, which provides the parameters, operating requirements, principles and environmental factors within which the Scheme engages in responsible corporate citizenship. The framework serves to guide the Scheme's decision-making regarding governing principles relating to strategy, policy and tactical plans for responsible corporate citizenship.

This statement of our position on sustainability is part of the framework and will also be published or referred to in relevant documents such as this Report.

Other documents which operationalise our sustainability position include our Procurement Policy and Socially Responsible Investing Policy. Other related policies and guidelines will be created and updated over time to reflect our position.

How we **define sustainability**

In accordance with our stakeholder-oriented worldview and our approach to responsible corporate citizenship, we believe that value for the Scheme, its members and the world around us is created through a system of resources and relationships. As such, we must manage and monitor our impact to ensure the balanced continuation of this system – this is both fundamental to our continued ability to operate and central to our core values as a Scheme.

We think of sustainability in two ways: the Scheme's sustainability, ensuring its ongoing ability to ensure access to affordable, quality healthcare for its members; and the Scheme's impact on the world around it, both positive and negative.

The world of sustainability assessment and reporting is currently in flux, with several frameworks, guidelines and sometimes-conflicting definitions in use[4]. The Scheme is not required by its governing legislation to report in this regard[5], but our view as a responsible corporate citizen is that it is best practice for us to assess our impact, develop targets where appropriate, and work to achieve them.

The Scheme views its own impacts as direct, and those impacts created by the activities of Discovery Health and other stakeholders such as asset managers, healthcare providers and financial advisers on behalf of the Scheme as indirect impacts of the Scheme.

Our **sustainability priorities**

As a medical scheme, our funds are safeguarded for the benefit of our members and how we spend these funds is strictly regulated[1]. Our highest priority is that our members are able to access the healthcare they need, and therefore, the sustainability of the Scheme (financial, operational and relational) is essential. In support of this and in service to our members' interests, we remain committed to improving the quality, health outcomes, value and type of care that our members can access, positively influencing the effectiveness of the South African healthcare landscape as a whole, and ensuring the Scheme is governed in accordance with best practice.

We consider business decisions related to sustainability in light of the nature and resulting priorities of the Scheme, and our actual or potential impact. This gives rise to the need to make trade-offs which we consider and manage carefully. For example, while the Scheme's direct environmental impact is minimal, its impact on healthcare systems (and related socio-economic impact) is extensive. Our focus on working with stakeholders to encourage the adoption of quality of care initiatives and measures may therefore be prioritised over environmental matters.

1 *For example, the Scheme cannot make charitable donations, or engage in corporate social investment and/or socio-economic development spending.*

Our **sustainability journey**

Although our own sustainability, our members' interests and responsible corporate citizenship have long been at the heart of the Scheme's values, our formal sustainability assessment and reporting journey is in early stages. Our intention is to map our existing impacts, positive and negative; develop an assessment utilising an appropriate framework, such as the Sustainable Development Goals; incorporate sustainability impacts more explicitly into our strategy; align related policies and other documents; and develop appropriate targets and report on them.

We will report on our progress as we refine our approach to sustainability and develop plans to increase our net positive impact. We will also continue to monitor the consolidation and alignment of various global sustainability frameworks, standards and guidelines, to stay abreast of those that may be relevant to the Scheme.

How this statement was **developed**

In collaboration with independent consultants, the Scheme executives engaged in a sustainability workshop with the primary aim of giving careful consideration to DHMS' position on sustainability and how to clearly communicate this to our stakeholders – with reference to both our current position and our intent for the future. The workshop also marked the first early and formal phase of sustainability strategy development – a process that is ongoing – the ultimate aim of which will be integration into the Scheme's overall strategy.

Discovery Health Medical Scheme registration number 1125

Treating Customers Fairly

Treating Customers Fairly (TCF) is a concept prescribed by the Financial Sector Conduct Authority for financial institutions supervised by it. It is based on six fairness outcomes, 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.

Even though the Scheme is not legally required to follow the principles of TCF, we have adopted the principles as prescribed for other financial institutions. As a registered Financial Service Provider in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS), 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.

Suitable advice

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

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.

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.

Clear communication

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

Claims, complaints and changes

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

Discovery Health Medical Scheme registration number 1125

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, content and causes of complaints received
- Fair treatment of customers relating to privacy of information
- 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 of key fairness indicators related to the objectives of TCF. In addition, the Dispute Committee can 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.

More about TCF

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 interactions with our other stakeholders.

The results of these assessments 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 alternative strategies if required. The Committee monitors the effectiveness of these plans and the resolution of specific incidents and stakeholder concerns.

More about Vested

Stakeholders can contact the Scheme Office and the Principal Officer directly, and 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 that 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 addressed. 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.

Resources *pg 186*

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.

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 discuss Scheme initiatives and support healthcare providers in addressing their challenges and concerns, and attending 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 knock-on effects of the pandemic and other external factors. Balancing affordability with sustainability is critical to ensuring that 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.

Value-based healthcare that places members at the centre of care is one of the Scheme's key strategic priorities in a delivery model that prioritises health results over volume of services. We reimburse healthcare providers on health outcomes rather than inputs, enabling access for 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, aligning with 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, such as facilitating access to innovative health technologies like continuous glucose monitoring devices, and the introduction of the Assisted Reproductive Therapy Benefit on selected benefit plans.

Better healthcare at lower cost? Here's how it's happening for you

Discovery Health Medical Scheme registration number 1125

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. For example, if a member registers for the maternity benefit they are contacted with information regarding the detailed benefits available to them, and how to access the benefits.

Learn more about your health

Discovery Health's infrastructure and member support systems provide a range of engagement options for our members, including comprehensive information on the website, which also features an AI virtual agent capable of responding to member questions. Additionally, members can 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 Act.

More about how to submit a complaint, compliment or dispute *pg 186*

Measuring member satisfaction

The Scheme maintained a high average member perception score in 2023: 8.81 out of 10 (2022: 8.87). 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

- To get the best care, you should have one doctor who co-ordinates your care
- A guide to visiting your doctor
- The WELLTH Fund is investing in you

DIGITAL CARE FOR EASE OF ACCESS

- Virtual Urgent Care
- Virtual Physical Therapy
- Internet-based cognitive behavioural therapy for mental health
- Find what you need on our new Discovery Health app

Get quality home-based care services in the comfort of your home

- Home Care services

The Advanced Illness Member Support Programme, for members who are dealing with life-changing or advanced illness.

- Advanced Illness Member Support Programme

CARING FOR MEMBERS WITH SPECIFIC CONDITIONS

- Cardio Care
- Kidney Care
- Diabetes Care

GOING TO HOSPITAL?

See how your hospital is rated, how other patients experienced it and how to be safer in hospital. You'll need to be logged in to view some of these links.

- Hospital scorecard
- Patient survey score
- Patients' safer hospital care guide

SUPPORT AND HELP

- Need something? Here's how you can reach us
- Choose the best plan for you and your family
- Plan and benefit information for 2024
- Benefits and cover; understanding your plan
- About DHMS and Scheme Rules
- Medical scheme terminology
- Looking for something else?

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. There were over 6 300 employer groups belonging to the Scheme in 2023 and Discovery Health Medical Scheme remains secure in its position as an industry leader for employers across a diverse range of sectors.

Industry wide perception surveys are regularly conducted to establish how satisfied employers are with their administration provider. In 2023, an independent survey conducted by PMR.africa[1] placed Discovery Health, the administrator and manager care service provider to the Scheme, as the highest ranked administrator amongst employer groups with a mean score of 8.57 out of 10. A medical scheme administrator and managed care study by NMG Consulting in 2023 also placed Discovery Health as at the top for administration and managed care services; delivering the best overall offerings to clients; the leading brand and the most likely to be recommended[2]. Such awards and surveys reaffirm DHMS' confidence in the ability of Discovery Health to fulfil our requirements in providing services to our employer group members on our behalf.

After the years of disruption caused by the COVID-19 pandemic, 2023 saw an increasing number of employees returning to central workplaces and employer groups elevating their focus on employee wellness, corporate social responsibility, and providing a safe and supportive environment for their workforce.

Providing employer groups with an integrated health and wellness solution

During 2023, Discovery Health offered DHMS employer groups and their employee members a fully integrated corporate health and wellness solution with value added services, including:

- Digital and physical wellness screening against various health metrics, allowing wellness specialists to identify members at risk and refer them for appropriate care;
- Improved service experience through an enhanced employee intelligence dashboard (EID), offering employers integrated servicing and reporting for DHMS and other Discovery Health-administered employers; and Discovery Healthy Company, a proactive, digitally enabled employee assistance programme.

In addition, DHMS offered employers:

- Extended financial support in 2023 through an additional contribution freeze until April 2023 for members and employers who subsidise member contributions. DHMS postponed contributions totalling R8.6 billion over the 2021 to 2023 period through increase deferrals.
- Thought leadership and guidance about pertinent issues faced by employers, including post-COVID-19 healthcare trends, the digitisation of healthcare, the importance of improving screening and prevention behaviour and healthcare policy updates.
- National training on product and benefit enhancements for 2024 for key decision makers, supported by comprehensive employee training sessions.

1 *Source: PMR.africa National Survey on Accredited Medical Scheme Administrators 2023 (www.pmrafrica.com).*
2 *Source: NMG Consulting's Medical Scheme Administrator and Managed Care Study 2022/3. Available from NMG Consulting (https://www.nmg-consulting.com/).*

HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES

The healthcare operating environment remains complex and challenging. Following the disruption of the COVID-19 pandemic, the Scheme has seen a worsening of chronic disease burden, particularly of mental health, and from an economic perspective low growth and rising interest rates have placed pressure on the cost of living. We are facing regulatory uncertainty across the healthcare system due to the proposed National Health Insurance (NHI) Bill. Notwithstanding the complexity, South Africa's private health system remains robust and continues to deliver exceptional care on all global benchmarks and measures.

The Scheme shares many of the concerns and challenges of healthcare providers. To address our challenges on the Scheme's behalf, Discovery Health engages extensively with healthcare professionals and provides them with support through digital tools that, amongst other aspects, enable a personal health record for our members and access to telemedicine.

Discovery Health has further developed initiatives to support healthcare professionals with their own health, management science training and, through Discovery Group, funding for training for scarce skills and clinical excellence. These initiatives, although unrelated to the Scheme, support our key stakeholders and make the healthcare system more robust and sustainable to the benefit of our members.

Looking back at **2023**

OUR CHALLENGE

Improving access to people-centred population health management and education

HOW WE'RE ADDRESSING IT

- **WELLTH Fund**
  With the support of healthcare providers, the WELLTH Fund is designed to encourage members to review their screening needs and do their healthcare checks, aiding in early identification, diagnosis and management of potential risks, with less progression to severe disease.

  Since its launch, there has been significant increase in preventative screening health checks (a requirement to access the WELLTH Fund), and utilisation of general primary healthcare services including general practitioner consultations, dental care, and women's health services funded from the WELLTH Fund.
  - 575 860[1] health checks done since inception

WELLTH Fund information for Healthcare Professionals

OUR CHALLENGE

Streamlining clinical care and practice administration and expanding access and convenience to care

HOW WE'RE ADDRESSING IT

- **Utilising data and digitisation to support healthcare providers, and help them to extend access and convenience to doctor and patient**

- **Upgrade to the health professional digital engagement platform, HealthID**
  In 2023, HealthID and its supporting platform underwent substantial and necessary updates, enabling practice managers, practice nurses, and other key practice personnel to access the system without impacting the doctor's profile. Navigation menus were also streamlined to enhance provider consultations.

- **Launch of new digital care delivery options, accessible through the new improved Discovery Health app**
  - **Virtual urgent care** – if members cannot be seen by their Primary Care Provider (PCP), virtual urgent care can be immediately provided by highly skilled emergency room doctors before referral for further care or back to their PCP.
  - **Digital therapeutics for mental health** – an internet-based cognitive behavioural therapy (iCBT) solution, delivered in partnership with Silvercloud® by Amwell®, which provides members with exclusive access to innovative mental healthcare technology, where prescribed by the treating healthcare professional such as psychologists/psychotherapists.
  - **Virtual physical therapy** – DHMS introduced a first-in-local-market virtual physical therapy solution, available on the Discovery Health app, providing members with access to a sophisticated virtual physical rehabilitation platform, as prescribed by their attending healthcare professionals such as physiotherapists and biokineticists.

Health ID | Discovery Health App | Virtual Physical Therapy | Digital Mental Health | Virtual Urgent Care (Speak to a Doctor 24/7)

1 *As at 20 February 2024.*

HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES continued

Looking back at **2023** *continued*

OUR CHALLENGE

Evolving burden of disease demands adaptable practice models, prioritising patient convenience, collaboration, technology and a focus on preventive care for improved outcomes and practice success

HOW WE'RE ADDRESSING IT

FUTURE-FOCUSED PRACTICE OPERATING MODELS

Keeping pace with the evolving environment, and improving patient outcomes and practice success requires new workflows and technologies. In adapting practice care delivery, administration models should prioritise patient needs, provide convenient care options, and leverage technology to foster improved care co-ordination and collaboration of healthcare professionals. These changes are exemplified by disease management programmes that promote and incentivise the sharing of improved outcomes value with health professionals.

- **Disease Prevention Programme (DPP)**
  Members living with high blood pressure, elevated blood sugar, high body-mass-index (BMI) and elevated cholesterol and blood triglycerides, collectively known as cardiometabolic syndrome, have a significantly elevated risk of developing diabetes and cardiovascular disease. Discovery Health's predictive model uses inputs such as health check results, claims patterns, family history and personal demographics to identify members that may be eligible for the Disease Prevention Programme. Members enrolled on the programme have access to appropriate risk funded benefits to promote lifestyle changes, preventative treatment as required, care co-ordination and support. Since implementation in 2023, the Scheme continually looks for opportunities to enhance enrolment into the programme.

- **CAD Care Programme**
  The CAD Care Programme is a shared value initiative that aims to improve the quality and cost outcomes for patients diagnosed with coronary artery disease. Practices can assist their patients to expanded risk funded CAD Care benefits and share in the value of the improved care outcomes and cost efficiencies.

- **Kidney Care Programme**
  The Kidney Care Programme has been designed to support members living with chronic kidney disease by making it easier to manage their condition with tools and benefits for the lifelong journey. There are **2 600** registered Kidney Care chronic dialysis members.
  - Providers of chronic dialysis **38**
  - Units of chronic dialysis **247**
  - Treating specialists **166**

  Over the past ten years, the Kidney Care Programme has achieved significant improvement in quality of care and clinical outcomes for members. The overall clinical outcome score has improved by 13.3% over the years through collaboration with providers of chronic dialysis, treating specialists and members. Medication compliance has also shown a continuous improvement of 28% from 2013 (65%) to 2023 (93%).

Healthcare Professional Guide to the Care Programmes

OUR CHALLENGE

Providing doctors with access to information and personal support

HOW WE'RE ADDRESSING IT

- **Conference engagement**
  In 2023, the Scheme's administration and managed care provider, Discovery Health, participated in 42 healthcare provider conferences, where engagement took place on several Scheme initiatives including Hospital at Home, the WELLTH Fund, CAD Care, spinal care, virtual therapy, and digital healthcare. These engagements enabled active listening to providers' needs and concerns, and discussion on how best these could be addressed; they also provided an opportunity to share the Scheme's strategic direction and information regarding initiatives pertinent to providers' disciplines.

- **Doctor Resilience Suite**
  Discovery Health supports healthcare professionals through various initiatives, and in 2023 awareness was raised around the Discovery Resilience Suite, which includes:
  - Vitality Active Rewards for Doctors (VARD) – an exclusive wellness programme for doctors, available free of charge, where they can earn Discovery Miles for going the extra mile. VARD has increased from a base of 6 000 by more than 500 doctors in 2023;
  - Young Doctor Mental Health Helpline – a helpline run by the South African Depression and Anxiety Group which supports doctors in crisis. Call volumes reached averages of 200 per month in 2023.

Tools and information at the Healthcare Professional Zone | Active Rewards for Doctors | Healthy Company for Doctors

HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES continued

Looking back at **2023** *continued*

OUR CHALLENGE

Supporting clinical excellence and training

HOW WE'RE ADDRESSING IT

Discovery Health funded attendance for 16 healthcare professionals to a Future-proof your Healthcare Practice management science programme at Henley Business School.

- **Discovery Foundation[1]**
  The grants disbursed by the Discovery Foundation Awards aim to address the challenges faced by South Africa's healthcare system through the retention of doctors in public healthcare, training specialists for rural areas, developing academic medicine and research centres, and increasing the number of sub-specialists in the country to adequately meet South Africa's healthcare needs. These initiatives align with our core purpose and key healthcare insurance offering.
  - The Foundation has set a target to train 600 medical specialists by 2026, with 405 individuals supported from 2006 to 2023.
  - In 2023, the Foundation approved three sub-specialist awards and four academic awards, disbursing R12 million in support of clinical excellence. Recipients of awards came from a range of sub-specialities including radiology, head and neck surgery, cardiology, and pharmacology.

Discovery Foundation

2024 and beyond

OUR CHALLENGE

Streamlining clinical care and practice administration and expanding access and convenience to care

HOW WE'RE ADDRESSING IT

- **Utilising data and digitisation to support healthcare providers, and help them to extend access and convenience to doctor and patient**
  Following on from the HealthID relaunch in 2024, further updates will continue to build on the upgraded technology platform.

  Through the new population health dashboard developed in HealthID for providers, care programmes will be a prominent feature, encouraging member enrolments by the provider. The dashboard will further facilitate improved outcomes by alerting providers of gaps in care.

- **Supportive care after an admission**
  DHMS introduced a Re-admission Prevention Benefit in 2021, targeted at mitigating some of the preventable factors associated with re-admissions. Data is used in predictive modelling to identify those at highest risk of a re-admission.

  The benefit has been updated for 2024 with a focus on coaching and has the following three components:
  - Coaching over 30 days from discharge – done by Discovery Healthcare Coaching Services (DHCS);
  - A GP follow-up consultation – within 30 days following discharge; and
  - A medicine reconciliation done at the point of discharge by the treating doctor or the GP during follow-up.

Supportive care after an admission

OUR CHALLENGE

Supporting clinical excellence and training

HOW WE'RE ADDRESSING IT

- **Discovery Foundation[1]**
  In 2017, the Discovery Foundation commissioned Percept to conduct a research project looking specifically at the current and future HR needs of the South African Health system. The report has revealed an increasing deficit of specialists across various surgical disciplines. Accordingly, the Discovery Foundation will continue to specifically channel resources towards the training of surgery sub-specialists, including anaesthetists and radiologists.

  The Foundation will continue to run its annual events, including the alumni conference and awards. The Foundation is launching regional round table events for alumni as well as a peer mentorship programme to benefit alumni in the early stages of their careers.

- **Sharing practice profiles**
  Develop and distribute practice profile reports, enabling health professionals to benchmark against their peers and work to enhance care delivery outcomes.

Discovery Foundation

1 *The Discovery Foundation is an independent trust that aims to address the skills shortages and quality of healthcare particularly in rural and underserved areas in South Africa. It was set up in 2006 as part of Discovery Limited's Black Economic Empowerment transaction and generates funding through dividend income and grants received from the Discovery Group. DHMS does not contribute to it.*

HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES continued

2024 and beyond *continued*

OUR CHALLENGE

Evolving burden of disease demands, adaptable practice models, prioritising patient convenience, collaboration, technology and a focus on preventive care for improved outcomes and practice success

HOW WE'RE ADDRESSING IT

FUTURE-FOCUSED PRACTICE OPERATING MODELS

- **PCP nomination**
  The programme aims to promote well-co-ordinated and integrated care, delivered by a multi-disciplinary team under the guidance of a single PCP, to ensure better clinical outcomes and enhanced patient experience with greater efficiency in care delivery.

- **Hospital at Home**
  Hospital at Home safely delivers hospital-level care for clinically appropriate conditions with the same, and often superior, health outcomes compared to traditional in-hospital care.
  - 37% lower cost per event (CPE) vs In-Hospital.
  - High patient satisfaction scores: Hospital at Home received a 9/10 rating.

  In 2022 Discovery Health collaborated with other providers on a pilot study to enhance the development of the Hospital at Home offering in South Africa. The pilot utilises Discovery Health's evidence-based care pathways as a guideline for nine medical conditions and has been live for a year at four sites. Preliminary results show favourable length of stay (LOS) and cost per event outcomes.

- **Maternity care delivery innovation**
  In consideration of the high Caesarean section rates, including Caesarean sections performed before the recommended gestational age, and neonatal intensive care unit (ICU) rates observed by the Scheme, Discovery Health is collaborating with the profession to develop and promote a high-quality and cost-effective birthing pathway to enhance Scheme sustainability and improve access to obstetric services.

Nominating a primary care doctor | Your patients can now have hospital-level care at home

OUR CHALLENGE

Mitigating the increasing non-communicable disease burden

HOW WE'RE ADDRESSING IT

- **People centred population health management and education through personal health pathways**
  To mitigate the increasing burden of disease from chronic non-communicable lifestyle disease, the Scheme and Discovery Health are working on developing and implementing an intelligent science-based disease prevention and management programme, where identified personalised "next best actions" and personal health pathways, customised to member-specific needs, will motivate engagement in healthy lifestyle and health-seeking behaviours.

  Look out for further communication during 2024.

OUR CHALLENGE

Providing doctors with access to information and personal support

HOW WE'RE ADDRESSING IT

- **Conference engagement**
  Scheduled for participation in 33 events during 2024, Discovery Health's participants will listen, lead and engage in discussions around various strategic topics, including digital mental healthcare, personal health pathways, maternity healthcare, and spinal healthcare.

- **Doctor Resilience Suite**
  In 2024, these support assets will become proactive rather than reactive. This involves re-branding, re-naming and representing the assets in the suite to doctors. While the suite will still contain elements such as VARD and the Young Dr Mental Health Helpline, opportunities for personal and practice success and how best to leverage these tools will be highlighted.

Tools and information at the Healthcare Professional Zone | Active Rewards for Doctors | Healthy Company for Doctors

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, providing comprehensive and independent advice to existing and prospective members in choosing the healthcare cover best suited to their 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. They also assist them to match their financial and health 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, as well as providing support and assisting with claims resolutions if needed.

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, but all members are entitled to the services of a designated financial adviser. 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 current 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.

An industry-wide survey was conducted in the first quarter of 2023 to establish how satisfied financial advisers are with the administration, servicing and product marketing of DHMS by Discovery Health. Across all categories Discovery Health rated highly with scores well above the industry benchmark and an average score of 8.2 out of 10, as well as notably ranking highest for treating advisers fairly[1]. Discovery Health was also awarded Product Supplier of the Year at the 2023 Financial Intermediaries Association of Southern Africa (FIA) Intermediary Experience Awards[2].

1 *Source: Catalyst Research and Strategy Health Monitor (Nov 2022 – April 2023).*
2 *Source: FIA. https://fia.org.za/fia-awards/.*

Engagements in 2023

The annual update on the Scheme's product and benefit enhancements for 2024 was provided in a national rollout to over 200 business consultants and agents. It was also presented and broadcast to more than 7 500 financial advisers at the annual product launch event. Following the product update, approximately 15 virtual sessions and 25 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.

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 2024.

Thought leadership

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

Financial advisers can also access competitor industry analysis, sales aids and marketing material to support and better understand the Scheme's differentiated offerings.

The Discovery Health Insights hub is updated regularly to provide advisers, employers and members with access to the latest insights on health systems, the impact of healthy living and condition management.

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:

- Adviser360, launched in 2023, is an integrated and centralised sales platform which features a seamless new business online journey as well as a range of sales and marketing tools to support advisers.
- Digital communication channels, such as virtual agents and WhatsApp for financial advisers, continue to provide extensive and convenient service support infrastructure.
- The launch of the new Discovery Health app in September 2023, with enhanced digital self-servicing tools and new features to better understand and monitor health cover, is expected to reduce advisers' service loads.

In 2024, the Scheme has enhanced efforts to engage closely with financial advisers and gain better insights through their perspective, given their crucial role in assisting members to navigate a complex healthcare and medical scheme environment.

DISCOVERY HEALTH

Discovery Health (Pty) Ltd is a leader in healthcare administration and managed care with a proven track record of excellent service and innovation. Providing services to over 3.5 million medical scheme beneficiaries, Discovery Health provides administration and managed care services to DHMS, as well as 18 other restricted schemes.

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.

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. 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 which, 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.

Vested training was conducted for six functional teams in Discovery Health, and ongoing training assessments are conducted annually. Implementation of this training and assessment programme is intended for three more teams in 2024.

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 Committee and the Innovation Committee, 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 committees report on a regular basis to the Scheme's Stakeholder Relations and Ethics Committee and Risk Committee respectively.

How Discovery Health supports the Scheme's value creation *pg 93*

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 inclusivity, diversity, and 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 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 of 13 members must respond with agility 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 flat organisational structure offers limited scope for promotion, the Scheme's culture and value proposition for employees is assessed periodically to enable interventions that promote staff satisfaction and retention, and support a healthy, engaging workplace culture. Additionally, regular performance discussions help employees maintain focus on the Scheme's strategic objectives, their role objectives and career development. The Scheme employs a mature knowledge management and retention strategy to allow for the transition and recruitment of scarce skills.

The Scheme appointed independent expert consultants to conduct a role grading and benchmarking exercise during 2022/2023. The aim of this exercise was to ensure that the remuneration practices of the Scheme are competitive, and to enable the Scheme to attract and retain high-calibre staff capable of managing and overseeing its complex operations. Recommendations were implemented in 2023, after approval by the Trustees.

All employees and their dependants[1] have access to Discovery Healthy Company, a comprehensive employee assistance programme that incorporates physical, emotional and financial wellbeing, and legal support. The Scheme also continues to monitor its hybrid workplace model, implemented in 2022, and will adjust this as needed 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 in line with our employee value proposition strategy.

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.*

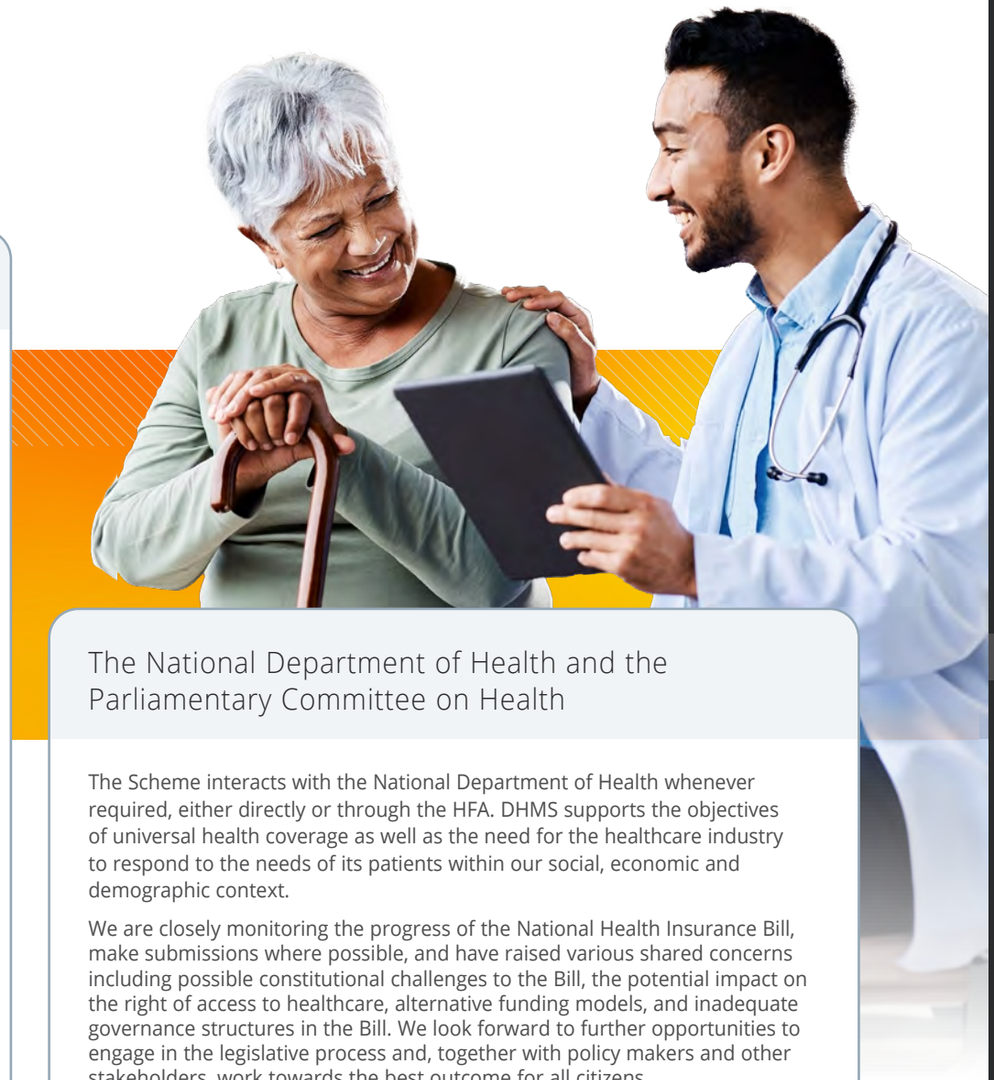
REGULATORY BODIES

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, 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.

Regulatory and industry matters dealt with in 2023 *pg 73*



Council for Medical Schemes

The CMS regulates all medical schemes in South Africa, and 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 a high standard 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 2023, the CMS published 50 circulars and the Scheme engaged with the content and submitted responses as required, as well as responding to other ad hoc and formal enquiries from the CMS. The CMS also publishes annual reports, providing a detailed overview of the state of the medical schemes industry. The Scheme 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.

CMS publications

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 are closely monitoring the progress of the National Health Insurance Bill, make submissions where possible, 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.

More about the NHI Bill *pg 75*

SECTION 6

Governance **and leadership**

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[1] 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.

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 with sustainable access to affordable and equitable healthcare means going beyond compliance and maintaining our thought leadership in this arena to ensure that we create and protect value for these and other key stakeholders, while limiting value erosion.

More about our business model *pg 25*

In accordance with the Trustees' ongoing focus on good governance, and with an awareness of the importance of supporting institutional memory in an environment where trustees serve a limited term, the Trustees mandated the Scheme Office to develop frameworks to standardise certain practices and align them with best practice in governance, ethics, and legal and business principles. Frameworks developed and approved by the Trustees include those for procurement and related party contracting, and these frameworks will be tested and refined over time to ensure their robustness, reliability and applicability to various situations in supporting business decisions.

1 *For our purposes, fit and proper refers to honesty and integrity, competency, and operational ability requirements for all Trustees, key individuals, and Scheme representatives.*

Discovery Health Medical Scheme registration number 1125

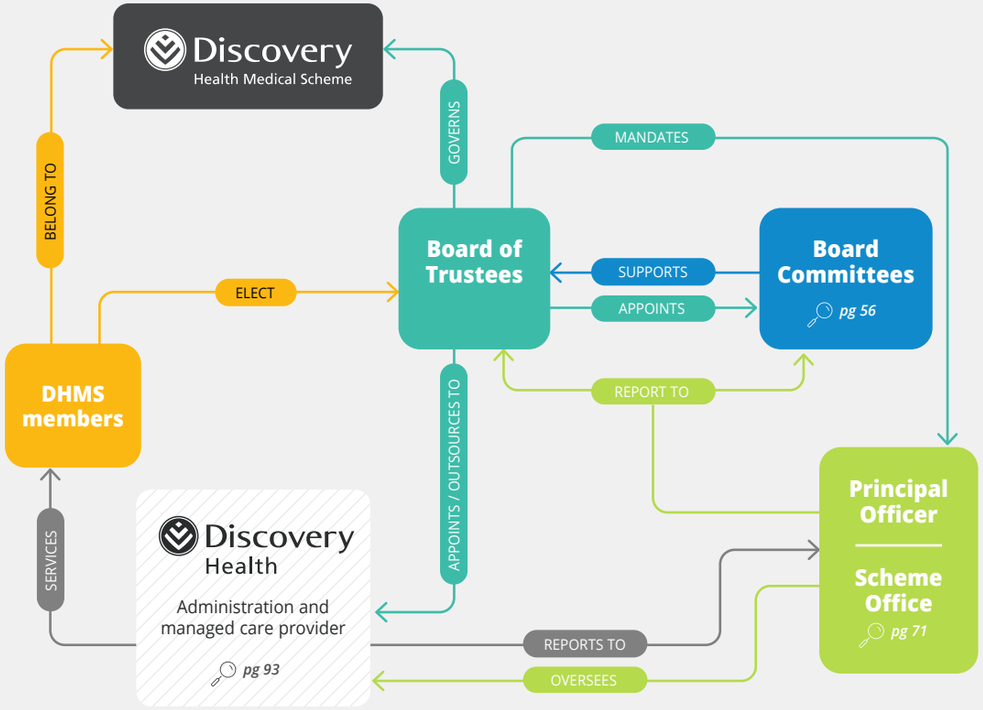
The Board of Trustees

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.

Furthermore, Trustees have a duty of care to the Scheme, whereby they are expected to:

- Act with honesty and integrity
- Avoid conflicts of interest
- Act in the members' interests
- Keep members' information confidential
- Comply with the Scheme Rules and relevant legislation

Our governance structures



Trustees are accountable to the Scheme's members and their foremost 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 discharge their fiduciary duties to ensure effective leadership and stewardship beyond attendance at meetings.

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 at the Scheme's Annual General Meeting (AGM), with the balance either elected by Scheme members or appointed by the Trustees, provided that the number of appointed Trustees shall not at any given time, exceed three.

The Scheme has no influence over the election of 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 four[1] years each, with a cooling-off period of two years after two consecutive terms, provided they are elected or appointed to serve a second term). 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.

1 *During 2023, this term length was amended by the Trustees from three years to four, and this change was approved by the Council for Medical Schemes. No Trustees involved in making this decision are able to benefit from the change; i.e. their original term length of three years remains the same.*
The previously rapid turnover of Trustees and Independent Committee Members was found to be detrimental to the oversight and management of the Scheme due to the intensive learning required by new Trustees to understand the complex nature of the Scheme's business and perform their duties. This change will improve the duration and transfer of institutional knowledge.

Discovery Health Medical Scheme registration number 1125

The role of the Trustees

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

- Monitor, evaluate and make decisions regarding the equitable treatment of and benefits for all Scheme members in the interests of members and the sustainability of the Scheme;
- 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 members and other stakeholders;
- Evaluate the services offered by the administration and managed care provider (Discovery Health (Pty) Ltd) and whether they 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

- To appoint, delegate and evaluate oversight functions to the Principal Officer;
- To ensure the keeping of proper registers, books and records of all operations of the Scheme, and proper minutes of all resolutions passed by the Trustees;
- To ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the rules of the Scheme;
- Take all reasonable steps to ensure that contributions are paid timeously in accordance with the Medical Schemes 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 management of the Scheme by applying sound business principles to ensure its strong financial position;
- 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;
- Ensure that the rules, operation and administration of the Scheme comply with the provisions of the Medical Schemes Act and all other applicable laws; and
- Ensure that proper control systems and record keeping are employed by and on behalf of the Scheme.

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.

Activities of the Board in 2023

Operating context

- Considered and discussed key factors in the operating environment likely to impact the healthcare industry and the Scheme. These included:
  - The South African (SA) economic outlook, including market and geo-political headwinds.
  - The importance of engaging with key stakeholder groups, such as member advocates.
  - The prevalence and growth of new health and information technology.
  - The increasing prevalence of chronic disease.
  - The influence of the SA policy landscape on the risks and opportunities of the Scheme.

Strategic and performance matters

- Reviewed the Scheme's proposed strategy for 2024, ensuring that it addressed the Scheme's material matters.
- Deliberated on a complaint to the Competition Commission on behalf of the industry by the Health Funders Association (HFA) regarding polymerase chain reaction (PCR) test overpricing by pathology laboratories during COVID-19[1].
- Evaluated the affordability and sustainability of DHMS, considering a changing demographic risk profile.
- Deliberated on the 2023 actuarial valuation report, including the consideration of changes to increase affordability – while being cognisant of the impact of the SA economic climate thereon – balanced with adequate contribution increases to ensure Scheme sustainability. This included Scheme Rule amendments for the implementation of new and modified benefits.
- Considered the response of members and other stakeholders to the annual launch of Scheme benefit changes for 2024, as well as the risks posed by health insurance products.
- Considered the fraud allegations made by a whistleblower regarding Mediclinic hospital group, and satisfied themselves with processes established to investigate and address the matter.

Governance

- Reviewed and approved various policies and frameworks due for review, and mandated the Scheme Office to make required operational changes.
- Contemplated its 2024 Charter as well as all Committees' Terms of Reference and approved these after deliberation.
- Oversaw and directed the preparations for the AGM, including:
  - Reviewed the report and recommendations of the Nomination Committee (NomCo) and the Independent Electoral Body (IEB) on improvements in the proxy process.
  - Discussed AGM communications and processes.
  - Reviewed the AGM Risk Register and satisfied itself that appropriate risk mitigation was in place.
  - Considered proposed motions and determined that no valid motions had been submitted.
  - Considered the impact on stakeholders of hybrid AGMs and Trustee elections.
  - Directed the Scheme Office to engage NomCo and the IEB to consider the viability of a virtual or hybrid AGM, and subsequently resolved that the Scheme would convene a hybrid AGM and Trustee election in 2024.
- Deliberated the optimal tenure for Scheme Trustees, as well as the optimal cycles of Trustee vacancies to ensure the management and retention of institutional knowledge.
- Reviewed the outcome of the effectiveness reviews and was satisfied with the results.
- Convened an Ad Hoc Committee of the Board of Trustees to consider the possible renewal of the lease of the Scheme's premises and facilities, as well as to recommend the annual operating expenses budget to the Board for approval, and appointed three Trustees as members of the Committee.
- Reviewed lease contract variations, rates, and the results of a benchmarking exercise to compare other facilities, and approved the renewal of the lease for a further five years.
- Engaged The Ethics Institute (TEI) to conduct an ethics culture assessment to provide an ethics opportunity and risk profile, and reviewed the feedback of the Stakeholder Relations and Ethics Committee on the results thereof.
- Considered the impact of the transition from IFRS 4 to IFRS 17: *Insurance Contracts*, which became effective for annual reporting periods beginning on or after 01 January 2023.

Regulatory Matters

- Reviewed the progress of the Section 59 Investigation Panel, and considered submissions to be made by Discovery Health (Pty) Ltd (Discovery Health) and the Scheme with emphasis on demonstrating that there is no racial discrimination in the fraud, waste and abuse processes followed by Discovery Health on our behalf.
- Considered the impact of developments such as the passing of the National Health Insurance (NHI) Bill and considered input of experts and stakeholders in this process.
- Received regular updates on the activities of the CMS and the Scheme's engagements with its representatives, as well as various industry activities relating to the CMS.
- Considered feedback to be provided to the CMS on the Section 44 (4) Inspection draft response and approved it for submission.

Outsourcing

- Reviewed feedback from the Services Renewal Committee on the administration and managed care fee increase for 2023.
- Discussed the requirement for a new service provider for the independent actuarial review of the annual value-added assessment, and appointed NMG Group (NMG) for a three-year period.
- Obtained an independent review of the value supplied to the Scheme by some of the Scheme's service providers with the objective of ensuring that the Scheme receives commensurate value for the fees paid.

Human capital management and remuneration

- Reviewed feedback and recommendations from the Remuneration Committee with regards to role and salary benchmarking and incentives.
- Addressed succession planning requirements by making necessary appointments.

Reporting and assurance

- Discussed and further developed the Scheme's material matters, and approved them for inclusion in the Scheme's Integrated Report.
- Considered feedback from the Audit Committee wherein it reported on its assessment of the Integrated Report, including annual Financial Statements, and its recommendation that they be approved and prepared on a going concern basis.
- Reviewed and approved the Integrated Report and annual Financial Statements.

1 *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. The Competition Commission declined to refer HFA's complaint to the Competition Tribunal based on the consent agreements which were entered into with the respective pathology labs in December 2021. This was expected, and the HFA has subsequently self-referred the matter to the Tribunal.*

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.

Our approach to remuneration *pg 70*

Board evaluations

The Board is assessed annually, either by external independent parties or through self-assessment. The last full Board evaluation was conducted by PG Governance in December 2023 resulting in an overall evaluation score of 95% (rated as excellent by PG Governance). As part of the evaluation, PG Governance reviewed responses against King IV corporate governance best practice and the Medical Schemes Act 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 2024.

The Board is satisfied that the diverse skills and experience of its members enables the Board 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
Ms Joan Adams SC	Trustee	Elected	23 Jun 22	2025 AGM[1]
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	13 Aug 23
Mr John Butler SC	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 20
	Trustee	Elected	01 Sep 21	2024 AGM[1]
Mrs Lalita (Gita) Harie	Trustee	Elected	01 Sep 21	2024 AGM[1]
Dr Max Price	Trustee	Elected	23 Jun 22	2025 AGM[1]
Mr Marius du Toit	Trustee	Elected	23 Jun 22	2025 AGM[1]
Ms Michelle Norton SC	Trustee	Appointed	01 Jan 23	31 Dec 25
Dr Rendani Mbuvha[3]	Trustee	Appointed	01 Aug 23	31 Jul 27
Dr Dhesan Moodley[3]	Trustee	Appointed	01 Sep 23	31 Aug 27

1 All elected Trustees' terms run from the AGM at which they were elected to the date of the AGM at the end of their term. The dates of the AGMs differ slightly from year to year, but are usually scheduled in June.

2 Dr Brynard's term will end on the date of the 2024 AGM. Last year's Integrated Report incorrectly indicated the end of her term to be 31 August 2024, as the end of her first term had been extended to August 2021 as a result of the delay of the 2021 AGM, due to COVID-19. However, as the 2024 AGM is scheduled for June, her second term will end on this date.

3 Dr Rendani Mbuvha and Dr Dhesan Moodley are appointed for four-year terms due to a Scheme Rule change, approved by the CMS, which allows for Trustees and ICMs elected and/or appointed at any date after 14 July 2023 to serve four-year terms. See footnote 1 on pg 49 for more information.

Discovery Health Medical Scheme registration number 1125

2023 Meeting Attendance Record

Board

Board Meetings attendance in 2023		18 Jan[A]	22 Feb	23 Feb	28 Mar[A]	20 Apr	26 Apr[A]	26 May	07 June[A]	11 Aug[A]	18 Aug[A]	13 Sep	22 Sep[A]	10 Oct[A]	23 Nov
Chairperson (Trustee)	Ms Michelle Norton SC[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairperson (Trustee)	Mr John Butler SC[2]	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	–	–	–
Trustees	Ms Joan Adams SC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dr Susette Brynard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mrs Lalita (Gita) Harie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Johan Human[3]	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	–	–
	Dr Rendani Mbuvha[4]	–	–	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓
	Dr Dhesan Moodley[5]	–	–	–	–	–	–	–	–	–	–	✓	✓	✓	✓
	Dr Max Price	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Marius du Toit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairperson: Audit Committee	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independent Committee Members	Prof Laurel Baldwin-Ragaven[6]	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Ms Melanie Bosman[6]	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Mr Andrew Bryce	–	–	–	–	–	–	–	–	–	–	✓	–	–	–
	Dr Alewyn Burger[6]	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Ms Henda van Deventer[6]	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Mr Bongani Hlophe	–	✓	–	–	–	–	✓	✓	✓	–	–	–	–	✓
	Mr Ndumiso Luthuli SC[6]	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
	Dr Nonkululeko Mlaba[6]	–	✓	–	–	–	–	–	–	–	–	–	–	–	–

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 duration of such meetings.

- *A meeting was convened on 18 January 2023 to discuss the 2023 contribution increase and the self-administered antigen testing benefit.*
- *A meeting was convened on 28 March 2023 to discuss the proposed rule amendments, Virtual Urgent Care (VUC) programme and the AGM.*
- *A meeting was convened on 26 April 2023 to appoint the new Chairperson of the Board, due to Mr John Butler's term coming to an end in June 2023.*
- *A meeting was convened on 07 June 2023 to discuss feedback from the Remuneration Committee and a response to the CMS' draft response on a Section 44 matter.*
- *A meeting was convened on 11 August 2023 to discuss Board and Committee reconstitution, new Trustee signatories and salary benchmarking.*
- *A meeting was convened on 18 August 2023 to discuss salary benchmarking.*
- *A meeting was convened on 22 September 2023 to discuss and consider the revised 2024 benefits and contribution increases.*
- *A meeting was convened on 10 October 2023 to discuss queries from the CMS regarding the 2024 benefit and contribution changes.*

1 Appointed as a Trustee effective 01 January 2023 and appointed as Chairperson of the Board effective 14 June 2023.
2 Chairperson of the Board until his term ended on 13 June 2023.
3 Term as a Trustee ended on 13 August 2023.
4 Appointed as a Trustee effective 01 January 2023 and appointed as Chairperson of the Board effective 14 June 2023.
5 Appointed as Trustee effective 01 September 2023.
6 Invited to attend the Board of Trustees Strategy Session on 22 February 2023.
– Not required to attend.
x Apology tendered.

Discovery Health Medical Scheme registration number 1125

Our Trustees[1]

MS MICHELLE NORTON SC (62)

CHAIRPERSON

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 01 January 2023. She serves on the Stakeholder Relations and Ethics, Product and Remuneration Committees, and was appointed Chairperson effective 14 June 2023.

MS JOAN ADAMS SC (60)

BLuris LLB; MInstD

Ms Adams SC has been an advocate for 36 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, served on the Investment Committee, and currently serves on the Remuneration, Risk, and Stakeholder Relations and Ethics Committees.

MR JOHN BUTLER SC (57)

Chairperson from 01 January 2022 to 13 June 2023

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 served on the Stakeholder Relations and Ethics, Services Renewal, and Remuneration Committees. His final term ended on 13 June 2023, and he was Chairperson of the Board from 01 January 2022 until the end of his tenure.

DR SUSETTE BRYNARD (67)

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 has also been elected to 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 (65)

BA (Social Work); BA (Hons) Social Science (Psychology); Certified Director (IoDSA[2])

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.

1 *All ages are at 31 December 2023.*
2 *Institute of Directors in South Africa.*

Discovery Health Medical Scheme registration number 1125

MR JOHAN HUMAN (53)

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 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 05 September 2016, and was re-appointed for a second term in August 2020. His term ended on 13 August 2023, he chaired the Investment and Product Committees, and served on the Audit and Services Renewal Committees.

DR RENDANI MBUVHA (33)

BSc (Hons); MSc; PhD; FIA[1]; FASSA[2]; CERA[3]

Dr Mbuvha is an associate professor in Actuarial Science at the University of Witwatersrand and the Google DeepMind Academic Fellow in Machine Learning at Queen Mary University of London. He has extensive expertise in actuarial practice and machine learning research, with previous roles at ABSA and Milliman.

Dr Mbuvha currently serves as an independent non-executive director at Bidvest Life Limited, where he chairs the remuneration committee. Additionally, he chairs the Climate Index subcommittee of the Actuarial Society of South Africa.

Dr Mbuvha was appointed as a trustee in August 2023 and serves on the Audit, Investment and Product Committees.

DR DHESAN MOODLEY (61)

Masters in Metabolic, Functional and Anti-aging Medicine; MMed (Sports Science); MBChB; MBA; EDP Economics; Certified Director (IoDSA[4])

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, the Institute of Directors in Southern 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. His tenure ended on 22 June 2022, and he was appointed as a Trustee with effect from 01 September 2023, after his cooling off period. He now serves on the Clinical Governance and Product Committees, and chairs the Investment Committee and the Ad Hoc Committee of the Board.

DR MAX PRICE (68)

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 the 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 June 2022, chairs the Clinical Governance Committee, and serves on the Stakeholder Relations and Ethics, Product, and Services Renewal Committees.

MR MARIUS DU TOIT (61)

BCom (Mathematics); FASSA[2]

Mr du Toit has extensive experience as a professional actuary, as well as in long-range strategic planning and policy decision making, revision and creation of legislation, actuarial governance, and compliance. He has advised retirement 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[5], and Acting Chief Financial Officer and Chief Actuary of the FSB[6].

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, chairs the Product Committee and serves on the Audit, Investment, and Services Renewal Committees.

1 *Fellow of the Institute of Actuaries UK.*
2 *Fellow of the Actuarial Society of South Africa.*
3 *Chartered Enterprise Risk Actuary.*
4 *Institute of Directors in South Africa.*
5 *Financial Sector Conduct Authority.*
6 *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[1] 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.

1 *As stated in footnote 1 on pg 49, during 2023, term length was amended by the Trustees from three years to four and approved by the CMS. Any ICMs commencing their appointments after 14 July 2023 will serve four-year terms.*

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 12 November 2023, DHMS appointed PG Governance to conduct independent evaluations of the Board and the Committees. The Board further assessed the performance and effectiveness of the various Committees. Each Committee received an overall score tallied from the evaluations. These results indicate that our Committees are operating at a level rated as excellent by PG Governance:

Audit Committee 95%	**Product Committee** 96%	**Remuneration Committee** 97%	**Risk Committee** 100%
Clinical Governance Committee 96%	**Stakeholder Relations and Ethics Committee** 96%	**Investment Committee** 98%	

All Committees deliberated on the feedback received from PG Governance, put action plans into place where appropriate and the findings were reported to the Board, together with recommendations for how to enhance performance where necessary.

The Dispute and Nomination Committees exclude any Trustee representation in order to maintain impartiality and independence in fulfilling their duties. They are not assessed through this process. As an operational committee, the Dispute Committee undertook a qualitative-focused 360 degree assessment of its functioning, which indicated that it is functioning satisfactorily, and this was reported to the Stakeholder Relations and Ethics Committee which directly oversees the Dispute Committee.

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 skilled and experienced members with extensive financial, actuarial, governance, 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 Management, Compliance, and Forensics functions; and

THIRD LINE
Internal Audit, appointed external auditor, appointed independent actuary 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 2023 benefit year. The members of the Audit Committee and Trustees are satisfied with the level and type of assurance the Scheme obtains.

Activities during 2023

During 2023, the Committee paid particular attention to the implementation of the new insurance reporting standard IFRS 17: *Insurance Contracts*, effective from 01 January 2023, monitoring the transition to IFRS 17 and ensuring the implementation targets were on track, taking technical considerations into account, and able to produce annual financial statements that are in accordance with IFRS. The Committee also concluded its process of finding a suitable audit firm to succeed PricewaterhouseCoopers Inc. (PwC) for the financial period beginning 01 January 2024. Despite the Mandatory Audit Firm Rotation (MAFR) rule being set aside during the year, the Committee considered the long tenure of PwC and recommended the appointment of Deloitte[1] for the financial period beginning 01 January 2024.

1 *Deloitte Touche Tohmatsu Limited*

The Committee considered the results of the 2022 committee effectiveness review and the recommendations provided in the reports. The Committee 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 2023 have fulfilled its responsibilities in accordance with its terms of reference.

Report of the Audit Committee *pg 99*

Composition and meetings in 2023

During 2023, the Board appointed chartered accountant Busisiwe Mathe CA (SA) as an Independent Committee Member, ensuring continuity of such skills within the Audit Committee. As such, at the end of 2023, the Audit Committee comprised two Trustees and four 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 2023

		18 Jan[A]	23 Mar	10 Aug	23 Aug	08 Sep[A]	19 Oct	15 Nov[A]
Chairperson (Independent Member)	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓
Committee Members	Ms Melanie Bosman (Independent Member)	✓	✓	✓	✓	×	✓	✓
	Dr Alewyn Burger (Independent Member)	✓	✓	✓	✓	✓	✓	✓
	Mr Marius du Toit (Trustee)	✓	✓	✓	✓	×	✓	✓
	Mr Johan Human (Trustee)[1]	✓	✓	✓	–	–	–	–
	Mrs Busisiwe Mathe (Independent Member)[2]	–	–	✓	✓	✓	✓	✓
	Dr Rendani Mbuvha (Trustee)[3]	–	–	–	✓	✓	✓	✓

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 duration of such meetings.

- *A Joint Audit and Product Committee meeting was convened on 18 January 2023 to discuss the 2023 contribution increase.*
- *An ad hoc Committee meeting was convened on 15 November 2023 to discuss the IFRS 17 implementation audit and review the updated IFRS 17 Annual Financial Statements.*
- *An ad hoc Committee meeting was convened on 08 September 2023 to discuss changes to the 2024 actuarial valuation report including product and benefit recommendations. Eric Mackeown chaired the meeting in his capacity as the Chairperson of the Audit Committee.*

1 Term as a Trustee ended on 13 August 2023.
2 Appointed as an Independent Committee Member effective 01 June 2023.
3 Term as a Committee Member commenced on 11 August 2023.
– Not required to attend.
x Apology tendered.

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. The Committee will continue to carefully consider how the Scheme should balance its solvency requirements against the provision of future Scheme benefits, managing higher utilisation and keeping contributions affordable especially in this current environment where growth is constrained industry wide.

With 2023/24 being a transitionary period for the Scheme's external auditors, the Committee will also focus on ensuring a smooth transition between PwC and Deloitte.

Discovery Health Medical Scheme registration number 1125

MANDATORY AUDIT FIRM ROTATION COMMITTEE

The MAFR Committee was established during 2022 to oversee 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 01 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.

The Committee was dissolved following the approval to appoint Deloitte at the Scheme's 2023 AGM.

Composition and meetings in 2023

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 and did not meet during 2023.

Clinical Governance Committee

The Clinical Governance Committee has been 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 all matters related to clinical governance including evidence-based funding policies and practices, and various strategic risk management initiatives designed to manage healthcare utilisation risk. It oversees the functions performed by Discovery Health in terms of the managed care agreement including management of clinical exceptions and ex-gratia 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.

In line with its annual strategic themes and priorities, the Committee periodically engages with various experts in the healthcare system, including hospital providers and specialists from different medical disciplines locally and abroad. The Committee also engages with Health Quality Assessment (HQA), an independent industry body that measures and reports on quality of care in the private sector. 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 2023

During 2023, 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.

Given the ever-evolving healthcare landscape and seeking to keep up to date with innovations in health technology, diagnostics and treatment approaches, the Clinical Governance Committee regularly invites external experts in specific fields of interest related to the Scheme's strategic focus areas. In 2023, the Committee invited external experts in the field of medical genetics and endocrinology, and considered their inputs relative to the Scheme's genomics and obesity risk management strategy.

Other strategic focus areas the Committee considered include alternative healthcare delivery solutions such as digital healthcare products, virtual service platforms, alternative settings of care, and the 2024 benefit changes. Besides emerging innovations, the Committee continued to consider the growing burden of chronic diseases of lifestyle and enhanced prevention and management solutions to mitigate this trend, such as personalised health pathways. In the oncology area, the Committee approved enhanced breast cancer and lung cancer journeys including enhanced risk funding for pathology diagnosis and coaching in breast cancer, and a funding protocol for low dose CT scan screening for lung cancer. The Committee considered the results of the 2022 committee effectiveness review and is satisfied that its activities, recommendations and reporting to the Trustees during the year have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

At the end of 2023, the Committee comprised three Trustees (one of whom chaired the Committee), three 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 2023

		02 Mar	01 Jun	07 Sep	02 Nov
Chairperson (Trustee)	Dr Max Price (Trustee)	✓	✓	×	✓
Committee Members	Prof Laurel Baldwin-Ragaven (Independent Member)	✓	✓	✓	✓
	Mrs Lalita (Gita) Harie (Trustee)	✓	✓	✓	✓
	Dr Nonkululeko Mlaba (Independent Member)[1]	✓	✓	✓	✓
	Dr Dhesan Moodley[2]	–	–	✓	✓
	Dr Dineo Tshabalala[3]	–	–	✓	✓
	Dr Unati Mahlati (Chief Medical Officer)[4]	✓	✓	✓	✓

1 Acted as Chairperson for the meetings on 01 June 2023 and 07 September 2023.
2 Term as a Trustee started on 01 September 2023.
3 Appointed as a Committee Member effective 01 June 2023.
4 Scheme Executive. All other Committee Members are non-executive.
– Not required to attend.
X Apology tendered.

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 2024 will include improving member's health outcomes, and scaling up of existing and new managed care interventions to mitigate the Scheme's aging profile and increasing burden of disease. 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.

Discovery Health Medical Scheme registration number 1125

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 a panel of the Dispute 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 professionals 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, but since then the preference is to convene in-person hearings where practically possible;
- 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. Healthcare 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 2023

In 2023, 956 (98%) of the 972 member disputes lodged in terms of Rule 27[1] were settled or withdrawn prior to a hearing (2022: 874-member related disputes, one forensic dispute – 754 (86%) settled or withdrawn)[2]. No forensic disputes were lodged in 2023. There were 33 dispute hearings during 2023 with 29 rulings issued; 19 of which were in favour of the Scheme, eight in favour of members, and two 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.

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.

Composition and meetings in 2023

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 2023 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.

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.
2 2022 data has been restated. This data was previously extracted in February 2023, and included 62 disputes pending a hearing as of December 2022. 60 of these matters did not proceed to a hearing subsequent to the extraction of data and so were deemed settled or withdrawn. These are now included in the 2022 numbers. Data for 2023 is extracted after 01 March 2024 and includes all such matters."

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 Investment, Credit Risk and Responsible Investing Policies for the Scheme 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 and tactical asset allocation strategies and approving plans for implementation;
- Reviewing investment strategies, performance of the investment portfolio, asset classes and of asset managers against established benchmarks, and reporting to the Trustees quarterly on the performance of the portfolio;
- 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 policies and statutory requirements, and where there is deviation from the policies, investigating the reasons for this and recommending corrective action to the Trustees;
- Assisting the Trustees in preparing their annual report on investment performance and compliance.

Activities during 2023

- Considered the Scheme's strategic asset allocation across various asset classes, taking account of the prevailing economic outlook, and oversaw the implementation of the asset allocation plan.
- Reviewed a report on the optimisation of the equity portfolio resulting in the termination of two mandates, the appointment of a new manager and changes in the allocation of funds to the managers.
- Reviewed the investment strategies and performance of asset managers relative to their benchmarks.
- Monitored the equity benchmark considering changes to the JSE's benchmark capping and the concentration risk arising from Naspers and Prosus, resulting in a change to the benchmark.
- Monitored the performance of the tactical foreign currency hedges in place.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included onsite visits by the Scheme.
- Reviewed the Scheme's Credit Risk Policy, resulting in changes to the credit metrics that make up the policy.
- 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 2022 committee effectiveness review, and is satisfied that its activities, recommendations and reporting to the Board during 2023 fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

At the end of 2023, 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 attends 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 2023

		16 Feb[1]	14 Apr	11 May	15 Aug	26 Oct
Chairperson (Trustee)	Mr Johan Human[2]	✓	✓	✓	–	–
Chairperson (Trustee)	Dr Dhesan Moodley[3]	–	–	–	○	✓
Committee Members	Ms Joan Adams SC (Trustee)[4]	✓	✓	✓	✓	–
	Dr Rendani Mbuvha (Trustee)[5]	–	–	–	✓	✓
	Mr Marius du Toit (Trustee)[6]	✓	✓	✓	✓	✓
	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓	✓
	Ms Henda van Deventer (Independent Member)	✓	✓	✓	✓	✓

1 The meeting of 16 February 2023 was a strategy session.
2 Term as a Trustee ended on 13 August 2023.
3 Term as a Trustee commenced and appointed to the Investment Committee as of 01 September 2023.
4 Member of the Investment Committee until 31 August 2023.
5 Term as a Trustee commenced on 01 August 2023 and appointed to the Investment Committee as of 14 August 2023.
6 Chaired the meeting on 15 August 2023 due to Johan Human's term ending on 13 August 2023 and in the absence of the Board having appointed a new Chairperson. He was not remunerated separately as Chairperson for this.
○ Attended the meeting in August as an invitee prior to the commencement of his term and was not remunerated for this.
– Not required to attend.

FUTURE FOCUS AREAS

During 2024, 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 selection of asset managers.

NOMINATION COMMITTEE

The NomCo is an independent committee of the Board, comprised of members who are not Trustees of the Scheme. The Committee is established by the Board to oversee the nomination and election processes as set out in the Framework for the Nomination and Election of Trustees, which includes:

- Oversight of the nominations process from a governance perspective as well as overseeing the nominations process implemented by the IEB.
- Oversight of the following to the extent that they relate solely to the election and/or appointment of Trustees and/or Independent Committee Members:
  - AGM and/or special general meeting (SGM) voting processes;
  - Proxy processes.
- All other aspects of the AGM or SGM remain the ultimate responsibility of the Trustees unless specific formal requests are made of the NomCo. This is to ensure that independence related to elections and appointments is maintained.
- For the 2023 AGM and Trustee election, the Trustees approved the appointment of Mazars South Africa as the independent third-party service provider to assist the NomCo.

Activities during 2023[1]

The 2023 AGM was successfully convened on 08 June 2023. The NomCo oversaw this process from a governance perspective in terms of its mandate. The following activities and this process were undertaken by Mazars in 2023 as an independent third-party service provider, to assist the NomCo to:

- Review the notice of the AGM;
- Oversee and manage the proxy appointment process;
- Receive motions from members and provide them to the Scheme;
- Manage the registration of attendees at the AGM;
- Oversee any other aspects that members are required to vote on; and
- Prepare final project reports for the Board and submission to the CMS.

The Committee reported to the Trustees on its activities for the 2023 AGM and fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

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

Nomination Committee attendance in 2023		15 Mar	16 Mar	22 Mar	26 Apr	05 May	18 May	01 Jun	14 Jun	14 Aug	22 Aug	29 Aug	04 Sep	03 Oct	14 Nov	21 Nov	30 Nov
Chairperson (Independent Member)	Mr Andrew Bryce	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Committee Members	Ms Berenice Lue Marais (Independent Member)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mrs Alexandra Muller (Independent Member)	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

x Apology tendered.

- *All Committee meetings were convened to either discuss vetting of prospective Independent Committee Members and appointed Trustees; alternatively to engage on AGM and Trustee election processes.*

FUTURE FOCUS AREAS

The 2024 AGM and Trustee election is scheduled to take place on 27 June 2024. The NomCo 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

The Product Committee 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, sustainability, competitive landscape and the interests of members and healthcare providers.

Activities during 2023

The Committee held five meetings during 2023, of which three were combined meetings with the Audit Committee. 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 benefit proposals, actuarial valuation report, and marketing and communication for the 2024 products and benefits enhancements, taking into account demographic risks, the needs of members, and the competitor landscape. They also reviewed the related Scheme Rule changes, and recommended all of these for the Board's approval. The Committee continuously monitors developments in the policy and regulatory space, including the proposed NHI and Low-Cost Benefit Options (LCBOs) framework development. The Committee considered the results of the 2022 committee effectiveness review and is satisfied that it has fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

At the end of 2023 the Committee comprised six Trustees, one of whom chaired the Committee, one who is the Chairperson of the Board, and one who 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 meetings.

Product Committee
attendance in 2023

		18 Jan[A]	31 Mar	26 Jul	23 Aug	08 Sep[A]
Chairperson (Trustee)	Mr Johan Human[1]	✓	✓	✓	–	–
Chairperson (Trustee)	Mr Marius du Toit (Trustee)[2]	✓	✓	✓	✓	×
Committee Members	Dr Susette Brynard (Trustee)	✓	✓	✓	✓	✓
	Dr Dhesan Moodley[3]	–	–	○	○	✓
	Dr Rendani Mbuvha[4]	–	–	✓	✓	✓
	Ms Michelle Norton SC (Trustee)[5]	✓	✓	✓	✓	✓
	Dr Max Price (Trustee)	✓	✓	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer)[6]	✓	✓	✓	✓	✓

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 duration of such meetings.
- *A joint Audit and Product Committee meeting was convened on 18 January 2023 to discuss the 2023 contribution increase.*
- *A joint Audit and Product Committee meeting was convened on 08 September 2023 to discuss the 2024 actuarial valuation report including product and benefit recommendations. Eric Mackeown chaired the meeting in his capacity as the Chairperson of the Audit Committee.*

1 Term as a Trustee ended on 13 August 2023.
2 Appointed as Chairperson of the Product Committee effective 14 August 2023 to replace Johan Human.
3 Term as a Trustee commenced on 01 September 2023.
4 Term as a Trustee commenced on 01 August 2023. Attended the meeting of 26 July 2023 as an invitee prior to the commencement of his term and was not remunerated for this.
5 Appointed as a Committee Member effective 23 February 2023.
6 Scheme Executive. All other Committee Members are non-executive.
○ Attended the meetings of 26 July 2023 and 23 August 2023 as an invitee prior to the commencement of his term and was not remunerated for this.
x Apology tendered.
– Not required to attend.

A joint Audit and Product Committee meeting was convened on 23 August 2023 to discuss the revised DHMS actuarial valuation report. Thereafter the Product Committee met, without the Audit Committee.

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 assists with overseeing human resources strategies and policies, and ensuring compliance with these policies. It also oversees the remuneration of, and further makes recommendations to the Board regarding remuneration structures for, Trustees and Independent Committee Members. Recommendations relating to the remuneration of Trustees 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:

- Annually considering and recommending remuneration policies that are fair, in line with best practice and responsible for all staff levels in the Scheme.
- Considering current industry practice, professional executive recruitment organisations' publications, and the independent remuneration industry report for the purposes of benchmarking the Scheme's remuneration policies in respect of the Principal Officer, staff, Trustees and Independent Board Committee Members.
- Benchmarking and setting remuneration fees of Trustees and Independent Committee Members.
- Annually reviewing the Scheme's employee value proposition (EVP).
- Annually considering and approving employee training requirements and/or requests.
- 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.

Activities during 2023

- 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 2023 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.
- Concluded the Scheme employee salary benchmarking exercise.
- Considered and recommended Scheme human resources policies to the Board for approval.
- Considered and approved training and development requirements for Scheme employees.
- Considered the results of the 2022 committee effectiveness review making changes where required.
- Considered and recommended the filling of Board Committee and committee vacancies.

The Committee is satisfied its activities, recommendations and reporting to the Board during 2023 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

At the end of 2023, the Committee comprised three Trustees and two Independent Committee Members. The Principal Officer attends Committee meetings by invitation.

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.*

Remuneration Committee attendance in 2023

		30 May	27 July[A]	01 Aug[A]	08 Aug[A]	16 Aug[A]	09 Nov
Chairperson (Independent Member)	Mr Bongani Hlophe	✓	✓	✓	✓	✓	✓
Committee Members	Ms Joan Adams SC (Trustee)	✓	✓	✓	✓	✓	✓
	Mr John Butler SC (Trustee)[1]	✓	–	–	–	–	–
	Dr Susette Brynard (Trustee)	✓	✓	✓	✓	✓	✓
	Mr Ndumiso Luthuli (Independent Member)	✓	✓	✓	✓	x	✓
	Ms Michelle Norton SC (Trustee)[2]	✓	x	✓	✓	✓	✓

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 duration of such meetings.
- *A Remuneration Committee meeting was convened on 27 July 2023 to discuss remuneration benchmarking.*
- *A Remuneration Committee meeting was convened on 01 August 2023 to discuss remuneration benchmarking.*
- *A Remuneration Committee meeting was convened on 08 August 2023 to discuss remuneration benchmarking.*
- *A Remuneration Committee meeting was convened on 16 August 2023 to discuss remuneration benchmarking.*

1 Term as a Trustee ended on 13 June 2023.
2 Appointed as Committee Member effective 23 February 2023.
– Not required to attend.
x Apology tendered.

FUTURE FOCUS AREAS

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

- Completing the review of the remuneration policy together with the remuneration architecture to ensure its relevance and to make progressive improvements;
- 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, operations and the Shariah Compliant Arrangements. 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 with support from the Discovery Group Risk function.

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 the business strategy.

Activities during 2023

- 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 the administrator's systems strategy.
- Considered the status of the annual disaster recovery and business continuity tests.
- Reviewed and monitored reports on the service levels delivered by Discovery Health and the administrator's forensic activities.
- Assessed the value added to the Scheme by Discovery Health.
- Reviewed the appointment of a new party to provide peer review services in respect of the Discovery Health value-added services.
- Reviewed the Scheme's non-healthcare expenses against budget and compliance with the Procurement Policy.
- Reviewed reports on the Shariah Compliant Arrangements.
- Reviewed the frameworks that support the Scheme's governance activities and recommended them to the Board for approval.
- Reviewed the Committee's terms of reference.

The Committee considered the results of the 2022 committee effectiveness review and is satisfied its activities, recommendations and reporting to the Board during 2023 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

At the end of 2023, 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 2023

		16 Mar	13 Jul	10 Aug	19 Oct
Chairperson (Trustee)	Mrs Lalita (Gita) Harie	✓	✓	✓	✓
Committee Members	Ms Joan Adams SC (Trustee)	✓	✓	✓	✓
	Dr Alewyn Burger (Independent Member)	✓	✓	✓	✓
	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer)[1]	✓	✓	✓	✓
	Mr Selwyn Kahlberg (Chief Operations Officer)[1]	×	✓	✓	✓

1 Scheme Executive. All other Committee Members are non-executive.
X Apology tendered.

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. Key focus areas will include stability of the operations supporting the administration of the Scheme, 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 2023

- Reviewed the impact on and responses of stakeholders to the launch of DHMS' 2023 and 2024 annual plan, benefit and contribution updates, including the deferral of the annual contribution increase, and activities planned to support the changes.
- Reviewed the results of a survey of medical scheme customer satisfaction, covering areas such as complaints, quality, expectations, fairness, satisfaction, value and loyalty, and considered areas for improvement.
- Considered the 2023 marketing strategy and brand positioning.
- Considered a new sustainability position statement for the Scheme, for inclusion in the Integrated Report.
- Reviewed proposed improvements to ethics and stakeholder related policies.
- Received training on the ethics of non-beneficial care[1], and considered proposed initiatives by Discovery Health to better manage non-beneficial care and support members and providers in this situation.
- Considered the results of an ethical culture assessment of DHMS conducted by The Ethics Institute. The Scheme was benchmarked against approximately 70 other international organisations in the 100th percentile.
- Reviewed reports relating to the Committee's social and ethics mandate, including overall stakeholder engagement and risk, disputes and complaints, customer engagement, the Scheme's workplace, Treating Customers Fairly and high-risk and complex medical cases.
- 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 2022 committee effectiveness review conducted by the IoDSA. The Committee received a score of 4.7/5.0 and was considered by the IoDSA to be performing at an 'excellent' level. The evaluator made no significant conclusions or suggestions for the Committee.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2023 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2023

At the end of 2023, 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 2023

		16 Mar	06 Jul	09 Nov
Chairperson (Trustee)	Dr Susette Brynard (Trustee)	✓	✓	✓
Committee Members	Ms Joan Adams SC (Trustee)	✓	✓	✓
	Mr John Butler SC (Trustee)[1]	✓	–	–
	Mrs Lalita (Gita) Harie (Trustee)	✓	✓	✓
	Ms Michelle Norton SC (Trustee)[2]	✓	✓	✓
	Dr Max Price (Trustee)	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer)[3]	✓	✓	✓

1 Term as a Trustee ended on 13 June 2023.
2 Appointed as a Committee Member effective 23 February 2023.
3 Scheme Executive. All other Committee Members are non-executive.
– Not required to attend.

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. In 2024, work to be done by the Committee includes overseeing the development of an ethics management plan for the Scheme, as well as the review of various ethics-related policies.

1 Non-beneficial care, also known as futile care, is the continued provision of medical care or treatment to a patient when there is no reasonable hope of a recovery, where it cannot achieve its purpose, or is not in the patient's best interests.

AD HOC COMMITTEE OF THE BOARD OF TRUSTEES

During 2023, the Board appointed an ad hoc Committee to consider the possible renewal of the Scheme's office lease agreement with Discovery Central Services, and to review the 2024 other operating expenses budget. The Committee is expected to meet at least once annually to review the other operating expenses budget and thereafter make a recommendation to the Board.

Activities during 2023

The Committee convened once during 2023 to review the lease variation agreement and the other operating expenses budget for recommendation to the Board for approval.

Composition and meetings in 2023

The Committee comprised three Trustees.

Ad Hoc Committee of the Board of Trustees
attendance in 2023

		25 Oct[A]
Chairperson (Trustee)	Dr Dhesan Moodley	✓
Committee Members	Dr Rendani Mbuvha (Trustee)	✓
	Mr Marius du Toit (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 duration of such meetings.*

- *The Ad Hoc Committee of the Board of Trustees convened a meeting on 25 October 2023 to consider the possible renewal of the Schemes' office lease agreement and to review the Scheme's 2024 budget for other operating expenses.*

FUTURE FOCUS AREAS

Future focus areas to be determined by the Board as required.

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 01 January 2023. During 2022 the Board, on recommendation from this Committee, approved the fee models and the wording of the agreements.

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 2023

One meeting was held during which the Services Renewal Committee reviewed a report on the fee model. The Committee, having completed its purpose and duties as set out in the Terms of Reference, was dissolved by the Board of Trustees.

Composition and meetings in 2023

At the time of its dissolution the Committee comprised four Trustees.

Services Renewal Committee
attendance in 2023

		07 Jun[A]
Chairperson (Trustee)	Mr Johan Human	✓
Committee Members	Mr John Butler SC (Trustee)	✓
	Mr Marius du Toit (Trustee)	✓
	Dr Max Price (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 duration of such meetings.*

- *Only one meeting was convened for the year 2023 after which the Committee was dissolved by the Board of Trustees.*

Independent 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 Committees Member	Appointed	01 Sep 19	31 Aug 22
	Chair of the Audit Committee, Independent Risk and Investment Committees Member	Re-appointed	01 Sep 22	31 Aug 25
Dr Alewyn Burger	Independent Audit and Risk Committees Member	Appointed	01 Jan 20	31 Dec 22
	Independent Audit and Risk Committees 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
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
Mrs Busisiwe Mathe	Independent Audit Committee Member	Appointed	01 Jun 23	30 May 26
Dr Dineo Tshabalala	Independent Clinical Governance Committee Member	Appointed	01 Jun 23	30 May 26

1 Due to the variation of Dispute Committee panellists, 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
(67)

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
(52)

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. Expertise in governance, International Financial Reporting Standards (IFRS) and financial sector regulation.

MR ANDREW BRYCE
(68)

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

MEMBER OF THE NOMINATION COMMITTEE

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

DR ALEWYN BURGER
(72)

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, and 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
(47)

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
(49)

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, with significant knowledge of the employee benefits industry. Formerly a senior management consultant, chair, and non-executive chair of several national and international entities, as well as a member of the King III Sustainable Development Reference Group. Currently a majority shareholder in a management consultancy, and on the transformation committee of the Africa division of a global audit firm.

MR NDUMISO LUTHULI
(48)

BProc; LLB; BCL[7]; MBA

MEMBER OF THE REMUNERATION COMMITTEE

Member of the Johannesburg Society of Advocates, practising commercial, administrative and constitutional law. Formerly served as in-house legal counsel and project finance adviser in a consulting engineering firm, and was an Archbishop Tutu Leadership Fellow.

1 *Note: all ages as at 31 December 2023.*
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.*
7 *BCL: Bachelor of Civil Law.*

Discovery Health Medical Scheme registration number 1125

MR ERIC MACKEOWN (66)

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 (59)

MBA (International Business); BA Economics

MEMBER OF THE NOMINATION COMMITTEE

Over 20 years of leadership, governance, strategic business development, and international experience. Has previously held 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 an expert adviser and independent non-executive director for various companies in the private, public and non-profit sectors.

MRS BUSISIWE MATHE (43)

CA(SA)

MEMBER OF THE AUDIT COMMITTEE

Independent consultant, with over 15 years' experience at a professional services firm, seven of which were as a partner. In-depth knowledge in governance, risk, audit, information technology, cybersecurity, and data privacy. Track record of leading external and internal audits, IT audits, digital transformation, cybersecurity and data privacy projects at listed and unlisted companies across multiple sectors. Currently serving as an independent non-executive director; member of the audit & risk committee and the social & ethics committee of a JSE-listed company.

DR NONKULULEKO MLABA (52)

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. Worked as a specialist radiation oncologist in both the public and private sectors. Deep understanding of managed healthcare, healthcare regulation and clinical research.

MRS ALEXANDRA MULLER (47)

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 for various companies.

DR DINEO TSHABALALA (40)

MBChB (UKZN); MMed Int Med (WITS); FCP(SA); Cert Medical Oncology(SA)

MEMBER OF THE CLINICAL GOVERNANCE COMMITTEE

A senior lecturer and consultant in the Department of Internal Medicine Division of Medical Oncology at Charlotte Maxeke JHB Academic hospital. Currently joint staff at WITS University Medical School, working as a medical oncologist and pursuing her research interests.

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.

Discovery Health Medical Scheme registration number 1125

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.

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.*

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 actual number of 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.

Our full Remuneration Policy

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 the Scheme's administration and managed care provider, Discovery Health, and other service providers, as well as oversees work done on the Scheme's behalf to ensure it is in accordance with the contractual agreements in place.

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.

Discovery Health Medical Scheme registration number 1125

Delegation of authority

To ensure effective accountability and responsibility within the Scheme, the Trustees can confer certain powers to its Committees and Scheme management through a formal delegation of authority process. This process provides a framework for the Committees and Scheme management to:

- Achieve strategic priorities;
- Effectively manage the Scheme within legislative compliance requirements;
- Balance the interests of Scheme stakeholders;
- Minimise and avoid conflicts of interest;
- Ensure checks and balances; and
- Practice good corporate governance.

The delegation of authority is reviewed and updated periodically to ensure relevance to operating requirements and alignment with the accountabilities and authorities of Scheme employees.

Our employees and their remuneration

The Trustees, with the support of 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 was concluded in 2023 and recommendations were implemented where appropriate. The aim of the benchmarking exercise was 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.

Albeit with our small staff compliment, the Scheme prides itself on creating a diverse and inclusive work environment that supports a high-performance culture.

In 2023, 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's Secretariat team both assists in the development and education of the Trustees and Independent Committee Members, and acts as an adviser on governance matters to the Chairperson, Board and executive management team. The Secretariat is responsible for ensuring sound corporate governance based on best practice, and ensures the efficient and effective functioning of the Board and its Committees; the expedient flow of information between the executive team and Trustees; and the development, management and review of governance policies and procedures.

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 and member of the iFHP Sustainability Network.

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[5]; FASSA[6]; FIA[7]

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[8]; MMed; MBA

Member of the board and clinical advisory committee of HQA[9], member of the iFHP Medical Effectiveness High Cost Drugs Network.

The CMO advises on and oversees clinical governance, strategic 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[10]; MPhil (in progress)

Member of SAICA[11] 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 and the Scheme's sustainability.

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; CGISA[12] (Chartered Secretary – in progress)

Board member of the Mobile Applications Laboratory NPC (mLab).

The HCG is responsible for governance effectiveness and legislative compliance, and ensuring adherence to global best practice to ensure informed and legally sound decision making. This includes the management, co-ordination, and responsibility for the Scheme Secretariat and Compliance functions.

HEAD: LEGAL AND ETHICS (HLE)

MR HOWARD SNOYMAN

LLB; MSc Med (Bioethics and Health Law); Dip Sports Management; Adv Dip Sports Management; Certified Deal Architect[13]; (EP) SA[14]; Certified Ethics Officer; Certified Fraud Examiner; PhD (Bioethics and Health Law - in progress)

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[1].

The HLE advises on, formulates, and oversees strategic and operational legal and ethics protocols and activities, including escalated member disputes and complaints, governance, oversight of all Scheme contracts and litigation including activity at industry level, 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 *CFA: Chartered Financial Analyst.*
6 *FASSA: Fellow member of the Actuarial Society of South Africa.*
7 *Financial Intermediaries Association.*
8 *FCPHM: Fellow of the College of Public Health Medicine of South Africa.*
9 *HQA: Health Quality Assessment.*
10 *CIMA: Chartered Institute of Management Accountants.*
11 *SAICA: South African Institute of Chartered Accountants.*
12 *CGISA: Chartered Governance Institute of Southern Africa.*
13 *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.*
14 *Ethics Practitioner SA.*

Regulatory and industry matters dealt with in 2023

Fraud, waste and abuse

Fraud, waste and abuse (FWA) has a severe impact on medical schemes and their members. Excessive utilisation of healthcare services inflates claims, and as schemes need to price contributions to cover expected claims this translates into materially higher contribution increases for members. In 2023 alone, Discovery Health recovered over R500 million for the Scheme. In recognition of this problem, the CMS has held FWA summits and, taking industry submissions into account, 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.

The CMS also convened an inquiry 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 professionals, 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 05 April 2021 in this regard. The interim report found no fault with the processes and practices operated by Discovery Health on DHMS' behalf.

In late 2023, the S59 Investigation Panel sent an updated report by their statistical expert to GEMS, Medscheme and Discovery Health for comment. In February 2024 the Scheme and Discovery Health – with the support of independent experts - submitted a report in response, detailing a number of errors found in the Panel's report. At the time of writing, we await a response to the submission and 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. The CMS declined to register the amendment. 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 have the amended 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. From 2013 onwards, the CMS refused to acknowledge that Rule 14.7 was registered and valid.

The purported non-validity of the Rule 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. On 09 May 2023, the CMS stamped the Scheme's Main Body of Rules, including Rule 14.7, thus acknowledging the Rule as registered in law.

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 and the Scheme and Discovery Health contributed to the industry submission through the HFA in November 2019.

CMS matters *continued*

In January 2024 the CMS re-established the PMB review advisory committee. Thus far, discussions undertaken by the committee are with regards to reviewing the outcomes of the work undertaken by the PMB costing committee to cost the draft primary healthcare package that was proposed in 2019. It is presently not clear whether and when a review of the existing PMB package will be undertaken.

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.

To develop a roadmap for LCBOs, 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 and to 31 March 2025 in Circular 16 of 2024.

Circular 53 of 2022 requested industry submissions on the draft LCBO guidelines; DHMS contributed to these and awaits publication of the updated guidelines. In November 2023 the CMS and the National Department of Health (NDoH) issued a joint statement indicating that the Minister of Health had been briefed by the CMS and that the LCBO report had been handed over to the Minister, who will make a determination regarding LCBOs.

DHMS will continue to seek expanded access to quality and appropriate care for low-income and uninsured households, which will expand and improve medical scheme risk pools, and reduce pressure on public sector resources and infrastructure. We continue to submit applications for LCBO exemptions with consideration of the circumstances brought about by the existence of primary care products in the insurance sector, to the exclusion and detriment of the medical schemes industry, and also prejudicing policyholders of these products who cannot benefit from Tax Credits in terms of the Income Tax Act, nor benefit from the protection afforded members of medical schemes. It is unfortunate that our latest LCBO application has been declined by the CMS, as such approval would have expanded access to private healthcare to a segment of the population which has previously not had such access.

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 responded. The Scheme is still awaiting the issuance of the final report.

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 IFRS, which is 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. There has been no movement on this matter and the Scheme continues to disclose income received from investments as investing cashflows in its Annual Financial Statements.

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 request under the Promotion of Administrative Justice Act 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.

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 communication from the CMS is awaited.

Discovery Health accreditation

All third-party administration and managed care providers are required to renew their CMS accreditation every two years.

In December 2023, the CMS granted accreditation to Discovery Health for two years to 31 December 2025 subject to compliance with the conditions stipulated. Some of the conditions are carried forward from previous accreditation periods and are the subject of two appeals awaiting set down dates. The appeals relate to questions asked in the Scheme's application form and the processes followed for the processing and communication of non-confirmed PMBs. The Trustees and Principal Officer closely monitor the fulfilment of these conditions in line with their governance responsibilities and fiduciary duties.

Mandatory auditor rotation

In June 2017, the IRBA issued a rule prescribing that auditors of public interest entities in South Africa must comply with MAFR as of 01 April 2023.

As a public interest entity, DHMS established the MAFR Committee during 2022 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 01 January 2024. The rule was set aside by the Supreme Court of Appeal on 31 May 2023 but despite this, the Audit Committee and Board were still of the view that from a good governance perspective the Scheme should continue to rotate its auditor. Deloitte were identified as a suitable firm, and their appointment was approved at the Scheme's 2023 AGM.

Discovery Health Medical Scheme registration number 1125

National Health Insurance (NHI)

In 2023, there were significant developments with regards to the NHI Bill which was passed by the National Council of Provinces. The Bill was passed by the National Assembly in June 2023 and thereafter referred to the National Council of Provinces for debate and further public engagement.

The NHI Bill was passed by the National Council of Provinces on 06 December 2023 without any further amendments despite constructive inputs from various stakeholders. The NHI Bill has subsequently been sent to the President for assent into law. The Scheme and other stakeholders have submitted petitions to the President appealing to him to send the Bill back to Parliament for amendment to address significant constitutional flaws.

DHMS fully supports the progressive realisation of universal health coverage for all South Africans, and the NHI is instrumental to the realisation of universal health coverage. It is, however, our view that the current version of the Bill requires amendments to ensure it is workable while also addressing certain constitutional concerns. Our primary concern is that the NHI Bill (and specifically Section 33 of the Bill, which directly threatens the sustainability of the private healthcare sector) will have the unintended consequence of reducing access to and the quality of healthcare services across the entire population, for both public and private sector users. This is in direct contravention of Section 27 of the Constitution, which requires the State to achieve the progressive realisation of everyone's right to have access to healthcare services, and contrary to the objectives of the NHI Bill itself.

All of DHMS' submissions made during engagement on the NHI Bill have supported the provision of universal health coverage to all South Africans. DHMS supports an integrated approach to providing this cover within a social solidarity framework[1]. Our submissions, including the petition, have raised the adverse impact of the proposed single fund model on the right of access to healthcare and the challenges of this model, and included recommendations for a workable approach. We have also noted concerns regarding the governance structures proposed in the Bill.

Members and other stakeholders should be assured that, even if the Bill is not amended, medical schemes will continue to cover all of the healthcare services they currently cover for the foreseeable future, due to the phased implementation and the economic growth required to establish and support the NHI.

Understanding the NHI bill

1 *The use of a model which includes multiple private and public funders, designed to support cross-subsidisation for health and financial status.*

Road Accident Fund (RAF)

RAF tariffs

The 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"[2]. 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 was heard in May 2023, in which the court was asked to review and set aside the tariffs. A request was made for discovery of the documents relating to the RAF's decision to implement the impugned tariffs. The RAF has refused to provide these documents, and hence the aspect of the application dealing with the setting aside of the tariffs has been postponed sine die. The interdict (referred to above) accordingly remains in place. In the interim, the RAF published new tariffs which were (broadly speaking) more acceptable to the industry. Given that the RAF is still refusing to pay claims for past medical expenses that have been covered by medical schemes (see below), we are not yet in a position to determine how the new tariffs are being applied.

2 *Judgment 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).*

Road Accident Fund (RAF) *continued*

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 to the member as they are insured elsewhere, which is 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 in October 2022. However, at the time of publication, the RAF continues to deny these claims and the legal action continues with a definitive ruling on the breach by the RAF and its CEO of their constitutional obligations yet to be issued.

Competition commission – COVID-19 PCR tests pricing matter

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.

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.

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.

The Competition Commission declined to refer the complaint to the Competition Tribunal based on the consent agreements which were entered into with the respective pathology labs in December 2021. This was expected, and the HFA has subsequently self-referred the matter to the Tribunal.

Health Professions Council South Africa (HPCSA)

Towards the end of 2023, the HPCSA amended its ethical rules of conduct to enable practitioners registered under the Health Professions Act No. 56 of 1974, as amended, to practice in multi-disciplinary teams and share fees accordingly.

Changes to the ethical rules also allow hospitals (and other healthcare facilities) to employ doctors. These changes are in line with the Health Market Inquiry's recommendations of 2019 and will enhance the development of value-based contracting and other risk-sharing models between schemes and providers to improve efficiency across the healthcare system.

National Department of Health

Medicine prices are regulated by the NDoH, through the Medicines Act deploying a Single Exit Price (SEP) fixed price legislation with annual inflationary adjustments capped by the NDoH. Stakeholder submissions on the SEP adjustment methodology are considered by the Department's pricing committee.

Medicine prices and price inflation are of concern to schemes as, together with an increasing new high-cost medicine demand, they contribute to healthcare inflation, which every year is expected to be significantly above ordinary inflation due to a combination of tariff increases and increase in utilisation, driven by an increase in available healthcare services as well as changes in demographic profiles. Schemes' contributions have to track healthcare inflation and expected utilisation for the scheme concerned in order to be able to fund members' healthcare, and so all drivers of healthcare inflation directly impact on members' costs.

On behalf of the Scheme, Discovery Health regularly makes submissions to the NDoH's pricing committee regarding the severe impact on members of blanket and compounded annual SEP increases and South Africa's support of global price transparency that results in higher visible pricing for South Africa and precludes the benefit of confidential price discounting that is commonplace globally. Pharmaceutical companies are allowed to set the market entry prices of medicines without any regulatory adjudication beyond an annual capped increase. The NDoH announced a single exit price adjustment of 6.79% for 2024. While this is in line with industry expectations, it exceeds the Consumer Price Index rate and has potential to drive medical inflation.

More about healthcare inflation and claims costs *pg 84*

SECTION 7

Our performance

Scheme performance for the 2023 financial year

Key performance information *pg 78*

Financial Statements *pg 97*

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.

Discovery Health Medical Scheme registration number 1125

Overview

For the year ended 31 December 2023, DHMS delivered a negative insurance service result, before accounting for amounts attributable to future members[1], of R2 252 million (2022: negative R2 493 million), attributable to the delayed contribution increase for the 2023 benefit year, as well as the WELLTH Fund temporary benefit that was funded from reserves, not contributions. Despite this, results are better than expected due to lower-than-expected utilisation for most of 2023, particularly for the WELLTH Fund. The Scheme generated investment income of R2 418 million (2022: R2 222 million). The total comprehensive loss for the year after including investment income, before amounts attributable to future members, is R182 million (2022: R1 476 million).

Insurance liability to future members (previously members' funds) reduced slightly to R28.7 billion (2022: R28.9 billion[2]) with a solvency level of 30.60% (2022: 35.04%), exceeding 25% required by the Regulator.

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 24th 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 market conditions, characterised by difficult economic conditions impacting the growth of schemes, DHMS ended 2023 in a strong financial position and remains well placed to meet members' needs.

INVESTMENT INCOME
R2 418 million
(2022: R2 222 million)

INSURANCE LIABILITY TO FUTURE MEMBERS[3]
R28.7 billion
(2022: R28.3 billion)

NET DEFICIT
R240 million
(2022: R1 489 million deficit)

SOLVENCY LEVEL
30.60%
(2022: 35.11%)

CREDIT RATING
AAA

The Scheme has achieved the highest possible rating for a medical scheme in South Africa for the **24th consecutive year**

The **IFRS 17 accounting standard** is now applicable to the Scheme, and changes have therefore been made to the **terminology and presentation** of our Financial Statements. This introduces some **new terms into the main body of this Report as well as the Financial Statements**.

More about IFRS 17 and how it affects this Report *pg 98*

1 *Amounts attributable to future members represents a transfer from the insurance liability to future members (previously referred to as members' funds) in the statement of financial position, to insurance service result in the statements of comprehensive income, resulting in the total comprehensive loss for the year being nil.*
2 *Members' funds have been retrospectively adjusted for IFRS 17 implementation.*
3 *Previously referred to as members' funds.*

Growth **and sustainability**

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 alongside and on the next page, together with an explanation of why we consider these important.

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 decrease
0.12%
(2022: 1.67% increase)

Net beneficiary decrease
0.81%
(2022: 0.94% decrease)

Average age at year-end[1]
37.00
(2022: 36.57)

Pensioner ratio[2]
12.32%
(2022: 11.77%)

Annualised lapse rate
5.88%
(2022: 5.49%)

MEMBERSHIP SIZE

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

1 373 864
Principal members at 31 December 2023
(2022: 1 375 544)

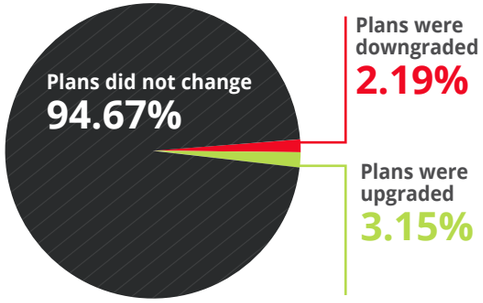
2 788 242
Beneficiaries at 31 December 2023
(2022: 2 810 992)

57.8%
Share of open scheme market
(2021: 57.6%)

PLAN MOVEMENTS

Low movement between plans indicates member satisfaction and appropriate benefit design and pricing.

From December 2023 – January 2024:[3]



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 2024 are
11.1%
lower than the next seven largest open medical schemes[4]
(2023: 12.3%[5]).

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 *We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans.*
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. Contribution rates on individual plans on other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*
5 *The differential reported for 2023 was updated from 12.2% to 12.3% to reflect the interim contribution increase effective 01 May 2023 by Sizwe-Hosmed.*

Discovery Health Medical Scheme registration number 1125

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
30.60%
(2022: 35.04%)[1]
exceeding the statutory solvency requirement of 25%.

AAA
Independent credit rating for claims paying ability[2]
(2022: 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
9.36%
(2022: 6.18%)

In 2023, the Scheme deferred the contribution increase to 01 April, providing relief to its members and passing on the benefit of excess reserves.

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims. In 2023, the Scheme deferred the contribution increase to 01 April, providing relief to its members and passing on the benefit of excess reserves. The Scheme also introduced the WELLTH Fund, a temporary benefit, as a mechanism to release excess reserves to its members. The deferral of the increase and the implementation of the WELLTH Fund resulted in the Scheme generating a negative insurance service result for the year. The WELLTH Fund and deferred contribution increase contributed R490 million and R1.5 billion to the total comprehensive loss respectively.

Total insurance service result[3] for the year
R2 069 million
negative
(2022: R1 017 million negative)

Total comprehensive loss[4] for the year of
R183 million
(2022: R1 476 million surplus)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE

For every R1.00 spent by DHMS on administration and managed care fees in 2022[5], our members received
R2.08
(2021: R2.02)
in value from the activities of Discovery Health (Pty) Ltd (Discovery Health). This is equivalent to nominal added value, over and above the fees paid, of R8.7 billion in 2022 (2021: R7.6 billion).

Administration fees
7.41%
of gross contributions
(2022: 7.56%)

Managed care fees
2.56%
of gross contributions
(2022: 2.64%)

1 *Restated due to IFRS 17 implementation. The figure disclosed in the 2022 Integrated Report was 35.11%.*
2 *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.*
3 *Total insurance service result excludes amounts attributable to future members. Amounts attributable to future members is R183 million (2022: R1 476 million).*
4 *Total comprehensive loss for the year excludes amounts attributable to future members.*
5 *As the assessment uses industry information reported by the Council for Medical Schemes (CMS), results are only available for the preceding year.*

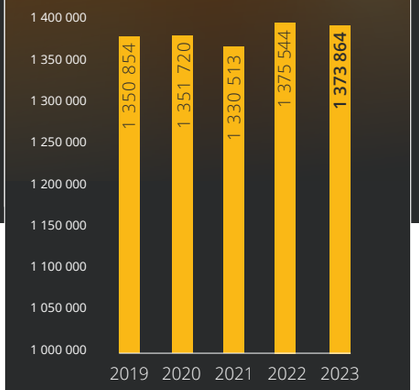
Discovery Health Medical Scheme registration number 1125

Historical **performance indicators**

Consistent with the stagnant South African economy, the medical scheme industry has remained stagnant over the past decade, with only a very slight increase in membership of 1.05% in 2022 compared to 2021[1]. In the same period, DHMS' principal members increased by 1.67% indicating that membership of a trusted scheme like DHMS is a priority for our members. Insurance liability to future members[2] are sufficient to assure members that the Scheme is able to take care of their healthcare needs.

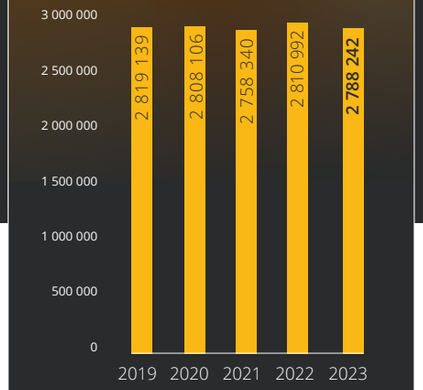
Scheme principal members

Decrease[3] **0.12%**



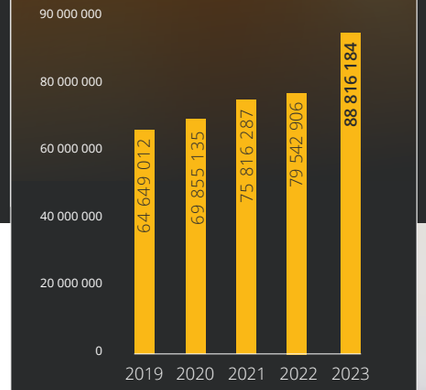
Scheme lives

Decrease[3] **0.81%**



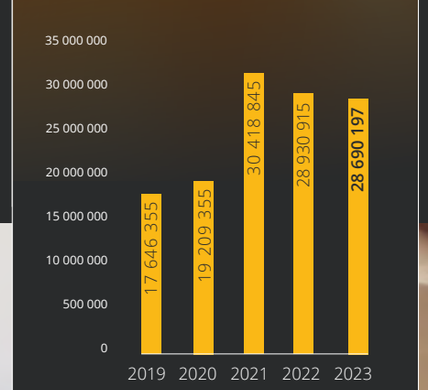
Gross contributions (R'000)

Increase[3] **11.66%**



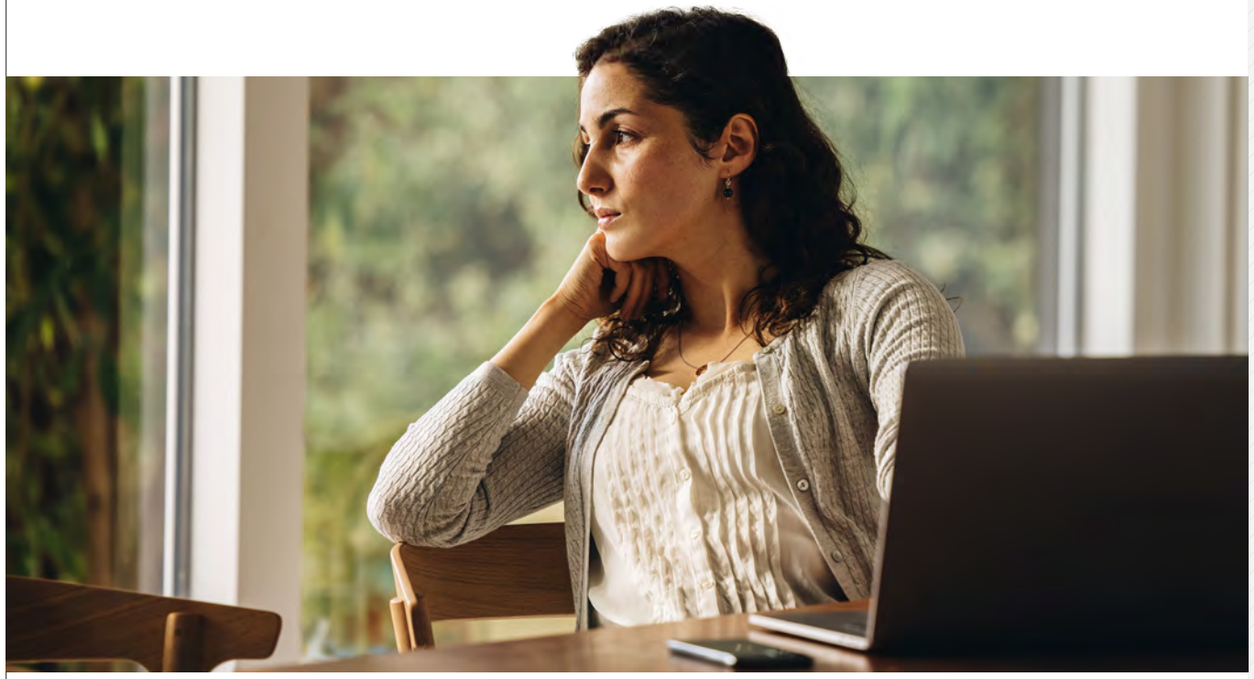
Insurance liability to future members (R'000)

Decrease[3] **0.83%**



1 *According to the 2022 CMS report, a total of 9 039 259 beneficiaries were covered, up from 8 945 053 at the end of 2021.*
2 *Previously referred to as members' funds.*
3 *Year-on-year change (2022 to 2023).*

Discovery Health Medical Scheme registration number 1125



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.

More about TCF *pg 35*

More about the Dispute Committee *pg 59*

With a total of 56 699 765[1] claims made in 2023, only 405 resulted in complaints to the CMS by DHMS members for 2023[2] (2022: 439 relative to 55 755 192[3] claims). This represents a 7.7% decrease in the number of complaints from 2022, and the ratio of internal disputes to CMS complaints has continued to improve from 39% in 2015, to 240% in 2023 (i.e. more than 2.4 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 2023, 956 (98%) of the 972 member disputes lodged in terms of Rule 27[4] were settled or withdrawn prior to a hearing (2022: of the 874 member disputes and one forensic dispute, 754 or 86% settled or withdrawn)[5]. No forensic disputes were lodged in 2023.

For member disputes, 33 hearings took place during 2023 with 29 rulings issued; 19 in favour of the Scheme, eight in favour of members, and two 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.

In 2023, only one complaint was made for every 139 999 claims made by members.

1 *Total claims made in 2023 extracted during February 2024; claims incurred during 2023 but not submitted by the date of extraction are not included.*
2 *This equates to 0.0071 complaints per 1000 claims, or one complaint to every 130 344 claims (2022: 0.0078 complaints per 1000 claims, or one complaint to every 127 005 claims).*
3 *Total claims made in 2022 extracted during February 2023; claims incurred during 2022 but not submitted by the date of extraction are not included.*
4 *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.*
5 *2022 data has been restated. This data was previously extracted in February 2023, and included 62 disputes pending a hearing as of December 2022. 60 of these matters did not proceed to a hearing subsequent to the extraction of data and so were deemed settled or withdrawn. These are now included in the 2022 numbers. Data for 2023 is extracted after 01 March 2024 and includes all such matters.*

Discovery Health Medical Scheme registration number 1125

Gross contribution income

The Scheme remained highly competitive with average contributions for 2024 that are 11.1% lower[1] than the next seven largest open medical schemes (2023: 12.3%)[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 was able to adopt a contribution increase deferral strategy for three years in a row from 2021 to 2023. DHMS was the first medical scheme in South Africa to implement a freeze on contribution increases effective from January to July 2021, with the same approach followed from January to October 2022 and January to April 2023.

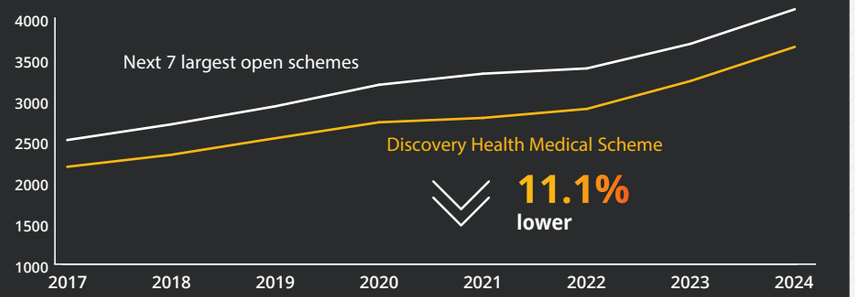
THE THREE CONTRIBUTION FREEZES HAVE SAVED DHMS MEMBERS APPROXIMATELY R8.5 BILLION[4] ACROSS 2021, 2022 AND 2023, A SIGNIFICANT RESPITE FOR MEMBERS UNDER FINANCIAL PRESSURE.

The utilisation discontinuities apparent within the Scheme due to COVID-19 enabled DHMS to defer contribution increases between 2021 and 2023 in order to support short-term affordability for its members. Utilisation levels have since stabilised resulting in DHMS returning to annual increase cycles from 2024. On 01 January 2024, contributions increased by a weighted average 7.5% across the various DHMS plans.

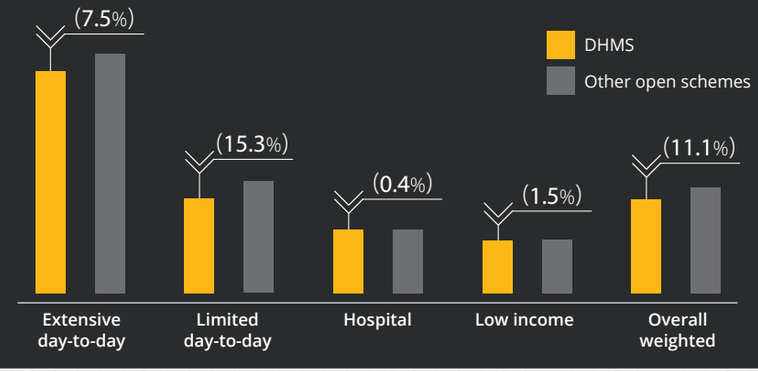
Gross contribution income (GCI) rose 11.66% to R88.8 billion (2022: R79.5 billion). The most significant net membership growth contributing to the increase in GCI was recorded in mid- to low-tier options, where the Smart series grew by 16 799 net members (2022: 11 974). With a net principal membership decline of 18 124, the Comprehensive series experienced the largest reduction (2022: 11 820, Priority series).

Discovery Health Medical Scheme registration number 1125

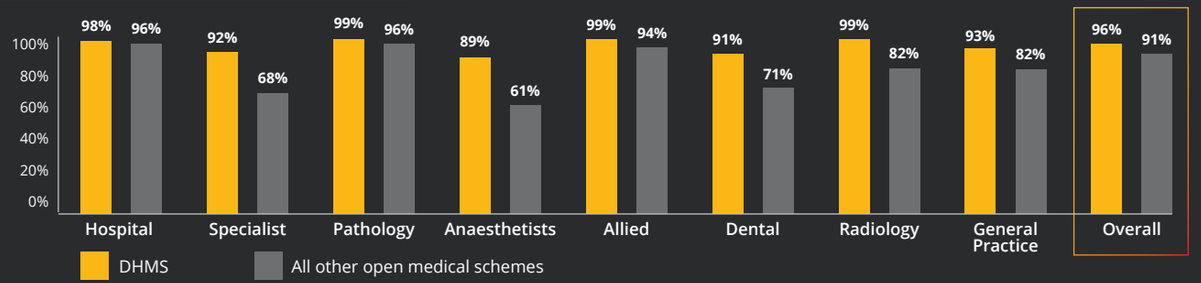
DHMS CONTRIBUTIONS ARE 11.1% LOWER THAN THE NEXT SEVEN LARGEST OPEN MEDICAL SCHEMES IN 2024



DHMS IS MORE AFFORDABLE ACROSS ALL OF PLAN CATEGORIES IN 2024



IN RETURN FOR THEIR CONTRIBUTIONS, DHMS CONTINUES TO PROVIDE EXCEPTIONAL CLAIMS COVER FOR MEMBERS. IN 2022, WE PAID 96% OF IN-HOSPITAL CLAIMS, VS 91% FOR ALL OTHER OPEN SCHEMES[5]



More about how we price contributions *pg 8*

Barriers to lower contribution rates *pg 9*

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. Contribution rates on individual plans on other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

2 *The differential reported for 2023 was updated from 12.2% to 12.3% to reflect the interim contribution increase effective 01 May 2023 by Sizwe-Hosmed.*

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 2023, DHMS experience indicates the normalisation of healthcare utilisation.*

4 *The estimated contribution savings provided to members across 2021, 2022 and 2023 has been updated to R8.5 billion (previously reported as R8.6 billion). At the time of calculation for the 2022 Integrated Report, the actual contribution income for the 2023 deferral period (January to March) had not yet been received, and so the savings were calculated based on the assumption that the plan distribution as at December 2022 would remain constant over the deferral period. This calculation has since been updated to reflect the actual contribution income received over January to March 2023, resulting in contribution relief for DHMS members of R8.5 billion through the 2021, 2022 and 2023 contribution increase deferrals.*

5 *Based on claimed amounts. Source: CMS Annual Report 2022-2023. Comparative data not yet available for the 2023 year.*

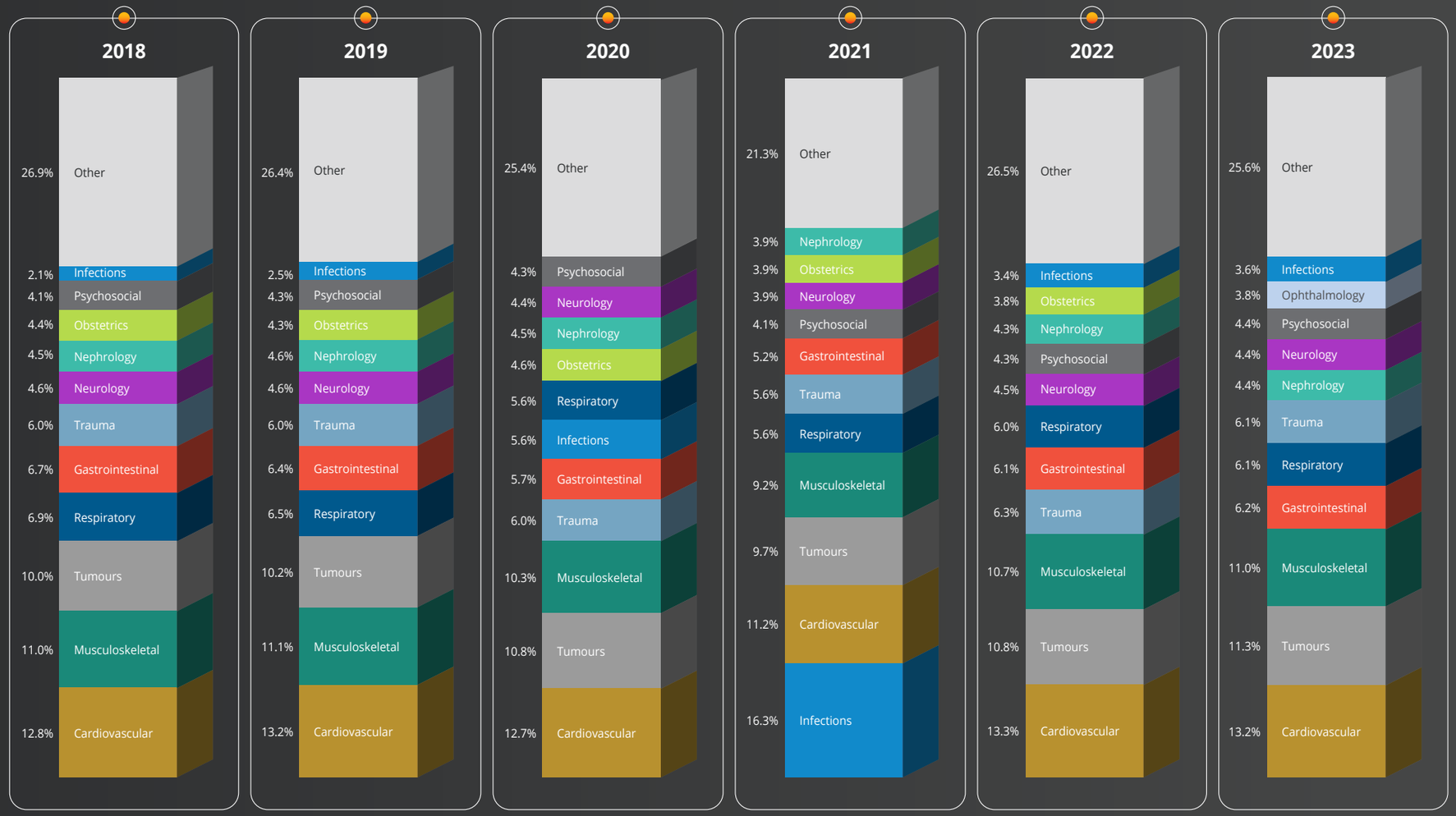
Net claims incurred

Net claims incurred increased by 11.35% to R65.6 billion (2022: R58.9 billion) and we saw utilisation returning to pre-COVID-19 levels in the latter part of 2023.

The gross claims ratio[1] decreased to 92.47% (2022: 92.90%) due to the deferral of the 2022 contribution increases to October 2022 and the 2023 contribution increases being deferred to April 2023. The Scheme's administration and managed care provider continues to provide robust risk management interventions to reduce claims costs and thereby contain contribution increases for members.

Claiming patterns are influenced by a changing burden of disease, as well as demographics and benefit design. Based on Discovery Health's analysis of the Scheme's claims experience, infections, driven by COVID-19, have increased and add 1% to the Scheme's overall claims cost. Tumours have also increased, partially driven by benefit availability. Mental health prevalence, included here in the psycho-social category, has increased but in line with other conditions, not relative to them. It also has a significant impact on the cost of other existing conditions.

CLAIM COST INCREASE BY DISEASE EPISODE



Shifting claims patterns in DHMS over time. The experience of other medical schemes would differ based on their benefit design and the demographics of the scheme.

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).*

Discovery Health Medical Scheme registration number 1125

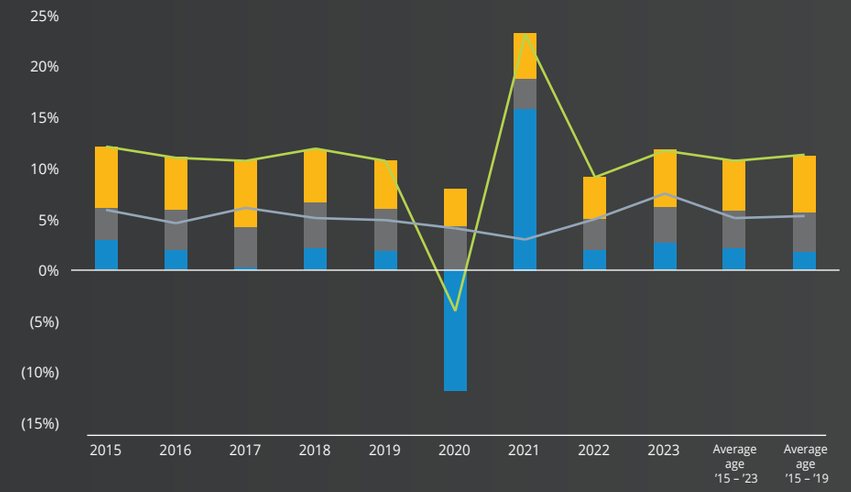
Net claims incurred *continued*

THE IMPACT OF HEALTHCARE INFLATION

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	2023	Average age '15 – '23	Average age '15 – '19
Supply-side impact	2.9%	1.9%	0.2%	2.2%	1.9%	-11.9%	15.9%	2.0%	2.7%	2.0%	1.8%
Demand-side impact	3.1%	3.9%	4.0%	4.4%	4.1%	4.3%	2.9%	3.0%	3.5%	3.7%	3.9%
Total utilisation	***6.0%***	***5.8%***	***4.2%***	***6.6%***	***6.0%***	***-7.6%***	***18.7%***	***5.0%***	***6.2%***	***5.7%***	***5.7%***
Tariff increase	6.0%	5.2%	6.5%	5.2%	4.7%	3.6%	4.4%	4.1%	5.6%	5.0%	5.5%
Total healthcare inflation[2]	**12.1%**	**11.0%**	**10.7%**	**11.9%**	**10.7%**	**-4.0%**	**23.1%**	**9.1%**	**11.7%**	**10.7%**	**11.3%**
CPI at Sep of prior year	5.9%	4.6%	6.1%	5.1%	4.9%	4.1%	3.0%	5.0%	7.5%	5.1%	5.3%

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.*

2 *Total healthcare inflation shown here represents real inflation as experienced by DHMS members, as it includes adjustments for changes in choice of plan. This is higher than experienced by the Scheme as the average new member tends to join the Scheme on lower plans with lower contributions and claims, thus reducing the increase seen by the Scheme. The numbers shown above are rounded.*

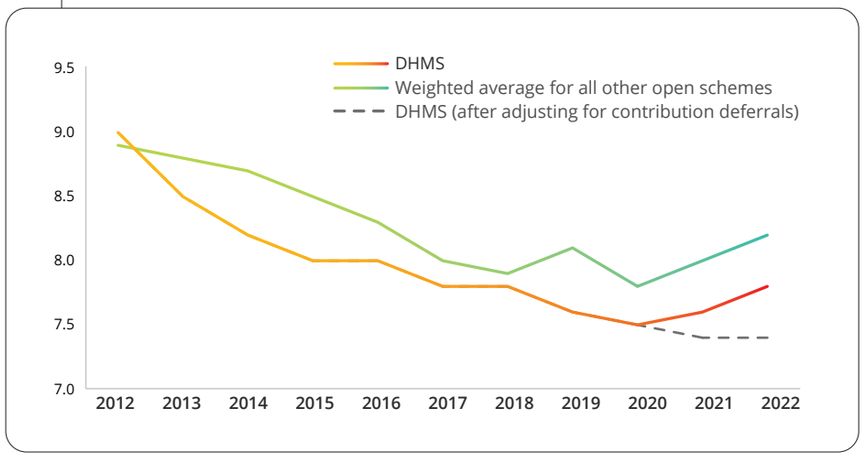
GROSS ADMINISTRATION EXPENDITURE

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 2023, gross administration fees increased by 9.50% to R6.582 billion (2022: R6.011 billion), driven by an increase in the average administration fee per member of 8.99% to R401.38 (2022: R368.28), largely due to an annual CPI-linked increase.

The Scheme's analysis of the CMS Annual Report 2022-2023 shows that, at 7.8% for 2022, DHMS continued to rank below the weighted average gross administration expenditure for open schemes as a proportion of GCI, which was 8.2% excluding the Scheme. The Scheme's gross administration expenditure is the fourth lowest out of 17 open medical schemes in the market[1].

The contribution increase deferrals in 2021, 2022 and 2023 intentionally reduced the gross contribution income received by DHMS, saving members over R8.5 billion[2]. After adjusting the administration expenditure percentage to allow for the planned-for effect of the contribution deferrals, members continue to benefit through a reduced administration expenditure percentage that is among the lowest in the industry. The graph below depicts the continued decrease in gross administration expenses as a proportion of GCI, compared to the weighted average of other open medical schemes.

Administration expenditure among the lowest in the industry (%)



1 *Based on the CMS Annual Report 2022-2023.*
2 *The estimated contribution savings provided to members across 2021, 2022 and 2023 has been updated to R8.5 billion (previously reported as R8.6 billion). At the time of calculation for the 2022 Integrated Report, the actual contribution income for the 2023 deferral period (January to March) had not yet been received, and so the savings were calculated based on the assumption that the plan distribution as at December 2022 would remain constant over the deferral period. This calculation has since been updated to reflect the actual contribution income received over January to March 2023, resulting in contribution relief for DHMS members of R8.5 billion through the 2021, 2022 and 2023 contribution increase deferrals.*

ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 8.39% to R2.3 billion (2022: R2.12 billion) is predominantly attributable to the CPI-linked increase of 7.89% from R129.91 to R140.15, in accredited average managed care costs per member per month. Managed care costs as a percentage of GCI decreased slightly from 2.67% in 2022 to 2.59% in 2023.

An analysis of the CMS Annual Report 2022-2023 demonstrates that the Scheme's managed care cost as a proportion of GCI was 2.7% compared to the weighted average of other open schemes (2.4%[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 2022, claims cost savings of R267.16 (2021: R238.96) 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 R3.22 (2021: R3.04) for every Rand paid in managed care costs, an exceptional return on investment of 322% (2021: 304%).

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 9.36% for 2023 (2022: 6.18%).

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 2023, the Scheme's solvency level of 30.60% (2022: 35.04%[1]) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R5 billion (2022: R8 billion).

R'000	2023	Restated[2] 2022
Insurance contract liability to future members	**28 690 246**	28 872 880
Less: cumulative unrealised net gain on re-measurement of investments	**(1 508 826)**	(1 002 934)
Accumulated funds (Regulation 29)	**27 181 420**	27 869 946
Gross annual contributions	**88 816 184**	79 542 906
Solvency ratio	**30.60%**	35.04%
Average accumulated funds per member at year-end	**19 785**	20 303

1 Previously reported as 35.11%, restated due to the implementation of IFRS 17.
2 Restated due to the implementation of IFRS 17.

Discovery Health Medical Scheme registration number 1125

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 11.71 for 2023 (11.76 in 2022). At year-end, only a very small proportion of contributions had not yet been collected.

Year ended	2023	2022
Gross contributions	**88 816 184**	79 542 906
Total outstanding – excluding December contributions	**94 087**	87 246
% Outstanding	**0.11**	0.11

RESERVE ACCOUNTS

Statement of Changes in Funds and Reserves *pg 106*

LIABILITY FOR INCURRED CLAIMS (outstanding claims)

Note 9 in the Financial Statements *pg 131*

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2023

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 2023, 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.

Section 33 (2) of the Act pertains to specific financial requirements applicable to medical schemes and outlines the statutory reserves that medical schemes are required to maintain. However, IFRS 17 provides a comprehensive framework for accounting for insurance contracts, including the recognition, measurement, presentation, and disclosure of insurance contracts. In this context, amounts attributable to future members, as determined under IFRS 17, are not subject to the specific provisions of Section 33 (2) of the Act, and are excluded from the non-compliance testing related to Section 33 (2) of the Medical Schemes Act.

For the year ended 2023 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	**(301 978)**	**(292 395)**
Classic Comprehensive	**(1 462 107)**	**(1 335 117)**
Essential Comprehensive	**(135 661)**	**(120 781)**
Coastal Core	**(359 507)**	**(239 624)**
Coastal Saver	**(514 720)**	**(299 467)**
KeyCare Plus	**(1 275 850)**	**(876 032)**

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 01 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 01 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.

Duplicate transactions for the same commission month resulted an overpayment to the broker that resulted in the maximum amount payable to a broker being exceeded. The quantification of the overpayment represents less than 0.05% of the total broker fees paid for the year.

In the instances where more than one broker was paid; the value is negligible. 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 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 two 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.

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 fourteen identified instances (2022: two) where brokers earned commission on their own health policies after 30 June 2022. These represent less than 0.001% of total broker fees paid for the year. The identified policies were correctly assigned to non-commissionable status and additional quality assurance measures implemented to prevent recurrences in the future.

Binding force of rules

Section 32 of the Act states that the rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.

Rule 7.1.2.2.2 states that the member must pay the requisite contribution in respect of such child as from the first day of the month following the birth or adoption.

The addition of the newborn rule was incorrectly applied on the policy administration system resulting in an additional month of free cover. The incorrect application of the Scheme Rule was based on the incorrect underwriting guideline stating that if the newborn is registered within 30 days, the member's contribution will be up to date.

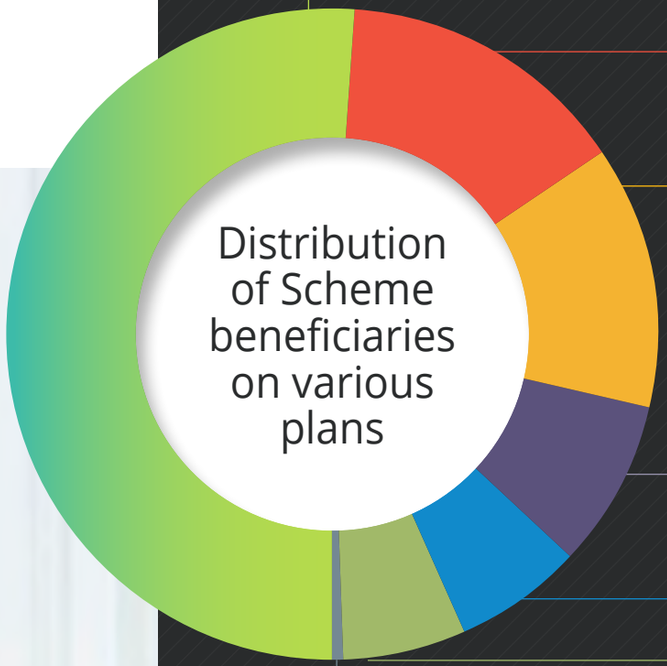
The system rule was updated to align with the Scheme billing rule.

A monitoring and oversight exception report was created (which will validate the date of birth against the cover start date and billing date) and will run for 3 months post the implementation of the system enhancement.

The value of the uncorrected contributions is negligible.

DHMS plans and beneficiary distribution[1]

BENEFIT OPTIONS	NETWORK EFFICIENCY DISCOUNT OPTIONS*
17 (2022: 17)	8 (2022: 7)



SAVER SERIES
52.1%
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta Saver*
- Essential Delta Saver*

KEYCARE SERIES
13.8%
- KeyCare Plus
- KeyCare Core
- KeyCare Start
- KeyCare Start Regional*

CORE SERIES
13.0%
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta Core*
- Essential Delta Core*

COMPREHENSIVE SERIES
7.8%
- Classic Comprehensive
- Classic Smart Comprehensive
- Essential Comprehensive
- Classic Delta Comprehensive*
- Essential Delta Comprehensive*

SMART SERIES
7.2%
- Classic Smart
- Essential Smart
- Essential Dynamic Smart*

PRIORITY SERIES
5.6%
- Classic Priority
- Essential Priority

EXECUTIVE SERIES
0.5%
- Executive

1 *For 2024, the Comprehensive series was simplified into two plans: Classic Comprehensive and Classic Smart Comprehensive. This was done to ensure the sustainability of the Comprehensive series and its extensive benefit offering. For more information on 2024 plans and benefits, see https://www.discovery.co.za/medical-aid/product-benefit-enhancements.*

Discovery Health Medical Scheme registration number 1125

Operational statistics per benefit plan[1]

FOR THE YEAR ENDED 31 DECEMBER 2023

		COMPREHENSIVE			PRIORITY		SAVER			CORE			SMART		KEYCARE			
2023	EXECUTIVE	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	TOTAL
Number of members at the end of the accounting period	7 206	95 212	11 196	435	68 062	4 748	330 822	177 222	163 822	44 523	53 200	67 687	65 466	57 415	203 323	16 799	6 726	**1 373 864**
Number of beneficiaries at the end of the accounting period	14 327	196 143	19 672	819	147 688	9 353	719 088	372 386	360 436	94 782	116 018	151 704	132 581	67 339	349 177	27 901	8 828	**2 788 242**
Average number of members for the accounting period	7 386	98 065	11 519	434	69 307	4 776	331 425	171 936	165 313	44 657	51 612	68 295	64 243	53 517	201 661	16 093	6 215	**1 366 455**
Average number of beneficiaries for the accounting period	14 734	202 778	20 294	807	150 582	9 404	720 587	362 105	364 297	95 209	112 969	153 492	129 943	62 362	346 801	26 772	8 092	**2 781 229**
Average risk contributions per member per month (R')	11 180.77	8 953.22	7 563.37	8 541.39	6 072.58	5 424.84	4 765.33	3 875.48	4 329.92	5 045.17	3 999.00	4 327.35	3 824.54	1 990.28	2 617.45	2 158.20	1 702.73	**4 473.09**
Average risk contributions per beneficiary per month (R')	5 605.15	4 329.85	4 293.03	4 593.51	2 794.97	2 754.99	2 191.76	1 840.18	1 964.85	2 366.39	1 827.02	1 925.41	1 890.83	1 708.00	1 522.02	1 297.36	1 307.71	**2 197.69**
Average net claims incurred per member per month (R')	13 937.53	9 539.52	7 889.62	5 346.32	5 406.30	3 405.18	4 070.01	2 726.76	3 937.60	4 364.70	3 192.91	4 125.92	2 969.11	1 141.59	2 725.02	1 720.24	926.77	**4 001.28**
Average net claims incurred per beneficiary per month (R')	6 987.17	4 613.39	4 478.21	2 875.22	2 488.30	1 729.31	1 871.95	1 294.73	1 786.83	2 047.22	1 458.74	1 835.78	1 467.91	979.68	1 584.57	1 034.09	711.77	**1 965.88**
Average administration costs per member per month (R')	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	251.34	147.46	251.34	**401.38**
Average administration costs per beneficiary per month (R')	216.70	209.04	245.35	232.47	198.95	219.52	198.81	205.25	196.15	202.75	197.49	192.33	213.71	370.95	146.15	88.64	193.03	**197.20**
Average managed care: management services per member per month (R')	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	137.99	137.99	137.99	**138.70**
Average managed care: management services per beneficiary per month (R')	69.60	67.14	78.81	74.67	63.90	70.51	63.86	65.92	63.00	65.12	63.43	61.78	68.64	119.15	80.24	82.95	105.98	**68.15**
Average family size	1.99	2.06	1.76	1.88	2.17	1.97	2.17	2.10	2.20	2.13	2.18	2.24	2.03	1.17	1.72	1.66	1.31	**2.03**
Loss ratio (%)	125.93%	108.15%	106.19%	64.23%	91.34%	65.35%	88.34%	73.98%	94.17%	89.23%	83.34%	98.57%	81.27%	64.34%	108.16%	86.10%	61.82%	**92.47%**
Total non-healthcare expenses as a percentage of risk contributions (%)	5.02%	6.29%	7.45%	6.56%	9.27%	10.35%	11.78%	14.21%	12.90%	10.87%	13.60%	12.65%	14.16%	25.43%	13.02%	10.44%	18.63%	**11.57%**
Average non-healthcare expenses per member per month	456.44	456.43	456.44	456.45	456.45	456.46	456.51	456.59	456.48	456.47	456.55	456.47	456.55	456.66	275.58	171.77	275.76	**425.63**
Average non-healthcare expenses per beneficiary per month	228.82	220.73	259.08	245.48	210.09	231.81	209.97	216.80	207.14	214.10	208.58	203.10	225.71	391.89	160.24	103.25	211.78	**209.12**
Average age of beneficiaries (years)	48.74	45.98	51.13	41.21	42.44	40.55	36.62	33.73	37.90	43.20	40.05	42.08	33.31	36.18	32.09	36.49	36.10	**37.00**
Pensioner ratio (beneficiaries over 65 years)	31.29%	24.98%	35.36%	16.10%	18.66%	15.38%	11.42%	8.10%	12.43%	20.12%	15.97%	18.19%	6.57%	5.53%	9.24%	14.50%	10.12%	**12.32%**
Average relevant healthcare expenses per member per month	14 080.49	9 682.95	8 031.27	5 486.06	5 546.74	3 545.11	4 209.85	2 866.90	4 077.30	4 501.81	3 332.59	4 265.56	3 108.23	1 280.51	2 831.02	1 858.23	1 052.62	**4 136.21**
Average relevant healthcare expenses per beneficiary per month	7 058.84	4 682.75	4 558.61	2 950.37	2 552.94	1 800.37	1 936.27	1 361.28	1 850.22	2 111.53	1 522.56	1 897.92	1 536.69	1 098.90	1 646.20	1 117.04	808.42	**2 032.17**
Net surplus/(deficit) per benefit plan	(293 381)	(1 343 956)	(121 719)	13 984	94 961	84 265	578 579	1 259 823	(306 646)	98 590	194 167	(242 953)	281 081	254 054	(881 375)	51 460	39 251	**(239 816)**

1 *Efficiency discount options (Delta, KeyCare Start Regional) are incorporated into their parent plans for operational statistics reporting purposes. For 2024, the Comprehensive series was simplified into two plans: Classic Comprehensive and Classic Smart Comprehensive. This was done in order to ensure the sustainability of the Comprehensive series and its extensive benefit offering. For more information on 2024 plans and benefits, see https://www.discovery.co.za/medical-aid/product-benefit-enhancements.*

Discovery Health Medical Scheme registration number 1125

Operational statistics per benefit plan *continued*

		COMPREHENSIVE			PRIORITY		SAVER			CORE			SMART		KEYCARE			
2022	**EXECUTIVE**	**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**	**TOTAL**
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)**

Discovery Health Medical Scheme registration number 1125

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%[1] 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 an insurance contract liability in the Financial Statements and is repayable in terms of Regulation 10 of the Act.

Note 9 in the Financial Statements *pg 132*

1 *For 2024, some PMSA contributions were reduced to keep overall contribution increases lower. For more information on 2024 plans and benefits, see https://www.discovery.co.za/medical-aid/product-benefit-enhancements.*

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 continued into 2023. We also saw utilisation returning to pre-COVID-19 levels in the latter part of 2023. However, given the Scheme's strong financial position and reserve levels, and based on the projected claims experience for 2024, the Trustees believe the Scheme remains able 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.

More about our auditors *pg 6*

How Discovery Health supports the Scheme's value creation

We outsource administration and managed care services to Discovery Health (Pty) Ltd.

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 an integrated model with a single provider rather than multiple providers as the Trustees believe it 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 using 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. These services include 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[1] 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.

1 Deloitte Touche Tohmatsu Limited.

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 which, 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.

To further embed Vested understanding and conduct, Vested training was conducted for six functional teams in Discovery Health, after which annual training assessments are conducted on an ongoing basis. We plan to implement this training and assessment programme with three more teams in 2024.

More about Vested

The Scheme's outsourced relationship with Discovery Health is operationalised by the Vested® model and through comprehensive contractual agreements.

Discovery Health Medical Scheme registration number 1125

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 2021 to 2022 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:

- 2022: **R2.08**
- 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. DHMS' average contributions for 2024 are 11.1% lower than the next seven largest open 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. Contribution rates on individual plans on other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

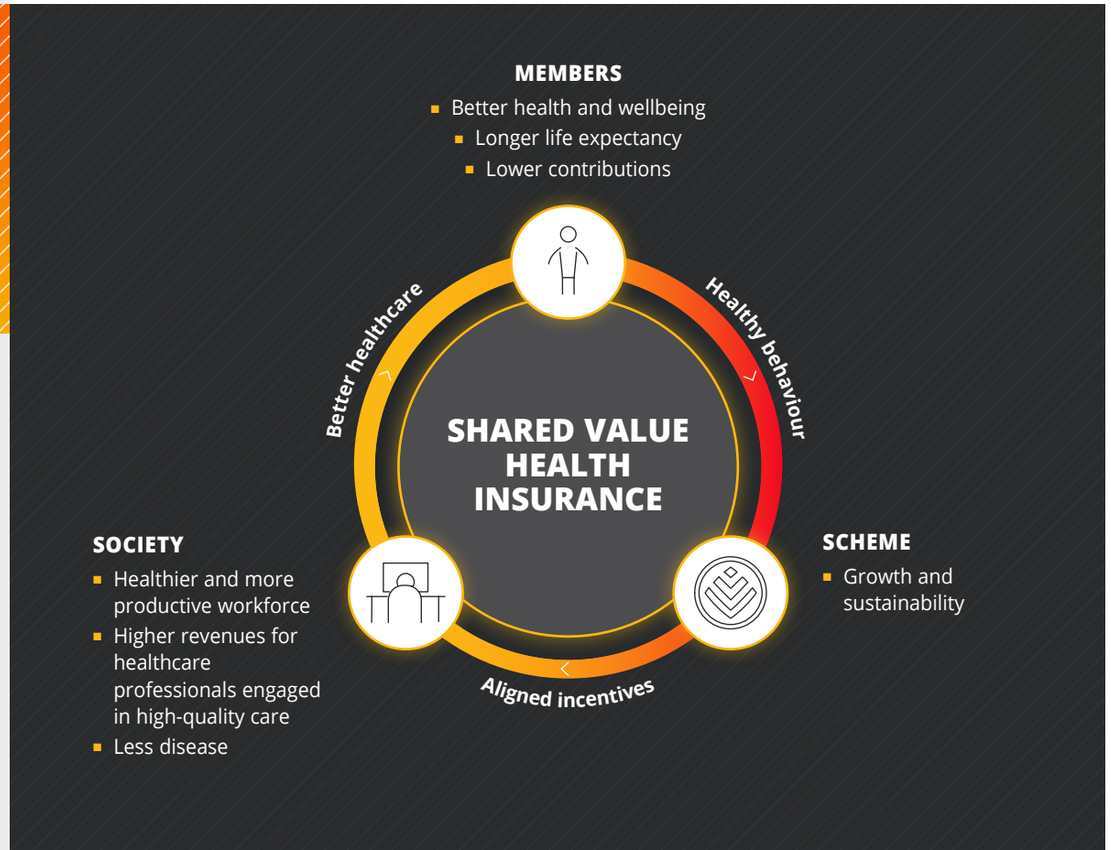
2 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2022, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.08 (2021: R2.02) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*

3 *The 2020 value added was 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 Medical Scheme registration number 1125

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 and a healthier society.



Discovery Health's work for members and healthcare professionals

Discovery Health's innovative and integrated approach provides state-of-the-art medical scheme risk management and service delivery, which extends 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 professionals 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.

More about what the Scheme does for members *pg 37*

More about engagement with healthcare providers *pg 40*

Discovery Health Medical Scheme registration number 1125

Robust fraud, waste and abuse (FWA) detection and recoveries to protect members

The majority of alerts regarding potential FWA come to us through our tip-offs line. To supplement these, Discovery Health utilises a range of advanced technologies for fraud detection, including predictive analytics, machine learning algorithms, and artificial intelligence. These technologies analyse large datasets to identify irregular patterns, anomalies, or suspicious behaviours in claims submissions.

Discovery Health also employs data mining techniques to identify trends indicative of potential fraudulent or irregular claims activities. These technologies are continuously being updated to adapt to new fraudulent schemes.

Since Discovery Health has direct business-to-business claims system integration with major hospital groups, hospital coding and billing is real-time and enables detailed and real-time audit trails to investigate unusual patterns, or deviations from established claiming norms.

Notwithstanding the sophisticated claims systems, fraud intelligent technologies and controls that are in place, Discovery Health continuously aims to improve the accuracy and robustness of its claims systems and is investing in a real-time reporting system that will allow for earlier detection of outlier claims, inconsistencies, potential duplicate billing, other fraudulent practices and potential non-compliance against contractual agreements.

In 2023, Discovery Health recovered over R500 million for Discovery Health Medical Scheme. This activity also generates a beneficial effect on claiming behaviour and Discovery Health estimates that the savings arising from this halo effect[1] are approximately R500 million per year for all the schemes administered by Discovery Health. Inclusive of the halo effect over time, Discovery Health estimates that contributions would be 14% higher than they currently are.

1 *This "halo effect" means that FWA prevention efforts have a broader impact beyond the cessation of identified fraudulent conduct by individual healthcare professionals. This can lead to billions of Rands in savings for medical schemes. Since the halo effect is calculated based on the claiming behaviour of practices that have been investigated, it does not account for the deterrent effect of having these processes in place and is hence likely to be an understatement of the full beneficial effect.*

Working with healthcare professionals to improve South Africa's healthcare system: the Future of SA Healthcare Inc.

As the world and South Africa emerged from the pandemic and began to re-imagine what the healthcare system might look like after COVID-19, Discovery Health sought to re-align with healthcare professionals to collaboratively identify a core set of activities and solutions designed to support the profession and enhance the country's healthcare system going forward.

A forum called the Future of SA Healthcare Inc. (FOSHI) was assembled, consisting of representatives from leading clinician societies and Discovery Health leadership. 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. Furnished with this vision, Discovery Health leadership conducted two rounds of 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 collaborative approach.

Over the course of 2023, FOSHI continued to lead adoption of the devised solutions. Moving into 2024, the FOSHI forum has defined a focused set of initiatives to positively shift the sentiment of the profession, and to adopt 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 Health's customer journeys[1] demonstrate its capabilities

At 31 December 2023, Discovery Health provided administration services to approximately 3.5 million scheme beneficiaries, including over 2.7 million for DHMS. Discovery Health services interact with millions of individuals during any given year, and the comprehensive and world-class service offerings, programmes and platforms they provide gives DHMS assurance that our members always have access to the best services and information available to suit their healthcare needs.

Discovery Health services interact with millions of individuals during any given year, and the comprehensive and world-class service offerings, programmes and platforms they provide gives DHMS assurance that our members always have access to the best services and information available to suit their healthcare needs.

Discovery Health works to empower DHMS members by providing trusted thought leadership on topical healthcare matters such as mental health, women's health, oncology and nutrition, available on the website through curated content hubs hosting articles, videos, podcasts and more.

Learn more about your health

On behalf of the Scheme, our administrator proactively contacts members to inform them of benefits available to them at relevant life stages, as well as to welcome new members and assist them to best manage their health plans. A range of engagement options is available to our members, including virtual agent capability using artificial intelligence to respond to member questions, and a highly responsive social media team that assists members on Facebook, X and Instagram. Members can also make contact via WhatsApp, the Discovery Health app, or the call centre.

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/.*

Discovery Health Medical Scheme registration number 1125

In 2023:

NEW BUSINESS

A new membership activated every
25 seconds

SERVICE AND CLAIMS

R8.6 billion billed in contributions per month

31 590 calls received per day

R49.4 million paid in claims per hour

318 880 claims received per day

2 785 hospital admissions approved per day

DIGITAL SUPPORT

610 372 website users per month

52 400 website logins per day

1 times per day the average user accesses website

590 730 mobile users per month

632 180 WhatsApp registered users

2 540 WhatsApp interactions per day

53 370 mobile logins per day

6 368 current HealthID users

25% % calls IVR* assisted
** Interactive Voice Response*

5 110 Virtual agent interactions per day

1 373 384 Social media followers

BENEFIT MANAGEMENT

724 744 HIV Programme members

77 677 Chronic Illness Benefit (CIB) Programme members

100 373 Oncology Programme members

MEMBER PROFILES

47 years Average principal member age

23 claims made by average members per year

54% family memberships and **45%** single memberships

Oldest life **106 years**

35 911 Vitality checks per month

Financials

SECTION 8

Statement of responsibility by the Board of Trustees

FOR THE YEAR ENDED 31 DECEMBER 2023

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).

Discovery Health Medical Scheme registration number 1125

The Financial Statements comprise the Statement of Financial Position at 31 December 2023, 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. The annual Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and the Medical Schemes Act, No 131 of 1998, as amended, (the Act) 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 (Discovery Health'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 2024. In considering this budget, the Trustees considered the changing demographics and the impact on the utilisation of healthcare services.

With the Scheme's strong financial position at 31 December 2023, the Scheme is in a position to absorb potential increases in claims resulting from increased utilisation. Based on the 2024 expected claims experience, this is not envisaged to impact the Scheme's ability to pay claims as they arise.

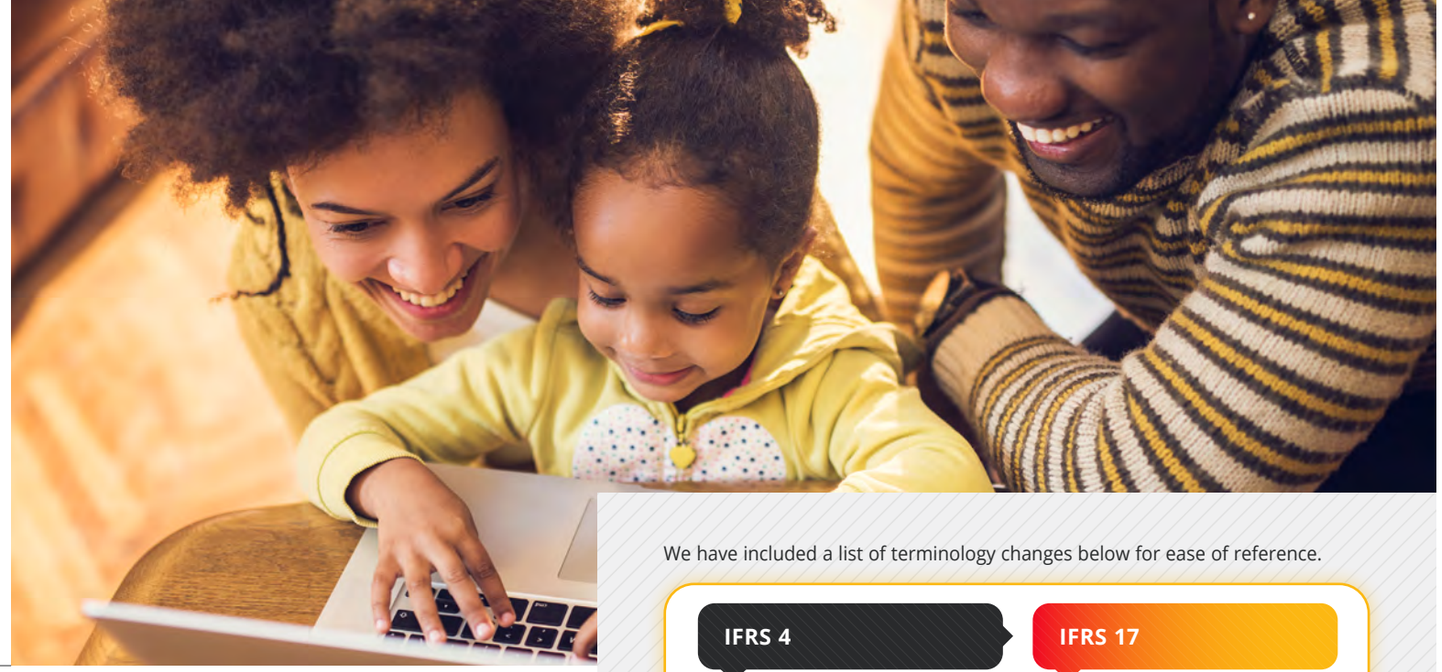
On the basis of this review and in light of the current financial position and available cash resources, the Trustees have no reason to believe that the Scheme will not be a going concern for the foreseeable future. The going concern basis has therefore been adopted in preparing the Financial Statements 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 101 – 104. The Financial Statements, which are presented on pages 105 – 185, were approved by the Board of Trustees on 18 April 2024 and are signed on its behalf by:

MICHELLE NORTON
Chairperson

MARIUS DU TOIT
Trustee

CHARLOTTE MBEWU
Principal Officer



About IFRS 17 – the new insurance accounting standard

International Financial Reporting Standards (IFRS) govern how financial statements report transactions and events, enabling consistency, transparency, and comparability between businesses worldwide. To further enhance the comparability of financial results published by insurers, the new IFRS 17: *Insurance Contracts* standard became effective from 01 January 2023 and is applicable to medical schemes, replacing the interim standard IFRS 4, issued by the International Accounting Standards Board.

Although IFRS 17 introduces significant changes to the terminology and presentation of our Financial Statements, there are no changes for members, to the nature or operations of the Scheme, its business model, any processes applied by the Scheme in fulfilling its obligation to members, or to how we manage the Scheme's reserves.

IFRS 17 only impacts the accounting treatment[1] of (medical aid) contracts[2] issued by the Scheme, which fall within the definition of insurance contracts in terms of IFRS.

Although not legally defined as such, medical schemes are regarded as mutual entities for purposes of accounting reporting when applying IFRS 17, as they present similar attributes to mutual entities, but there have been no changes to regulatory or legislative requirements applicable to medical schemes.

As mutual entities under IFRS 17, medical schemes' "accumulated member funds/reserves" are now referred to as "Insurance Contract Liabilities due to future members" and classified as liabilities in the financial statements. This is a fundamental change in the classification and presentation of the Scheme's reserves in the Statement of Financial Position in the Financial Statements.

An example of a notable change, albeit not material to the Scheme's overall financial position, is the introduction of a risk adjustment to be applied to what was previously known as the Incurred But Not yet Reported (IBNR) claims provision, which is now referred to as the Liability for Incurred Claims (LIC). The purpose of the risk adjustment is to allow for uncertainty in the estimated future cash flows related to the claims provision.

1 *The prescribed manner or method in which accountants record and present a specific business transaction or event in the company's Financial Statements.*
2 *In other words, membership agreements.*

We have included a list of terminology changes below for ease of reference.

IFRS 4	IFRS 17
Accumulated funds	Insurance liability to future members
Outstanding claims provision	Insurance contract liability
Personal Medical Savings Account liabilities	Insurance contract liability
Incurred But Not Yet Reported (IBNR)	Liability for Incurred Claims (LIC)
Risk contribution income	Insurance revenue
Relevant healthcare expenditure	Insurance service expense
Net healthcare result	Insurance service result

More information on the changes in the presentation of the Financial Statements *pg 113*

For more information, see our disclosure regarding the impact of the transition to IFRS 17 *pg 109*

Discovery Health Medical Scheme registration number 1125

Report of the Audit Committee

FOR THE YEAR ENDED 31 DECEMBER 2023

We are pleased to present our report for the financial year ended 31 December 2023. 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 Medical Schemes 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 01 January 2023 to 31 December 2023 in accordance with section 36 (2) of the Act on 18 December 2023.

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 narrated 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 2023. The Committee approved the actual audit fees incurred for the year ended 2022.

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 Chairperson of 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 14 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.

In its review of the Financial Statements, the Committee also reviewed the methodology and assumptions used by the Scheme in its implementation of IFRS 17 Insurance Contracts (IFRS 17) including the impact of the transition to IFRS 17 and is satisfied that the Financial Statements are in accordance with IFRS 17.

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 High 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 31 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 2023 as well as the Scheme's budget for the year ending 31 December 2024.

Insurance liability to future members (previously referred to as accumulated member funds) exceeded R28.7 billion with a solvency level of 30.6% at 31 December 2023. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) at 31 December 2023 to cover monthly claims expenditure 5.56 times.

On the basis of this review and taking note of the current net deficit of R183 million, before taking into account the amounts attributable to future members, the Committee considers that:

1. The Scheme's assets are currently equal to its liabilities; and
2. 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

18 April 2024

Independent Auditor's Report

To the members of Discovery Health Medical Scheme
Report on the Audit of the Financial Statements

Opinion

We have audited the Financial Statements of Discovery Health Medical Scheme (the Scheme), set out on pages 105 to 185, which comprise the Statement of Financial Position as at 31 December 2023, 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 material accounting policy information.

In our opinion, these Financial Statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2023, and its financial performance and cash flows for the year then ended in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board 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 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). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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
Valuation of the liability for incurred claims (LIC) in relation to insurance contract liabilities Refer to the following disclosure in the Financial Statements for details: ▪ Significant judgements and estimates section in the Accounting Policies note; ▪ Insurance contracts section in the Accounting Policies note; and ▪ Note 9 Insurance contract liability. As at 31 December 2023 the Scheme recognised insurance contract liabilities amounting to R8 525 966 000. The Scheme applied IFRS 17 -Insurance Contract Liabilities (IFRS 17) retrospectively for the first time in the current financial year ended in accounting for its insurance contract liabilities.	Our audit addressed this key audit matter as follows: We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the LIC from healthcare events that have occurred but have not yet been reported, which included the design and implementation of controls within the process. We obtained the actual claims data from the member administration system covering the year ended 31 December 2023 used in calculating the LIC from healthcare events that have occurred but are not yet reported. We assessed the completeness of the claims data on the member administration system by understanding management's controls. We selected a sample of claim transactions from the claim source and agreed these to the member administration system. No material inconsistencies were noted.

Key audit matter

The Scheme's insurance contract liabilities comprise the liability for remaining coverage (LFRC) and the liability for incurred claims.

In determining the LIC, the Scheme applies significant judgement and estimation uncertainties, due to the Scheme having to determine claims from healthcare events that have occurred but have not yet been reported.

The value of the LIC from healthcare events that have occurred but have not yet been reported is the sum of the probability-weighted estimate of the expected future cash flows and the risk adjustment. The LIC reported 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 LIC from healthcare events that have occurred but are not yet reported amounts to R1 978 604 000.

The most significant assumptions made in the determination of the LIC are:

- the future cash flow projections; and
- the risk adjustment for non-financial risk.

Future cash flow projections

The future cash flow projections comprise estimates of all future claim payments, receivables from third parties as well as the directly attributable expenses arising from the healthcare events within the boundary of the insurance contracts. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to determine the probability-weighted estimate of expected future cash flows. This model applies a combination of the Basic Chain Ladder (BCL) and the Cost Per Event (CPE) methods.

How our audit addressed the key audit matter

We substantively tested a sample of claims received by the Scheme in the 31 December 2023 financial year, selected from the member administration system, and evaluated 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 obtaining an understanding of 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 LIC from healthcare events that have occurred but are not yet reported. We noted no matters for further consideration with respect to the estimation process.

With the assistance of our internal actuarial experts we independently calculated the Scheme's probability-weighted estimate of future cash flow projections of the LIC from healthcare events that have occurred but are not yet reported, taking into account the claims data tested above. We compared our results with that of the Scheme and did not note any material exceptions.

With the assistance of our internal actuarial experts we tested the risk adjustment component of the LIC from healthcare events that have occurred but are not yet reported by performing the following procedures:

- We evaluated the Scheme's methodology relative to the principles of IFRS 17 to assess whether this approach is consistent with the principles of the risk adjustment under IFRS 17. The risk adjustment covers non-financial risk relating to insurance contracts and the compensation required by the Scheme in lieu of this risk, with reference to Scheme's risk appetite. We did not identify any matters requiring further consideration;
- We tested the risk adjustment by performing independent calculations using the Scheme's data and taking into consideration the Scheme's risk adjustment methodology. Based on the work we performed, we did not identify any matters requiring further consideration; and
- Based on the output of our independent stochastic models, we assessed whether our independently calculated liabilities are sufficient at the 75th percentile. We noted no matters requiring further consideration.

Key audit matter	How our audit addressed the key audit matter
Risk adjustments for non-financial risk In determining the Scheme's risk adjustment for non-financial risk, the Scheme uses a confidence level technique (value at risk) under IFRS 17. The Scheme's calibrated risk adjustment (using value at risk) is such that the insurance contract liabilities are held to be sufficient at the 75th percentile of the ultimate loss distribution. We considered the valuation of the LIC from healthcare events that have occurred but have not yet been reported to be a matter of most significance to the current year audit due to the significant judgement and estimation uncertainties in determining the future cash flow projections and the risk adjustments for non-financial risk.	We performed the following procedures to assess the adequacy of the LIC from healthcare events that have occurred but are not yet reported; ▪ We obtained the actual claims run-off report up to 31 March 2024 from the Scheme's administrator and compared the claims paid post year-end to the LIC from healthcare events that have occurred but are not yet reported 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 2024. 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 2023". 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 IFRS Accounting Standards as issued by the International Accounting Standards Board 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 23 years. The engagement partner, Linda Pieterse, has been responsible for Discovery Health Medical Scheme's audit for five years.

PricewaterhouseCoopers Inc.

PRICEWATERHOUSECOOPERS INC.

Director: Linda Pieterse

Registered Auditor

4 Lisbon Lane, Waterfall City, Jukskei View, 2090

30 April 2024

Statement of Financial Position

AT 31 DECEMBER 2023

	Notes	2023 R'000	Restated 2022 R'000	Restated 01 January 2022 R'000
Assets				
NON-CURRENT ASSETS		**25 022 693**	24 348 071	24 719 222
Property and equipment	1	**7 745**	8 317	9 658
Long-term employee benefit plan assets	25	**10 206**	8 314	7 998
Financial assets at fair value through profit or loss	3	**25 004 742**	24 331 440	24 701 566
CURRENT ASSETS		**12 281 727**	12 512 461	13 847 441
Financial assets at fair value through profit or loss	3	**7 865 155**	8 842 232	9 987 157
Derivative financial instruments	7	**65 826**	38 525	–
Trade and other receivables	4	**11 967**	6 040	10 728
Reinsurance contract assets	10	**3 043**	1 530	382
Cash and cash equivalents		**4 335 736**	3 624 134	3 849 174
– Personal Medical Savings Accounts trust assets arising from amalgamation	5	**–**	–	10 860
– Medical Scheme assets	6	**4 335 736**	3 624 134	3 838 314
TOTAL ASSETS		**37 304 420**	**36 860 532**	**38 566 663**
Liabilities				
NON-CURRENT LIABILITIES		**26 924 615**	25 292 164	25 356 256
Insurance liability to future members	11	**26 919 793**	25 284 429	25 347 585
Lease liability	2	**4 822**	7 735	8 671
CURRENT LIABILITIES		**10 379 805**	11 568 368	13 210 407
Lease liability	2	**1 654**	2 098	1 961
Insurance contract liability	9	**8 525 966**	7 886 759	8 126 348
Insurance liability to future members	11	**1 770 453**	3 588 451	5 001 301
Trade and other payables	8	**81 732**	91 060	80 797
TOTAL LIABILITIES		**37 304 420**	**36 860 532**	**38 566 663**

Statement of Comprehensive Income

FOR THE YEAR ENDED 31 DECEMBER 2023

	Notes	2023 R'000	Restated 2022 R'000
Insurance revenue	12	**73 328 203**	65 637 399
Insurance service expense	12	**(75 483 071)**	(66 724 592)
Net income from risk transfer arrangement/reinsurance	12	**85 723**	70 201
INSURANCE SERVICE RESULT		**(2 069 145)**	(1 016 992)
Other income		**3 378 968**	2 256 202
Investment income	19	**2 417 940**	2 221 987
Net gain on financial assets	20	**924 517**	3 117
Sundry income	21	**36 511**	31 098
Other expenditure		**(1 309 823)**	(1 239 210)
Other administration fees	13	**(648 298)**	(592 049)
Other operating expenses	14	**(191 266)**	(182 813)
Asset management fees	22	**(83 041)**	(103 130)
Finance costs	23	**(922)**	(1 266)
Net finance expense from insurance contracts	24	**(386 296)**	(359 952)
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE YEAR		**–**	**–**

Statement of Changes in Funds and Reserves

FOR THE YEAR ENDED 31 DECEMBER 2023

	2022 R'000
BALANCE AT 01 JANUARY 2022 (AS PREVIOUSLY REPORTED)	**30 418 845**
Transition restatement*	(30 418 485)
BALANCE AT 01 JANUARY 2022 (RESTATED)	**–**

* *Refer to the transition to IFRS 17 note in the accounting policies for the impact of the adoption of IFRS 17.*

Statement of Cash Flows

FOR THE YEAR ENDED 31 DECEMBER 2023

	Notes	2023 R'000	Restated 2022 R'000
Cash flows from operating activities			
CASH RECEIPTS FROM MEMBERS AND PROVIDERS		**88 566 368**	79 343 630
Cash received from members – contributions	9	**88 566 796**	79 334 330
Cash (paid to)/received from members and providers – other	27	**(428)**	9 300
CASH PAID TO PROVIDERS, EMPLOYEES AND MEMBERS		**(91 379 654)**	(83 154 581)
Cash paid to providers and members – claims and directly attributable expenses	9	**(89 714 174)**	(81 624 054)
Cash paid to reinsurer	10	**(310 596)**	(312 068)
Cash paid to providers and employees – other administration fees and operating expenses	27	**(815 950)**	(729 069)
Cash paid to members – savings plan refunds	9	**(538 934)**	(489 390)
CASH USED IN OPERATIONS		**(2 813 286)**	(3 810 951)
Purchase of financial assets	27	**(3 967 570)**	(7 774 847)
Proceeds from disposal of financial assets	27	**5 383 974**	9 410 317
Increase in long-term employee plan asset	25	**(6 770)**	(5 770)
Interest received	27	**1 802 684**	1 588 234
Dividend income	27	**397 566**	473 318
Interest paid	23	**–**	(102)
Asset manager fees paid	22	**(83 041)**	(103 130)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		**713 557**	(222 931)
Cash flows from financing activities			
Purchases of right-of-use asset	1	**–**	(145)
Purchases of leasehold improvements	1	**(142)**	–
Payment of lease liabilities	2	**(1 813)**	(1 964)
Net cash outflow from financing activities		**(1 955)**	(2 109)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**711 602**	**(225 040)**
Cash and cash equivalents at beginning of the year		**3 624 134**	3 849 174
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**4 335 736**	**3 624 134**

Discovery Health Medical Scheme registration number 1125

Accounting policies

FOR THE YEAR ENDED 31 DECEMBER 2023

General information

DHMS offers the insurance of hospital, chronic illness and day-to-day benefits and is administered by Discovery Health, a wholly owned subsidiary of Discovery Ltd, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act No. 131 of 1998, as amended, and is domiciled in South Africa.

Basis of preparation

The Financial Statements have been prepared in accordance with IFRS® Accounting Standards and IFRIC® Interpretations, 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® Accounting Standards 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 below.

The Financial Statements are prepared in accordance with the going concern principle using the historical cost basis except for certain assets and liabilities, which include:

- Financial instruments at fair value through profit or loss;
- Derivative financial instruments carried at fair value through profit or loss; and
- Insurance and reinsurance assets and liabilities – measured in terms of IFRS 17.

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 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 they may result in additional disclosure in the Financial Statements.

Standard	Scope	Effective date
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 01 January 2024
Amendments to IAS 1–Non-current liabilities with covenants	These amendments clarify how conditions with which an entity must comply within 12 months after the reporting period affect the classification of a liability. The amendments also aim to improve information an entity provides related to liabilities subject to these conditions. This amendment has no further impact on the Scheme.	Annual periods beginning on or after 01 January 2024

Standard	Scope	Effective date
Amendment to IFRS 16 – Leases on sale and leaseback	These amendments include requirements for sale and leaseback transactions in IFRS 16 to explain how an entity accounts for a sale and leaseback after the date of the transaction. Sale and leaseback transactions where some or all the lease payments are variable lease payments that do not depend on an index or rate are most likely to be impacted. This amendment has no further impact on the Scheme.	Annual periods beginning on or after 01 January 2024
Amendments to IAS 21 –Lack of Exchangeability (Amendments to IAS 21)	An entity is impacted by the amendments when it has a transaction or an operation in a foreign currency that is not exchangeable into another currency at a measurement date for a specified purpose. A currency is exchangeable when there is an ability to obtain the other currency (with a normal administrative delay), and the transaction would take place through a market or exchange mechanism that creates enforceable rights and obligations. This amendment has no further impact on the Scheme.	Annual periods beginning on or after 01 January 2025

INTERNATIONAL FINANCIAL REPORTING STANDARD 17 (IFRS 17): INSURANCE CONTRACTS

The effective date of IFRS 17 Insurance Contracts is for reporting periods beginning on or after 01 January 2023. IFRS 17 is mandatory for the Scheme effective from 01 January 2023.

IFRS 17 is a new accounting standard for insurance contracts that provides guidelines on recognising, measuring, presenting, and disclosing insurance contracts. It was introduced by the IASB in May 2017. IFRS 17 replaces the previous standard, IFRS 4 Insurance Contracts, issued in 2005 as an interim standard with limited prescribed changes to pre-existing insurance accounting practices applied by insurers.

IFRS 17 represents a positive step towards enhancing transparency, comparability, and understanding of how insurers earn profits from insurance contracts, namely insurance service results and financial results. The framework established by IFRS 17 outlines the specific requirements that entities must adhere to when reporting information related to both the insurance contracts they issue and the reinsurance contracts they hold. One of the noteworthy distinctions introduced by IFRS 17 pertains to the level of granularity at which insurance contracts are recognised and measured.

IFRS 17 is not limited to insurance companies but also those entities that issue any contract that results in transfer of significant insurance risk. Contracts issued by the Scheme fall within the scope of IFRS 17. These contracts are entirely aligned with those recognised under the previous IFRS 4.

Whilst the underlying contractual terms and economic risks and rewards of each insurance contract remain unaltered, IFRS 17 impacts the accounting treatment of insurance contracts and most notably the timing of recognition of insurance related profits and losses for accounting purposes. Importantly, it also separates the insurance related profit or losses between those arising from insurance service results and those arising from financial results.

Medical schemes have similar attributes as mutual entities. However, medical schemes are not legally defined as mutual entities and the current regulatory and legislative requirements remain applicable to medical schemes. When applying IFRS 17, payments to policyholders form part of the fulfilment cash flows regardless of whether those payments are expected to be made to current or future policyholders. Thus, the fulfilment cash flows of an insurer that is a mutual entity generally include the rights of policyholders to the whole of any surplus of assets over liabilities. This means that, for an insurer that is a mutual entity, there should, in principle, be no equity remaining and no net comprehensive income reported in any accounting period.

TRANSITION TO IFRS 17

Upon first adoption, IFRS 17 requires the standard to be applied fully retrospectively as if the standard always applied unless impracticable. If impracticable to do so, the entity can elect to either apply a modified retrospective approach or use the fair value approach.

The Scheme has determined that reasonable and supportable information was available for all contracts in force at the transition date that were issued within three years prior to the transition and is able to apply a fully retrospective restatement from inception for its groups of insurance contracts issued. The fully retrospective approach requires that the Scheme identify, recognise, and measure groups of insurance contracts as if IFRS 17 had always applied, derecognising any existing balances that would not exist had IFRS 17 always applied, and recognise any resulting net difference in Insurance liability for members.

The retrospective approach has limited impact on the Scheme, with the most significant impact being applying the treatment under IFRS 17 for mutual entities and a risk adjustment for non-financial risk to insurance cash flows. The purpose of the risk adjustment is to measure the effect of uncertainty in the fulfilment cash flows that arise from insurance contracts, other than uncertainty arising from financial risk.

The net impact of the retrospective application on the Scheme's Statement of Financial Position is summarised as follows:

	2022 R'000	2021 R'000
Audited and previously reported		
Accumulated funds as at 31 December	28 930 015	30 418 845
IFRS 17 ADJUSTMENT		
Adjustment as a result of the risk adjustment for non-financial risk on insurance contracts (Note 9)	(57 175)	(69 969)
Adjustment as a result of the risk adjustment for non-financial risk in reinsurance contracts (Note 10)	40	10
Restated		
Insurance liability to future members as at 01 January	28 872 880	30 348 886

Significant judgments and estimates

In the application of the Scheme's accounting policies, which are described below and in the notes, the Board of Trustees is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates. The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Following are the significant judgements, apart from those involving estimations (which are dealt with separately below), that have been made in the process of applying the Scheme's accounting policies and that have the most significant effect on the amounts recognised in the Financial Statements.

SIGNIFICANT JUDGEMENTS

ASSESSMENT AS TO WHETHER THE SCHEME IS A MUTUAL ENTITY

A medical scheme is not legally defined as a mutual entity and the assessment as to whether a medical scheme is a mutual entity was done based on the principles set out in IFRS.

IFRS 3 defined a "mutual entity" as "An entity, other than an investor-owned entity, that provides dividends, lower costs or other economic benefits directly to its owners, members or participants. For example, a mutual insurance company, a credit union and a co-operative entity are all mutual entities."

IFRS 17 does not define a "mutual entity" however it provides a key characteristic of a mutual entity in the basis of conclusion to the standard. IFRS 17 paragraph BC265 explains that "a defining feature of an insurer that is a mutual entity is that the most residual interest of the entity is due to a policyholder and not a shareholder." The Act is not explicit that members (i.e. policyholders) hold a residual interest or are entitled to the residual interest upon the liquidation of the medical scheme.

Section 64 of the Act requires the medical scheme rules to be followed in the event of liquidation.

The Rules of the Scheme do not contain specific guidance on how the assets of the Scheme should be distributed on liquidation. The Act prohibits the disposal of assets of a medical scheme except in limited, listed circumstances, one of them being the liquidation of the scheme. Members can opt for voluntary liquidation and can distribute the scheme's remaining assets amongst themselves. As the Scheme does not have shareholders, the current members will access the reserves through economic benefits such as funding reductions in contributions or deferral of contribution increases.

Although the rules do not specify how the assets should be distributed on liquidation, IFRS 17 states that "contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (i.e. no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation" (IFRS 17.2). Therefore, based on customary business practices, the remaining assets of the Scheme should be distributed to the members on liquidation if there are any and if the scheme does not amalgamate with another scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third-party e.g. another medical Scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members and not with an equity holder.

The substance of the legal framework issued regarding insurance contracts and observed practice is that once a contribution is paid to the medical scheme, the contribution is used to provide benefits to members. The benefits are provided by the medical scheme (or amalgamated schemes) through insurance coverage, reduced contributions, or payment to members on liquidation (based on votes taken by members).

It is therefore expected that the remaining assets of the scheme will be used to pay current and future members. Based on the above, the Scheme meets the definition of a mutual entity in IFRS.

The Scheme has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities and the educational material as issued by the IASB and the Scheme recognises any cumulative profit or losses as part of the insurance liability attributable to future members (which forms part of the insurance contract liabilities) on the face of the Statement of Financial Position.

Consequently, the Statement of Comprehensive Income reflects no total comprehensive income for the year. The movement in the insurance liability attributable to future members is included in the insurance service expenses line.

Due to the Scheme being a mutual entity, the assessment of onerous contracts are also affected.

ONEROUS CONTRACT ASSESSMENT

In the consideration of whether facts and circumstances indicate that a group of insurance contracts is onerous, the Scheme considers whether the expected deficit of the following year exceeds the insurance liability attributable to future members. In the rare scenario where the following year's deficit exceeds the insurance liability attributable to future members – the contracts written would be onerous and an onerous contract liability raised. Where the amounts attributable to future members exceed the following year's deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised.

UNIT OF ACCOUNT

Judgement has been applied to how the Scheme determined the unit of account for the measurement of its insurance contracts. Management has assessed the Scheme as a whole as the portfolio due to the holistic pricing methodologies and risk management strategy that manages the risk on a Scheme level.

The above is demonstrated by the following:

- Hospital claims are managed on a Scheme level.
- Chronic conditions are managed on a Scheme level, i.e. no matter the option the member will have access to the chronic condition management benefit.
- Risk transfer arrangements/reinsurance are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a Scheme level to manage member migration between different benefit options to ensure each option is sustainable.
- Risk (utilisation and concentration) is managed holistically.

RISK ADJUSTMENTS – LIABILITY FOR INCURRED CLAIMS

The risk adjustment for non-financial risk is applied to the present value of the estimated future cash flows and reflects the compensation the Scheme requires for bearing the uncertainty about the amount and timing of the cash flows from non-financial risk as the Scheme fulfils insurance contracts. Because the risk adjustment represents compensation for uncertainty, estimates are made on the degree of diversification benefits and expected favourable and unfavourable outcomes in a way that reflects the Scheme's degree of risk aversion. The Scheme estimates an adjustment for non-financial risk separately from all other estimates.

The risk adjustment was calculated at the portfolio level as the Scheme does not have groups due to laws that constrain the Scheme's ability to set a price for different members. The confidence level method was used to derive the overall risk adjustment for non-financial risk. In the confidence level method, the risk adjustment is determined by applying a confidence level to run-off triangles used to calculate the liability for incurred claims. The confidence level is set to 75% in line with the Scheme's risk appetite.

The Scheme will present the changes in the risk adjustment for non-financial risk in the insurance service result.

The methods and assumptions used to determine the risk adjustment for non-financial risk were not changed in 2022 and 2023.

RISK ADJUSTMENTS – RISK TRANSFER ARRANGEMENTS/REINSURANCE

For reinsurance contracts held, the risk adjustment for non-financial risk represents the amount of risk being transferred by the Scheme to the reinsurer. The same methodology applies to the risk transfer agreements as for the insurance contracts with regards to the determination of the risk adjustment.

SIGNIFICANT ESTIMATES

The preparation of financial statements requires the use of accounting estimates, which, by definition, will seldom equal the actual results. This note provides an overview of items that are more likely to be materially adjusted due to changes in estimates and assumptions in subsequent periods. Detailed information about each of these estimates is included in the notes below, together with information about the basis of calculation for each affected line item in the Financial Statements.

In applying IFRS 17 measurement requirements, the following inputs and methods were used that include significant estimates. The present value of future cash flows is estimated using deterministic scenarios.

The sensitivities with regard to the assumptions made that have the most significant impact on measurement under IFRS 17, are detailed in the Insurance Risk Management Report (Note 29) in the Financial Statements.

ESTIMATES OF FUTURE CASH FLOWS TO FULFIL INSURANCE CONTRACTS

Included in the measurement of portfolio are all the estimated future cash flows within the boundary of each group of contracts. The estimates of these future cash flows are based on probability weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur as at the measurement date. In making these estimates, the Scheme uses information about past events, current conditions and forecasts of future conditions. The Scheme's estimate of future cash flows is the mean of a range of scenarios that reflect the full range of possible outcomes. Each scenario specifies the amount, timing, and probability of cash flows. The probability weighted average of the future cash flows is calculated using a deterministic scenario representing the probability weighted mean of a range of scenarios.

The uncertainty in the insurance contracts lies in the number, severity, and timing of claims.

Assumptions used to develop estimates about future cash flows are reassessed at each reporting date and adjusted where required.

METHODS USED TO MEASURE THE INSURANCE CONTRACTS

The Scheme estimates insurance liabilities in relation to claims incurred for healthcare contracts.

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities for the claims incurred. The actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method. 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 chain ladder method involves an analysis of historical claims development factors and the selection of estimated development factors based thereon. The selected development factors are then applied to cumulative claims data for each period (in the Scheme's case, for the four months post year-end) that is not yet fully developed to produce an estimated ultimate claims cost for each healthcare year. The chain ladder method is the most appropriate for this claim pattern.

Run-off triangles are used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

The following was taken into account when estimating the liability for incurred claims:

- The homogeneity of the data.
- Changes in pattern of claims.
- Changes in the composition of members and their beneficiaries.
- Changes in benefit limits.
- Changes in the Prescribed Minimum Benefits (PMBs).

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 30.

Change in the accounting policy relating to the format of the Statement of Financial Position due to IFRS 17

This change is a direct result of our adoption of the IFRS 17, and as part of our commitment to align with IFRS 17, we have meticulously reviewed and updated our accounting policies. The most notable consequence of this transition is the presentation of our Statement of Financial Position, which has been restructured to reflect the impact of IFRS 17 on our financial reporting.

Outlined below are the key changes in the format of our Statement of Financial Position due to the implementation of IFRS 17:

Presentation of insurance contracts

IFRS 17 introduces a new presentation for insurance contracts, necessitating a distinct presentation of insurance contract assets/liabilities and reinsurance assets/liabilities on our Statement of Financial Position. This change enhances the clarity and transparency of our financial position.

Enhanced disclosures

In line with IFRS 17 requirements, we have expanded our disclosures pertaining to insurance contracts, including sensitivity analysis, risk exposure, and assumptions used in our calculations. These disclosures are incorporated into our Statement of Financial Position notes.

Table 1 sets out the change in disclosure of the Statement of Financial Position.

TABLE 1: COMPARISON OF STATEMENT OF FINANCIAL POSITION

Presentation under IFRS 4	Presentation under IFRS 17
Assets	**Assets**
NON-CURRENT ASSETS	NON-CURRENT ASSETS
Property and equipment	Property and equipment
Long-term employee benefit plan asset	Long-term employee benefit plan asset
CURRENT ASSETS	Financial assets at fair value through profit or loss
Financial assets at fair value through profit or loss	CURRENT ASSETS
Derivative financial instruments	Financial assets at fair value through profit or loss
Trade and other receivables	Derivative financial instruments
Cash and cash equivalents	Trade and other receivables
TOTAL ASSETS	Reinsurance contract asset
Funds and liabilities	Cash and cash equivalents
MEMBERS' FUNDS	**TOTAL ASSETS**
Accumulated funds	**Liabilities**
Liabilities	NON-CURRENT LIABILITIES
NON-CURRENT LIABILITIES	Insurance liability to future members
Lease liability	Lease liability
CURRENT LIABILITIES	CURRENT LIABILITIES
Lease liability	Lease liability
Derivative financial instruments	Insurance contract liability
Outstanding claims provision	Insurance liability to future members
Personal Medical Savings Account liabilities	Trade and other payables
Trade and other payables	**TOTAL LIABILITIES**
TOTAL FUNDS AND LIABILITIES	

Change in the accounting policy relating to the format of the Statement of Comprehensive Income due to IFRS 17

This change is a direct result of our adoption of the IFRS 17.

This change in accounting policy will be applied in preparing the Financial Statements for the year ended 31 December 2023. The change is applied retrospectively, with the comparative period presented as if this accounting policy had always been applied.

Table 2 sets out the change in disclosure of the Statement of Comprehensive Income.

TABLE 2: COMPARISON OF STATEMENT OF COMPREHENSIVE INCOME

Presentation under IFRS 4	Presentation under IFRS 17
Risk contribution income	**Insurance revenue**
Relevant healthcare expenditure	**Insurance service expense**
Net claims incurred	**Net income from risk transfer arrangement/reinsurance**
Risk claims incurred	**Insurance service result**
Third-party claim recoveries	**Other income**
Accredited managed healthcare services (no risk transfer)	Investment income
Net income on risk transfer arrangements	Net gain/(loss) on financial assets
Risk transfer arrangement fees paid	Sundry income
Recoveries from risk transfer arrangements	**Other expenditure**
Gross healthcare result	Other administration fees
Brokers service fees	Other operating expenses
Expenses for administration	Asset management fees
Other operating expenses	Finance costs
Net impairment losses on healthcare receivables	Net finance expense from insurance contracts
Net healthcare result	**TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE YEAR**
Other income	
Investment income	
Net (losses)/gains on financial assets	
Sundry income	
Other expenditure	
Expenses for asset management services rendered	
Other expenses	
Finance costs	
Interest paid on savings accounts	
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE YEAR	

Enhanced disclosures of IFRS 17 accounting policy choices made:

CLASSIFICATION OF CONTRIBUTION RECEIVABLES

The Scheme has accounted for all contribution debtors that relate to insurance services already rendered in Liability for Remaining Coverage (LFRC) at year-end.

CLASSIFICATION OF EXPENDITURES/INCOME OUTSTANDING AT YEAR-END THAT MEET THE DEFINITION OF FINANCIAL LIABILITIES OR FINANCIAL ASSETS

The fulfilment cash flows may include expenditures incurred in accounting standards other than IFRS 17, for example broker commission. When broker commission is outstanding, this would meet the definition of a financial liability. Where expenditures/income outstanding at year-end meet the definition of financial liabilities or financial assets, the Scheme has an accounting policy choice to either include the payable/receivables in the insurance contract liabilities or to recognise it as a separate IFRS 9 liability/asset such as trade and other payables/receivables. The Scheme has chosen to include these payables in the insurance contract liabilities.

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/ZAR).

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.

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.

Insurance contracts

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. In making this assessment, all substantive rights and obligations, including those arising from law or regulation, are considered on a contract-by-contract basis. The Scheme uses judgement to assess whether a contract transfers insurance risk and whether the accepted insurance risk is significant.

Separation of components

Before the Scheme accounts for an insurance contract it analyses whether the contract contains components that should be separated. There are three categories of components that have to be accounted for separately:

- Cash flows relating to embedded derivatives that are required to be separated;
- Cash flows relating to distinct investment components; and
- Promises to transfer distinct goods or distinct non-insurance services.

The Scheme does not have contracts with specified embedded derivatives. Certain of the contracts with members contain a Personal Medical Savings Account (PMSA) component. The PMSA, an investment component, and the insurance component of the insurance contract is highly interrelated.

The PMSA is a non-distinct investment component 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.

Level of aggregation

The level of aggregation has a significant impact on accounting for the insurance contract, including the measurement of insurance contracts and the extent of offsetting or cross-subsidisation to determine onerous contracts. A portfolio comprises contracts subject to similar risks and managed together. These are then divided into groups depending on their level of profitability. Once the group of insurance contracts has been established, it becomes the unit of account.

The contracts issued by the Scheme are subject to similar risks and managed together thus falling into the same portfolio with no further disaggregation into groups. The level of aggregation is assessed to be at a Scheme level.

Contract boundary

The Scheme uses the concept of contract boundary to determine what cash flows should be considered in the measurement of groups of insurance contracts. This assessment is reviewed every reporting period.

Cash flows are within the boundary of an insurance contract if they arise from the rights and obligations that exist during the period in which the member is obligated to pay contributions, or the Scheme has a substantive obligation to provide the member with insurance coverage or other services. A substantive obligation ends when both of the following criteria are satisfied:

- The Scheme has the practical ability to reassess the risks of the portfolio of insurance contracts and set a price or level of benefits that fully reflects the risks of that portfolio; and
- The pricing of contributions related to coverage to the date when risks are reassessed does not reflect the risks related to periods beyond the reassessment date.

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered; other risks, such as lapse or surrender and expense risk, are not included.

Cash flows outside the insurance contract boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria.

The Scheme has assessed its portfolio of insurance contracts to have a contract boundary of one year, which coincides with the Scheme's financial year.

Recognition and derecognition

The group of insurance contracts issued are initially recognised from the earliest of the following:

- The beginning of the coverage period;
- The date when the first payment from the member is due or actually received, if there is no due date; and
- When the Scheme determines that a group of contracts becomes onerous.

An insurance contract is derecognised when it is:

- Extinguished (i.e. when the obligation specified in the insurance contract expires or is discharged or cancelled); or
- If the terms are modified due to an agreement between the Scheme and its member or by regulation and the modification terms meet the requirement in IFRS 17.

If the modification does not comply with all the requirements of IFRS 17 the Scheme shall treat the changes in cash flow as changes in estimates of fulfilment cash flows.

Initial and subsequent measurement

The coverage period of each contract in the Scheme's portfolio of insurance contracts is one year or less. Therefore, the Scheme has made the accounting policy choice to simplify the measurement of its group of contracts using the Premium Allocation Approach.

For insurance contracts issued, on initial recognition, the Scheme measures the liability for remaining coverage at the amount of contributions received.

The carrying amount of the group of insurance contracts issued at each reporting period is the sum of:

- The Liability for Remaining Coverage; and
- The Liability for Incurred Claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the liability for remaining coverage is:

- Increased for amounts of expected contributions recognised as insurance revenue for the services provided for the period;
- Decreased for contributions received in the period; and
- Decreased by any investment component paid or transferred to the liability for incurred claims.

The insurance contract liabilities consist of two components:

- The insurance liability attributable to current members; and
- The insurance liability attributable to future members.

For insurance contracts issued at each of the subsequent reporting dates the liability for incurred claims included in the insurance liability attributable to current members is:

- The future cash flow projections; and
- The risk adjustment for non-financial risk.

Refer to Judgements and Estimates earlier in this note for the significant judgements and estimates used to determine the Liability for incurred claims and the estimates to determine the fulfilment cash flow.

The insurance liability attributable to future members consists of accumulated profits or losses of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act and they are:

- Increased by the net profits for the period; and
- Decreased by the net losses for the period.

Insurance revenue

As the Scheme provides services under the group of insurance contracts, it reduces the Liability for remaining coverage and recognises insurance revenue. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services.

For the group of insurance contracts measured under the Premium Allocation Approach, the Scheme recognises insurance revenue based on the passage of time over the coverage period of the group of contracts.

Insurance service expenses

Insurance service expenses include:

- Incurred claims and benefits excluding investment components;
- Other incurred directly attributable insurance service expenses;
- Changes that relate to current and past service (i.e. changes in the fulfilment cashflows relating to the liability for incurred claims);
- Changes that relate to future service (i.e. losses/reversals on onerous groups of contracts from changes in the loss components); and
- Amounts attributable to future members.

Cash flows that are not directly attributable to a group of insurance contracts, such as some product development and training costs, are recognised in other operating expenses as incurred.

The Scheme includes broker service fees as acquisition cash flows within the insurance contract boundary that arise from selling, underwriting and starting a group of insurance contracts and that are costs directly attributable to individual contracts and the group of contracts.

Insurance acquisition costs are expensed by the Scheme when it incurs the cost.

Insurance interest income and expenses

The non-distinct investment component (the PMSA) accrues interest. This is disclosed within the net finance expense from insurance contracts line item.

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 cede that 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.

Other incurred insurance service expenses

ACCREDITED MANAGED HEALTHCARE SERVICES (NO RISK TRANSFER)

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.

BROKER SERVICE FEES

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.

EXPENSES FOR ADMINISTRATION – DIRECTLY ATTRIBUTABLE COSTS

Expenses for administration are paid to the Scheme administrator and are expensed as incurred.

OTHER OPERATING EXPENSES – DIRECTLY ATTRIBUTABLE COSTS

Other operating expenses are expensed as incurred and include the following:

- Actuarial services;
- Third-party claim recovery services; and
- Benefit management services.

Risk transfer arrangements (Reinsurance)

Definition

Risk transfer arrangements are contractual arrangements entered into by the Scheme with a provider. The provider is paid a fixed fee per member to cover the risk of the number of incidents that occur during a specified period and the cost of providing the service. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependents.

Unit of account

Groups of reinsurance contracts held are assessed for aggregation separately from groups of insurance contracts issued. Applying the grouping requirements to reinsurance contracts held, the Scheme aggregates reinsurance contracts held concluded within a calendar year (annual cohorts) into groups of contracts for which there is a net gain at initial recognition.

Reinsurance contracts held are assessed for aggregation requirements on an individual contract basis. The Scheme tracks internal management information reflecting historical experiences of such contracts' performance. This information is used for setting pricing of these contracts such that they result in reinsurance contracts held in a net gain position without a significant possibility of a net cost arising subsequently.

Recognition and derecognition

The reinsurance contracts held that cover the losses of separate insurance contracts on a proportionate basis are recognised at the later of:

- The beginning of the coverage period of the group; or
- The initial recognition of any underlying insurance contract.

The Scheme does not recognise their reinsurance contract held until it has recognised at least one of the underlying insurance contracts.

Initial and subsequent measurement

The coverage period of each reinsurance contract in the Scheme's group of reinsurance contracts, is one year or less. Therefore the Scheme has made the accounting policy choice to simplify the measurement of it's group of reinsurance contracts using the Premium Allocation Approach.

For reinsurance contracts held, on initial recognition, the Scheme measures the remaining coverage at the amount of ceding contributions paid.

The carrying amount of a group of reinsurance contracts held at the end of each reporting period is the sum of:

- The remaining coverage; and
- The incurred claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

Subsequent measurement of the remaining coverage for reinsurance contracts held is:

- Increased for ceding contributions paid in the period; and
- Decreased for the amounts of ceding contributions recognised as reinsurance expenses for the services received in the period.

The Scheme does not adjust the asset for the remaining coverage for reinsurance contracts held for the effect of the time value of money. The reinsurance contributions are due within coverage periods which are one year or less.

Contract boundary

For groups of reinsurance contracts held, cash flows are within the contract boundary if they arise from substantive rights and obligations that exist during the reporting period in which the Scheme is compelled to pay amounts to the reinsurer or in which the Scheme has a substantive right to receive services from the reinsurer.

The Scheme's reinsurance contracts held have a duration of one year or less.

NET INCOME/(EXPENSE) FROM REINSURANCE CONTRACTS HELD

Reinsurance income consists of:

The amount that depicts the value the insurer benefits from entering into a risk transfer arrangement (i.e. the value of services received from the reinsurance provider).

Reinsurance expenses consist of:

- Reinsurance expenses;
- Other incurred directly attributable insurance service expenses; and
- Effect of changes in risk of reinsurer non-performance.

Reinsurance expenses are recognised similarly to insurance revenue. The amount of reinsurance expenses recognised in the reporting period depicts the transfer of received services at an amount that reflects the portion of ceding contributions the Scheme expects to pay in exchange for those services.

For groups of reinsurance contracts held measured under the Premium Allocation Approach, the Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

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:

- Insurance revenue.
- Claims incurred.
- Risk transfer arrangement fees.
- Accredited managed healthcare service fees.
- Expenses for administration (directly attributable and non-directly attributable).
- Broker service fees.
- Finance expenses from insurance contracts.
- Amounts attributable to future members.

The remaining items are allocated as detailed below:

- For insurance revenue that is 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.
- Risk adjustment is determined at a Scheme level and is apportioned to the benefit plans based on a percentage of the estimate of the provision for liability for incurred claims from healthcare events that have occurred but are not yet reported.
- The following items are apportioned based on the number of members per benefit plan:
  - Other operating expenditure (directly attributable and non-directly attributable);
  - Investment income;
  - Net fair value gains/(losses) on financial assets at fair value through profit or loss;
  - Sundry income;
  - Expenses for asset management services rendered;
  - Interest paid, excluding finance expenses from insurance contracts; and
  - Changes in expected recoverability of member and service provider claims receivables.

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 30. 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 2023

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 ten years when assessing the term under IFRS 16 Leases.

The asset's residual values and useful lives are reviewed at each reporting date and adjusted if appropriate. An assets' 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:

Effective from 01 July 2023, the Scheme renewed its lease agreement for office space for an additional 5-year term at a decreased rate. This resulted in a modification of the lease according to IFRS 16 as the lease term remained unchanged while the lease rate decreased.

R'000	Right-of-use asset Land and Buildings	Leasehold improvements	Total
Non-current			
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**
Gross carrying amount	**12 015**	**2 844**	**14 859**
Additions	**145**	**142**	**287**
Lease modification	**743**	**145**	**888**
Accumulated depreciation	**(6 696)**	**(1 593)**	**(8 289)**
BALANCE AT 31 DECEMBER 2023	**6 207**	**1 538**	**7 745**

1. Property and equipment continued

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**

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 re-measurements of the lease liability.

2. Leases continued

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 re-measured 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.

Note:

NATURE OF LEASING ACTIVITIES

The Scheme leases land and buildings for its office space. The lease for the office space is effective from 01 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 was reasonably certain that the renewal option will be exercised, and the term of this lease was determined as ten 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.

Accounting under IFRS 16, the modification of the lease resulted in adjustments to the carrying amount of the right-of-use asset and lease liability for the modified lease. The revised lease payments were used to re-calculate the present value of future lease payments.

As a consequence, the Scheme recognises a reduced lease liability, reflecting lower contractual payments over the remaining lease term. Simultaneously, the right-of-use asset is adjusted to reflect the updated present value of future cash flows associated with the lease.

The impact of the modification is reflected in the Statement of Financial Position, with the updated right-of-use asset and lease liability disclosed separately. Additionally, the updated lease expense will be recognised in the Statement of Comprehensive Income over the remaining lease term.

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.

2. Leases continued

R'000	Land and Buildings	Total
Right-of-use asset		
Gross carrying amount	12 015	12 015
Additions	145	145
Accumulated depreciation	(5 407)	(5 407)
BALANCE AT 31 DECEMBER 2022	**6 753**	**6 753**
Gross carrying amount	12 015	12 015
Additions	145	145
Lease modification	743	743
Accumulated depreciation	(6 696)	(6 696)
BALANCE AT 31 DECEMBER 2023	**6 207**	**6 207**
Lease Liability		
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**
Gross carrying amount	12 015	12 015
Lease modification	(2 466)	(2 466)
Interest expense	6 623	6 623
Lease payments	(9 696)	(9 696)
BALANCE AT 31 DECEMBER 2023	**6 476**	**6 476**

R'000	2023	2022
Maturity analysis – contractual undiscounted cash flows		
Less than one year	**1 654**	2 098
One to five years	**6 737**	11 388
More than five years	**–**	–
TOTAL UNDISCOUNTED LEASE LIABILITIES AT 31 DECEMBER	**8 391**	**13 486**
Lease liabilities included in the Statement of Financial Position at 31 December		
Non-current	**4 822**	7 735
Current	**1 654**	2 098
	6 476	9 833
Amounts recognised in the Statement of Comprehensive Income		
Depreciation	**1 289**	1 201
Interest on lease liabilities	**922**	1 164
Expenses relating to leases of low-value assets	**141**	76
Gain on lease modification	**3 355**	–
	5 707	2 441
Amounts recognised in the Statement of Cash Flows		
Total cash outflow for leases	**1 955**	2 109

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 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.

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.

3. Financial assets at fair value through profit or loss continued

Note:

R'000	2023	2022
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
– Offshore cash and bonds	**2 340 515**	2 196 242
– Equities	**9 565 664**	8 937 682
– Short duration bonds	**5 353 666**	5 488 733
– Flexible fixed income bonds	**9 719 048**	8 639 881
– Money market instruments	**5 229 427**	7 313 485
– Property	**661 577**	597 649
	32 869 897	33 173 672
Open ended, available on demand (Included as non-current)	**25 004 742**	24 331 440
Expected to settle within 12 months (Included as current)	**7 865 155**	8 842 232
	32 869 897	**33 173 672**
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	**33 173 672**	34 688 723
Acquisition and income earned	**4 182 983**	7 930 674
Disposals and expenses incurred	**(5 460 688)**	(9 410 317)
Net (losses)/gains on revaluation of financial assets at fair value through profit or loss (Note 20)	**973 930**	(35 408)
AT THE END OF THE YEAR	**32 869 897**	**33 173 672**

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 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.

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 30 sets out information about impairment of other receivables.

Note:		
R'000	2023	2022
Financial assets due from related parties (Note 25)		
Discovery Central Services (Pty) Ltd	**209**	–
Other receivables		
Sundry accounts receivable	**699**	271
Interest receivable	**8 046**	5 769
Prepaid expenses	**3 013**	–
TOTAL RECEIVABLES ARISING FROM OTHER RECEIVABLES	**11 967**	**6 040**

At 31 December 2023, 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. Personal Medical Savings Account trust assets arising from amalgamation

(Monies managed by the Scheme on behalf of members)

ACCOUNTING POLICY:

Quantum Medical Aid Society (QMAS) amalgamated into DHMS effective 01 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.

These 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 is reconciled monthly and arises from timing of cash flows to and from the portfolios.

Note:

R'000	2023	2022
Personal Medical Savings Account trust portfolio (Managed by Coronation)		
BALANCE AT BEGINNING OF THE YEAR	–	10 860
Transfers to Scheme funds (Active members)	–	(9 670)
Refunds to withdrawn members	–	(612)
Unclaimed Personal Medical Savings Accounts written off to Scheme funds	–	(578)
BALANCE AT THE END OF THE YEAR	–	–

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	2023	2022
Current accounts	**3 671 972**	3 022 200
Money market funds	**663 764**	601 934
	4 335 736	**3 624 134**

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 (CISCA). 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. 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	2023	2022
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	**65 826**	38 525
DERIVATIVE FINANCIAL ASSET AT THE END OF THE YEAR	**65 826**	**38 525**
Derivative financial asset at the beginning of the year	**38 525**	–
Net realised gain on derivative financial instruments	**76 714**	–
Realised gains on derivative financial instruments	**76 714**	–
– Synthetic forwards	**76 714**	–
Net fair value (loss)/gain on derivative financial instruments (Note 20)	**(49 413)**	38 525
Gains on revaluation of derivative financial instruments to fair value	**–**	38 525
– Synthetic forwards	**–**	38 525
Losses on revaluation of derivative financial instruments to fair value	**(49 413)**	–
– Synthetic forwards	**(49 413)**	–
DERIVATIVE FINANCIAL ASSET AT THE END OF THE YEAR	**65 826**	**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 30).

8. 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	2023	2022
Financial liabilities		
Balances due to related parties (Note 25)	**53 860**	49 745
Discovery Health (Pty) Ltd	**53 860**	49 564
Discovery Central Services (Pty) Ltd	**–**	181
Unallocated funds	**11 728**	15 105
Total accruals	**16 144**	26 210
General accruals	**15 991**	26 007
Leave pay provision	**153**	203
TOTAL ARISING FROM FINANCIAL LIABILITIES	**81 732**	**91 060**

At 31 December 2023 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

9. Insurance contract liability

R'000 INSURANCE CONTRACTS ISSUED	2023 Liability for incurred claims Liability for remaining coverage	2023 Liability for incurred claims Present value of future cashflows	2023 Liability for incurred claims Risk adjustment	2023 Total	2022 Liability for incurred claims Liability for remaining coverage	2022 Liability for incurred claims Present value of future cashflows	2022 Liability for incurred claims Risk adjustment	2022 Total
Net balance as at 01 January	**(2 423 867)**	**10 253 451**	**57 175**	**7 886 759**	(2 169 261)	10 225 640	69 969	8 126 348
INSURANCE REVENUE								
New contracts and contracts measured under the full retrospective approach at transition	**(73 328 203)**			**(73 328 203)**	(65 637 399)			(65 637 399)
TOTAL INSURANCE REVENUE	**(73 328 203)**	**–**	**–**	**(73 328 203)**	**(65 637 399)**	**–**	**–**	**(65 637 399)**
INSURANCE SERVICE EXPENSES								
Incurred claims and other directly attributable expenses		**71 998 702**		**71 998 702**		64 895 813		64 895 813
Insurance acquisition cash flows (broker fees)		**1 693 206**		**1 693 206**		1 612 455		1 612 455
Changes in fulfilment cash flows relating to the liability for incurred claims – past service		**52 368**	**(57 175)**	**(4 807)**		(139 241)	(69 969)	(209 210)
Changes in fulfilment cash flows relating to the liability for incurred claims – current service		**1 919 112**	**59 492**	**1 978 604**		1 844 365	57 175	1 901 540
INSURANCE SERVICE EXPENSES	**–**	**75 663 388**	**2 317**	**75 665 705**	**–**	**68 213 392**	**(12 794)**	**68 200 598**
INSURANCE SERVICE RESULT	**(73 328 203)**	**75 663 388**	**2 317**	**2 337 502**	**(65 637 399)**	**68 213 392**	**(12 794)**	**2 563 199**
Finance expense from insurance contracts issued		**386 296**		**386 296**		359 952		359 952
Unclaimed PMSA written off		**(758)**		**(758)**		(1 204)		(1 204)
TOTAL AMOUNTS RECOGNISED IN COMPREHENSIVE INCOME	**(73 328 203)**	**76 048 926**	**2 317**	**2 723 040**	**(65 637 399)**	**68 572 140**	**(12 794)**	**2 921 947**
– PMSA contributions and PMSA transferred from other schemes	**(15 488 896)**	**15 488 896**		**–**	(13 951 537)	13 951 537		–
CASH FLOWS				**–**				–
Contributions received	**88 566 796**			**88 566 796**	79 334 330			79 334 330
Incurred claims paid and other insurance service expenses paid		**(89 714 174)**		**(89 714 174)**		(81 624 054)		(81 624 054)
Refunds on death or resignation – PMSA		**(538 934)**		**(538 934)**		(489 390)		(489 390)
Recoveries from reinsurer[1]		**(397 521)**		**(397 521)**		(382 422)		(382 422)
TOTAL CASH FLOWS	**88 566 796**	**(90 650 629)**	**–**	**(2 083 833)**	**79 334 330**	**(82 495 866)**	**–**	**(3 161 536)**
INSURANCE CONTRACT LIABILITIES/(INSURANCE CONTRACT ASSETS) AS AT 31 DECEMBER	**(2 674 170)**	**11 140 644**	**59 492**	**8 525 966**	**(2 423 867)**	**10 253 451**	**57 175**	**7 886 759**

1 *Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.*

9. Insurance contract liability continued

Detail of contribution received and claims and other directly attributable expenses paid has been provided below:

R'000	2023	2022
Contribution received	**88 566 796**	79 334 330
Risk contributions	**73 347 275**	65 630 927
Personal Medical Savings Accounts contributions	**15 468 909**	13 911 979
Transfers received from other medical schemes	**19 986**	39 558
Changes in the expected recoverability of contributions	**(19 071)**	6 472
Movement in contributions received in advance	**28 909**	14 094
Movement in contribution refunds due to employers	**(5 125)**	6 062
Movement in contribution receivable	**(274 087)**	(274 762)
Claims and other directly attributable expenses paid	**(90 114 411)**	(82 007 772)
Risk claims	**(65 553 645)**	(58 908 874)
Personal Medical Savings Accounts claims	**(14 660 847)**	(13 592 080)
Directly attributable expenses	**(10 112 060)**	(9 291 723)
Changes in the expected recoverability of member and service provider claims receivables	**74 747**	(412 686)
Movement in risk adjustment	**2 317**	(12 794)
Movement in member and service provider claims	**(27 114)**	(12 627)
Movement in other insurance receivables	**(11 268)**	35 470
Movement in third-party receivables	**6 227**	(12 106)
Movement in forensic receivables	**(1 986)**	16 199
Movement in broker fees	**(6 253)**	(8 085)
Movement in balances due to third parties	**52 323**	45 755
Movement in risk transfer arrangements	**(2 715)**	(1 300)
Reported claims not yet paid	**125 863**	147 079

Detail of Personal Medical Savings Account has been provided below:

R'000	2023	2022
Personal Medical Savings Account	**7 985 016**	7 310 364
Balance as at 01 January	**7 310 364**	7 081 549
Personal Medical Savings Accounts contributions received	**15 468 909**	13 911 979
Net finance expense from insurance contracts	**386 296**	359 952
Transfers received from other medical schemes	**19 986**	39 558
Claims paid to or on behalf of members	**(14 660 847)**	(13 592 080)
Refunds on death or resignation	**(538 934)**	(489 390)
Unclaimed Personal Medical Savings Accounts written off to Scheme funds	**(758)**	(1 204)

10. Reinsurance contract assets

R'000 HEALTHCARE RISK – REINSURANCE CONTRACTS HELD	2023 Liability for incurred claims Liability for remaining coverage	2023 Liability for incurred claims Present value of future cashflows	2023 Liability for incurred claims Risk adjustment	2023 Total	2022 Liability for incurred claims Liability for remaining coverage	2022 Liability for incurred claims Present value of future cashflows	2022 Liability for incurred claims Risk adjustment	2022 Total
Insurance reinsurance contract assets as at 01 January	**(204)**	**(1 286)**	**(40)**	**(1 530)**	(52)	(320)	(10)	(382)
NET INCOME/(EXPENSES) FROM REINSURANCE CONTRACTS HELD								
An allocation of premiums paid	**(311 798)**			**(311 798)**	(312 220)			(312 220)
Amounts recovered from risk transfer arrangement/reinsurance		**397 832**		**397 832**		383 417		383 417
Changes in fulfilment cash flows relating to the liability for incurred claims – past service	**–**	**1 286**	**40**	**1 326**	–	320	10	330
Changes in fulfilment cash flows relating to the liability for incurred claims – current service		**(1 588)**	**(49)**	**(1 637)**		(1 286)	(40)	(1 326)
NET INCOME/(EXPENSES) FROM REINSURANCE CONTRACTS HELD	**(311 798)**	**397 530**	**(9)**	**85 723**	**(312 220)**	**382 451**	**(30)**	**70 201**
TOTAL AMOUNTS RECOGNISED IN COMPREHENSIVE INCOME	**(311 798)**	**397 530**	**(9)**	**85 723**	**(312 220)**	**382 451**	**(30)**	**70 201**
CASH FLOWS								
Premiums paid net of ceding commissions and other directly attributable expenses paid	**310 596**			**310 596**	312 068			312 068
Recoveries from reinsurance[1]		**(397 832)**		**(397 832)**		(383 417)		(383 417)
TOTAL CASH FLOWS	**310 596**	**(397 832)**	**–**	**(87 236)**	**312 068**	**(383 417)**	**–**	**(71 349)**
INSURANCE CONTRACT ASSETS AS AT 31 DECEMBER	**(1 406)**	**(1 588)**	**(49)**	**(3 043)**	**(204)**	**(1 286)**	**(40)**	**(1 530)**

1 Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

11. Insurance liability to future members

R'000	2023	Restated 2022
Balance at beginning of the year	**28 872 880**	30 348 886
Amounts attributable to future members	**(182 634)**	(1 476 006)
BALANCE AT THE END OF THE YEAR	**28 690 246**	**28 872 880**

12. Insurance revenue and service expenses

R'000	2023	2022
Insurance revenue		
Insurance revenue from contracts measured under the PAA		
Gross contributions	**88 816 184**	79 542 906
Personal Medical Savings Accounts contributions	**(15 468 910)**	(13 911 979)
Changes in the expected recoverability of contributions	**(19 071)**	6 472
TOTAL INSURANCE REVENUE	**73 328 203**	**65 637 399**
Insurance service expenses		
CLAIMS INCURRED	**(65 553 645)**	(58 908 874)
Risk claims	**(65 645 836)**	(59 047 174)
Third-party claim recoveries	**92 191**	138 300
OTHER INCURRED INSURANCE SERVICE EXPENSES	**(10 112 060)**	(9 291 724)
Insurance acquisition cash flows (broker fees)	**(1 693 206)**	(1 612 455)
Accredited managed healthcare services (no risk transfer)	**(2 298 183)**	(2 120 208)
Attributable expenses incurred – administration fees	**(5 923 146)**	(5 409 233)
Attributable expenses incurred – operating expenses	**(28 756)**	(35 140)
Changes in expected recoverability of member and service provider claims receivables	**(168 769)**	(114 688)
AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS	**182 634**	1 476 006
TOTAL INSURANCE EXPENSES	**(75 483 071)**	**(66 724 592)**
Net income from risk transfer arrangement/reinsurance		
An allocation of premiums paid	**(311 798)**	(312 220)
Amounts recovered from risk transfer arrangement/reinsurance and changes in fulfilment cash flows	**397 521**	382 422
TOTAL EXPENSES FROM REINSURANCE CONTRACTS HELD	**85 723**	**70 201**
TOTAL INSURANCE SERVICE RESULT	**(2 069 145)**	**(1 016 992)**

12. Insurance revenue and service expenses continued

Detail of accredited managed healthcare services and accredited administration services has been provided below:

R'000	2023	2022
Accredited managed healthcare services (no risk transfer)	**2 298 183**	2 120 208
Active Disease Risk Management Services and Disease Risk Management Support Services	**728 279**	671 553
Hospital Benefit Management Services	**688 650**	635 186
Managed Care Network Management Services and Risk Management	**652 233**	602 203
Pharmacy Benefit Management Services	**229 021**	211 266
Attributable expenses incurred – administration fees	**5 923 146**	5 409 233
Broker remuneration management	**85 810**	78 365
Claims management	**665 704**	607 946
Contribution management	**528 914**	483 023
Customer services	**2 940 112**	2 685 017
Financial management	**21 619**	19 744
Information management and data control	**1 079 149**	985 518
Member record management	**601 838**	549 620
Attributable expenses incurred – operating expenses	**28 756**	35 140
Actuarial services	**10 216**	9 329
Third-party claim recovery services	**18 540**	19 317
Benefit management services	**–**	6 494
COVID-19	**–**	6 074
Diabetic Retinopathy	**–**	420

13. Other administration fees

ACCOUNTING POLICY:

The Scheme pays an all-inclusive fee to the Administrator which has been allocated to Accredited administration services and Other administration services. Accredited administration services are directly attributable to the insurance contracts issued and are included in Insurance services expenses. Other administration services are not directly attributable and are included as other operating expenses. Fees paid to the Scheme administrator are expensed as incurred.

Note:

R'000	2023	2022
Other administration services	**648 298**	592 049
Advanced data analytics	**70 322**	64 220
Digital service offering	**25 970**	23 716
Distribution services	**45 149**	41 232
Enhanced employer reporting	**1 770**	1 616
Enhanced service offering	**14 207**	12 974
Enterprise risk management services	**13 999**	12 784
Forensic investigations and recoveries	**37 251**	34 019
Governance compliance and human resources	**8 859**	8 091
Internal audit services	**17 884**	16 332
Legal services	**4 170**	3 808
Marketing and stakeholder relations services	**307 774**	281 070
Product innovation	**16 726**	15 277
Quality management and monitoring services	**84 217**	76 910

14. Other operating expenses

ACCOUNTING POLICY:

Other operating expenses include expenses, other than directly attributable expenses, and are expensed as incurred.

Note:

R'000	2023	2022
Association fees	**5 289**	2 200
Audit fees	**8 797**	6 916
Audit services for the year ended 2023	**5 238**	–
Audit services for the year ended 2022	**3 559**	3 533
Audit services for the year ended 2021	**–**	3 383
Audit Committee fees (Note 15)	**1 849**	1 758
Bank charges	**9 473**	9 238
Clinical Governance Committee fees (Note 15)	**823**	719
Council for Medical Schemes	**63 854**	59 617
Credit rating expenses	**1 497**	1 333
Debt collecting fees	**3 413**	3 210
Depreciation	**1 602**	1 486
Dispute Committee fees	**1 707**	856
Fidelity Guarantee Insurance	**1 473**	3 221
General meeting costs	**5 895**	14 728
Investment Committee fees (Note 15)	**658**	631
Investment reporting fees	**5 344**	5 429
IT Infrastructure	**1 080**	1 031
Legal fees	**1 224**	594
Nomination Committee fees (Note 16)	**593**	1 148
Office operating costs	**5 172**	4 809
Practice Coding Numbering System (PCNS) fees	**3 590**	3 383
Principal Officer fees – Remuneration	**6 214**	5 528
Principal Officer fees – Unvested long-term employee benefit	**1 583**	1 770
Printing, postage and stationery	**49**	61
Professional fees	**13 125**	11 698
Remuneration Committee fees (Note 15)	**597**	262
Risk Committee fees (Note 15)	**424**	349
Scheme Office costs	**1 051**	911
Staff costs (Note 17)	**30 990**	28 907
Staff training	**334**	219
Sundry amounts written (back)/off	**0**	(7)
Telephone	**256**	246
Travel, accommodation and conferences	**1 360**	332
Trustees' remuneration and consideration expenses (Note 18)	**11 950**	10 230
	191 266	**182 813**

15. Board Committee fees and considerations

Note:

2023 R'000	Audit	Clinical Governance	Investment	Remuneration	Risk	Total
N Luthuli				**166**		**166**
N Mlaba		**361**				**361**
E Mackeown	**1 114**		**282**		**204**	**1 600**
A Burger	**261**				**220**	**481**
H Van Deventer			**376**			**376**
B Hlope				**431**		**431**
L Baldwin-Ragaven		**310**				**310**
M Bosman	**293**					**293**
B Mathe	**181**					**181**
D Tshabalala		**152**				**152**
TOTAL	**1 849**	**823**	**658**	**597**	**424**	**4 351**

2022 R'000	Audit	Clinical Governance	Investment	Remuneration	Risk	Total
S Ludolph	7					7
N Luthuli				147		147
N Mlaba		358				358
E Mackeown	1 011		257		182	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**	**719**	**631**	**262**	**349**	**3 719**

For detail of the Chairperson of the respective Committee refer to pages 54 - 56 and pages 68 - 69.

16. Other committee fees

Note:

R'000	2023	2022
Nomination Committee fees		
A Bryce – Independent Member (Chairperson)	**243**	425
B Marais – Independent Member	**174**	360
A Muller – Independent Member	**176**	363
	593	**1 148**

17. 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	2023	2022
Salaries and bonuses	**24 547**	22 357
Pension costs – defined contribution plans	**1 698**	1 482
Medical and other benefits	**1 390**	1 364
Long-term employee benefit service cost	**3 295**	3 684
Increase in leave pay accrual	**60**	20
	30 990	**28 907**
Number of employees at 31 December	**13**	13

18. Trustees' remuneration and considerations

Note:

The following table records the remuneration and consideration paid to Trustees during the year:

2023 R'000	Services as Trustee	Committee fees: Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
J Butler SC	663						55	74	53		845
M Norton (Chairperson effective 01 June 2023)	888					114	137	159	128		1 426
J Human	626	196		202		140			100		1 264
J Adams SC	707		204	198			147	176	95	9	1 536
S Brynard	630					181	128	177	133		1 249
L Harie	707		252		314			176	199	7	1 655
M du Toit	676	249		267		164			148	2	1 506
M Price	583				317	181		153	26		1 260
D Moodley	250			102	120	58				2	532
R Mbuvha	262	84		101		75			155		677
TOTAL	**5 992**	**529**	**456**	**870**	**751**	**913**	**467**	**915**	**1 037**	**20**	**11 950**

2022 R'000	Services as Trustee	Committee fees: Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
N Morrison	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	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
M 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**

19. 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	2023	2022
Financial assets at fair value through profit or loss:	**2 068 237**	2 017 168
Dividend income	**443 261**	473 318
Interest income	**1 624 976**	1 543 850
Cash and cash equivalents interest income	**349 703**	204 819
INVESTMENT INCOME PER STATEMENT OF COMPREHENSIVE INCOME	**2 417 940**	**2 221 987**
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	**349 703**	204 819
Financial assets at fair value through profit or loss:		
Interest income	**1 624 976**	1 543 850
TOTAL INTEREST INCOME	**1 974 679**	**1 748 669**

20. Net gains/(losses) on financial assets

Note:

R'000	2023	2022
Net fair value gains/(losses) on financial assets at fair value through profit or loss (Note 3):	**973 930**	(35 408)
Fair value gains on financial assets at fair value through profit or loss:	**981 353**	367 786
– Equities	**293 596**	282 492
– Money market instruments	**100 272**	65 224
– Flexible fixed income bonds	**178 957**	–
– Offshore bonds	**329 127**	–
– Property	**26 676**	–
– Short duration bonds	**52 725**	20 070
Fair value losses on financial assets at fair value through profit or loss:	**(7 423)**	(403 194)
– Equities	**(4 111)**	(37 518)
– Money Market	**(3 312)**	–
– Flexible fixed income bonds	**–**	(163 664)
– Offshore bonds	**–**	(148 272)
– Property	**–**	(53 740)
Net fair value (loss)/gain on derivative financial instruments (Note 7):	**(49 413)**	38 525
Fair value gains on derivative financial instruments:	**–**	38 525
Fair value losses on derivative financial instruments:	**(49 413)**	–
	924 517	**3 117**

21. Sundry income

Note:

R'000	2023	2022
Prescribed amounts written back	**29 780**	29 894
Unclaimed Personal Medical Savings Accounts written off to Scheme funds (Note 9)	**758**	1 204
Amounts received from administrator*	**2 618**	–
Gain on lease modification	**3 355**	–
	36 511	**31 098**

* *During the year under review an amount of R2.6 million was refunded to the Scheme by Discovery Health representing the interest foregone by DHMS relating to the duplicate payments made to providers and the period to recovery with the amount due updated until settled. The rate earned on the DHMS bank account held at RMB Corporate bank has been applied to determine the amount due.*

22. Asset management fees

ACCOUNTING POLICY:

Asset management fees are fees paid to 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	2023	2022
Asset management fees	**83 041**	103 130
	83 041	**103 130**

23. Finance costs

Note:

R'000	2023	2022
	922	1 266
Interest paid – other	**–**	102
Interest on lease liability (Note 2)	**922**	1 164
	922	**1 266**

24. Net finance expense from insurance contracts

ACCOUNTING POLICY:

Interest payable on members' Personal Medical Savings Accounts is expensed when incurred.

Note:

R'000	2023	2022
Net finance expense from insurance contracts	**386 296**	359 952
	386 296	**359 952**

25. 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 Board of 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 Board of Trustees who are compensated on a fee basis.

Close family members include close family members of the Board of Trustees and Executive Officers of the Scheme.

PARTIES WITH SIGNIFICANT INFLUENCE OVER THE SCHEME

Administrator

Discovery Health has significant influence over the Scheme, as Discovery Health participates in the Scheme's Financial and Operating Policy decisions but does not control the Scheme. Discovery Health provides administration, managed care services and wellness programmes. As Discovery Health 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.

25. 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	2023	2022
Statement of Comprehensive Income transactions		
COMPENSATION		
Short-term employee benefits	**(24 132)**	(18 504)
Trustee remuneration and consideration (Note 18)	**(11 950)**	(10 230)
Unvested long-term employee benefit	**(4 878)**	(5 454)
CONTRIBUTIONS AND CLAIMS		
Gross contributions received	**1 533**	1 363
Claims paid from the Scheme	**(828)**	(773)
Claims paid from the Personal Medical Savings Account	**(295)**	(389)
Interest paid on Personal Medical Savings Accounts	**(2)**	(19)
Statement of Financial Position transactions		
Long-term employee benefit plan asset	**10 206**	8 314
Plan asset	**19 941**	15 765
Plan liability	**(9 735)**	(7 451)
Long-term employee benefit plan asset	**10 206**	8 314
Balance at the beginning of the year	**8 314**	7 998
Additions	**6 770**	5 770
Unvested long-term employee benefit	**(4 878)**	(5 454)
Contribution debtors	**133**	116
Personal Medical Savings Account balances	**(4)**	(8)

25. 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 Ltd 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	2023	2022
Transactions with entities that have significant influence over the Scheme		
DISCOVERY HEALTH – ADMINISTRATOR		
Statement of Comprehensive Income transactions		
Administration fees paid	**(6 581 660)**	(6 010 611)
Attributable expenses incurred – administration fees (Note 12)	**(5 923 146)**	(5 409 233)
Attributable expenses incurred – operating expenses (Note 12)	**(10 216)**	(9 329)
Other administration services (Note 13)	**(648 298)**	(592 049)
Amounts received from administrator (Note 21)	**2 618**	–
New business underwriting costs	**(47)**	–
Employee systems programme (Healthy Company)	**(4)**	–
Statement of Financial Position transactions		
Balance due to Discovery Health	**(546 454)**	(503 023)
Attributable expenses incurred – administration fees	**(491 746)**	(452 678)
Attributable expenses incurred – operating expenses	**(848)**	(781)
Other administration services (Note 8)	**(53 860)**	(49 564)
DISCOVERY HEALTH – MANAGED CARE ORGANISATION		
Statement of Comprehensive Income transactions		
Managed healthcare services paid	**(2 298 183)**	(2 120 208)
Accredited managed healthcare services (no risk transfer) (Note 12)	**(2 274 339)**	(2 097 295)
Diabetes management services (Note 12)	**(23 844)**	(22 913)
Statement of Financial Position transactions		
Balance due to Discovery Health at year-end	**(190 710)**	(177 536)
Accredited managed healthcare services (no risk transfer)	**(188 852)**	(175 472)
Diabetes management services	**(1 858)**	(2 064)

** Total amount due to Discovery Health for the current financial year is R737 million (2022: R681 million).*

25. Related party transactions continued

R'000	2023	2022
Transactions with entities that have significant influence over the Scheme		
DISCOVERY THIRD PARTY RECOVERY SERVICES (PTY) LTD – THIRD-PARTY COLLECTION SERVICES		
Statement of Comprehensive Income transactions		
Third-party collection fees (Note 12)	**(18 540)**	(19 317)
Statement of Financial Position transactions		
Balance due to the Scheme at year-end	**18 937**	25 164
SOUTHERN RX DISTRIBUTORS (PTY) LTD – SPECIALIST PHARMACEUTICAL SERVICES		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(482 395)**	(432 163)
Statement of Financial Position transactions		
Claims due to provider	**(5 844)**	(6 112)
GROVE NURSING SERVICES (PTY) LTD – HOME-BASED NURSING SERVICES		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(43 290)**	(36 707)
COVID-19 management services (Note 12)	**–**	(6 074)
Statement of Financial Position transactions		
Balance due to provider	**(148)**	(471)
MEDICAL SERVICES ORGANISATION INTERNATIONAL (PTY) LTD – INTERNATIONAL TRAVEL SERVICES		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(149 553)**	(94 319)
Statement of Financial Position transactions		
Balance due to provider	**(474)**	(236)
DISCOVERY LIFE LTD – BROKER SERVICES FEES		
Statement of Financial Position transactions		
Balance (due to)/from Discovery Life Ltd at year-end	**(84)**	(71)
DISCOVERY CONNECT DISTRIBUTION SERVICES (PTY) LTD – BROKER SERVICES FEES		
Statement of Comprehensive Income transactions		
Broker fees paid	**(134 628)**	(121 412)
Statement of Financial Position transactions		
Balance due to Discovery Connect Distribution Services (Pty) Ltd at year-end	**(304)**	(162)
DISCOVERY CENTRAL SERVICES (PTY) LTD – CONTRACTUAL LEASE PAYMENTS		
Statement of Comprehensive Income transactions		
Contractual lease and non-lease payments	**(7 270)**	(6 772)
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note 4) (Note 8) – Non-lease	**209**	(181)
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note 2) – Lease	**(6 476)**	(9 833)
DISCOVERY BANK LTD – NEGOTIABLE CERTIFICATES OF DEPOSITS		
Statement of Financial Position transactions		
Negotiable Certificates of Deposits	**–**	23 601

25. Related party transactions continued

R'000	2023	2022
DISCOVERY LTD – FLOATING RATE NOTES		
Statement of Financial Position transactions		
Floating Rate Notes	**48 490**	69 696
DISCOVERY HEALTHCARE SERVICES (PTY) LTD – HEALTH COACHING SERVICES		
Statement of Comprehensive Income transactions		
Diabetes coaching programme	**(5 537)**	–
Cardiovascular coaching programme	**(5 145)**	–

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 01 January 2018. The agreements in place between the Scheme and Discovery Health for administration were renewed for a period of five years, commencing on 01 January 2023, following an extensive assessment of the services provided by Discovery Health. 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 01 January 2018. The agreement in place between the Scheme and Discovery Health for managed healthcare services was renewed for a period of five years, commencing on 01 January 2023, following an extensive assessment of the services provided by Discovery Health.

The Scheme and Discovery Health 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

25. Related party transactions continued

Third-party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health, 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 01 January 2023 to 31 December 2023 to Discovery Third-Party Recovery Services (Pty) Ltd for the amount of R21 million (2022: R19 million).

Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health, 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, 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.

Insurance acquisition costs (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 01 July 2018 with an initial period of five years and an option to renew for a further five years. Subsequent to the expiry of the initial term on 30 June 2023, the Trustees decided to renew the lease for another five-year period resulting in a re-negotiation of the terms of the lease as well as the lease payments. The lease payments are fixed and will increase annually at a rate set out in the lease and variation agreements.

The 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 (MSOI), a subsidiary of Discovery Health, to deliver of the following benefit offered by DHMS 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 (RSA) 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 01 October 2020. The Scheme and MSOI shall be entitled to terminate the agreement by giving the other party at least 90 days written notice.

25. Related party transactions continued

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.

Health Coaching services

The Scheme is billed by Discovery Healthcare Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health, to provide cardiovascular and diabetes management programs to members of the Scheme.

New business underwriting services

The Scheme is billed by Discovery Health (Pty) Ltd for the costs relating to evaluating the health status, medical history, and potential risk factors of individuals applying for medical aid coverage. This may involve medical examinations, laboratory tests, and review of medical records.

Employee systems program

The Scheme is billed by Discovery Health (Pty) Ltd for access to the Healthy Company digitally enabled employee assistance program. Healthy Company helps the Scheme's employees, their partners and anyone living in their household to deal with everyday situations and more serious concerns impacting their emotional, financial, physical or legal wellbeing.

26. Surplus/(deficit) from operations per benefit plan

2023	Executive Plan R'000	Classic Comprehensive R'000	Classic Smart Comprehensive R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comprehensive R'000	Essential Saver R'000	Essential Core R'000
Insurance revenue	990 927	10 534 599	44 478	2 702 997	18 947 615	5 049 489	1 045 325	7 993 630	2 476 042
Insurance service expense	(1 292 951)	(11 997 334)	(31 246)	(2 682 649)	(18 788 848)	(5 041 108)	(1 181 073)	(6 955 194)	(2 372 180)
Claims incurred	(1 234 395)	(11 217 072)	(27 822)	(2 336 995)	(16 172 317)	(4 492 144)	(1 089 644)	(5 621 105)	(1 975 747)
Risk claims	(1 236 118)	(11 234 481)	(27 834)	(2 340 033)	(16 193 109)	(4 498 783)	(1 091 225)	(5 629 053)	(1 978 464)
Third-party claim recoveries	1 723	17 409	12	3 038	20 792	6 639	1 581	7 948	2 717
Other incurred insurance service expenses	(58 556)	(780 262)	(3 424)	(345 654)	(2 616 531)	(548 964)	(91 429)	(1 334 089)	(396 433)
Insurance acquisition cash flows (broker fees)	(10 292)	(138 943)	(600)	(55 524)	(463 161)	(98 007)	(16 328)	(217 908)	(61 134)
Accredited managed healthcare services (no risk transfer)	(12 718)	(169 405)	(736)	(75 198)	(558 198)	(117 412)	(19 667)	(288 477)	(86 839)
Attributable expenses incurred – administration fees	(34 481)	(457 780)	(2 026)	(208 464)	(1 547 138)	(323 534)	(53 773)	(802 622)	(240 933)
Attributable expenses incurred – operating expenses	(159)	(2 117)	(9)	(965)	(7 156)	(1 494)	(249)	(3 721)	(1 119)
Changes in expected recoverability of member and service provider claims receivables	(906)	(12 017)	(53)	(5 503)	(40 878)	(8 517)	(1 412)	(21 361)	(6 408)
Net income/(expense) from risk transfer arrangement/reinsurance	46	628	8	1 722	2 024	610	87	(666)	324
An allocation of premiums paid	(1 633)	(23 955)	(47)	(3 014)	(22 515)	(7 379)	(1 872)	(7 443)	(3 122)
Amounts recovered from risk transfer arrangements/reinsurance	1 679	24 583	55	4 736	24 539	7 989	1 959	6 777	3 446
INSURANCE SERVICE RESULT BEFORE DISTRIBUTION OF AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS	(301 978)	(1 462 107)	13 240	22 070	160 791	8 991	(135 661)	1 037 770	104 186
Amounts attributable to future members	292 395	1 335 117	(14 007)	(100 562)	(593 117)	(99 139)	120 781	(1 264 669)	(195 937)
INSURANCE SERVICE RESULT	(9 583)	(126 990)	(767)	(78 492)	(432 326)	(90 148)	(14 880)	(226 899)	(91 751)
Other income	18 163	240 896	1 076	110 298	817 403	170 651	28 262	426 699	128 499
Investment income	13 072	173 565	768	79 053	586 316	122 686	20 387	304 078	91 347
Net gain on financial assets	4 894	64 714	296	30 052	222 233	46 115	7 568	118 023	35 772
Sundry income	197	2 617	12	1 193	8 854	1 850	307	4 598	1 380
Other expenditure	(8 580)	(113 906)	(309)	(31 806)	(385 077)	(80 503)	(13 382)	(199 800)	(36 748)
Other administration fees	(3 774)	(50 105)	(222)	(22 817)	(169 337)	(35 411)	(5 886)	(87 848)	(26 370)
Other operating expenses	(1 035)	(13 730)	(61)	(6 244)	(46 454)	(9 701)	(1 614)	(24 092)	(7 208)
Asset management fees	(449)	(5 964)	(26)	(2 715)	(20 143)	(4 214)	(701)	(10 442)	(3 135)
Finance cost	(5)	(67)		(30)	(224)	(47)	(8)	(115)	(35)
Net finance expense from insurance contracts	(3 317)	(44 040)	–	–	(148 919)	(31 130)	(5 173)	(77 303)	–
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

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26. Surplus/(deficit) from operations per benefit plan continued

2023	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Start R'000	Classic Smart R'000	Essential Smart R'000	TOTAL R'000
Insurance revenue	310 814	8 587 192	3 545 470	6 331 228	416 563	126 900	2 947 513	1 277 421	73 328 203
Insurance service expense	(232 666)	(9 103 514)	(3 905 587)	(7 684 515)	(398 993)	(101 074)	(2 778 035)	(1 118 738)	(75 665 705)
Claims incurred	(194 980)	(7 804 045)	(3 378 007)	(6 589 030)	(331 893)	(69 055)	(2 286 857)	(732 537)	(65 553 645)
Risk claims	(195 235)	(7 814 598)	(3 382 830)	(6 598 549)	(332 363)	(69 201)	(2 290 117)	(733 843)	(65 645 836)
Third-party claim recoveries	255	10 553	4 823	9 519	470	146	3 260	1 306	92 191
Other incurred insurance service expenses	(37 686)	(1 299 469)	(527 580)	(1 095 485)	(67 100)	(32 019)	(491 178)	(386 201)	(10 112 060)
Insurance acquisition cash flows (broker fees)	(6 659)	(225 101)	(83 832)	(185 585)	(12 555)	(3 963)	(74 440)	(39 174)	(1 693 206)
Accredited managed healthcare services (no risk transfer)	(8 043)	(278 742)	(115 055)	(333 926)	(26 648)	(10 291)	(107 493)	(89 335)	(2 298 183)
Attributable expenses incurred – administration fees	(22 293)	(771 702)	(318 809)	(547 371)	(25 628)	(16 869)	(299 897)	(249 826)	(5 923 146)
Attributable expenses incurred – operating expenses	(103)	(3 568)	(1 476)	(3 685)	(266)	(115)	(1 391)	(1 163)	(28 756)
Changes in expected recoverability of member and service provider claims receivables	(588)	(20 356)	(8 408)	(24 918)	(2 003)	(781)	(7 957)	(6 703)	(168 769)
Net income/(expense) from risk transfer arrangement/reinsurance	22	1 602	610	77 437	–	913	240	116	85 723
An allocation of premiums paid	(324)	(11 977)	(4 620)	(216 745)	–	(4 957)	(1 618)	(577)	(311 798)
Amounts recovered from risk transfer arrangements/reinsurance	346	13 579	5 230	294 182	–	5 870	1 858	693	397 521
INSURANCE SERVICE RESULT BEFORE DISTRIBUTION OF AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS	78 170	(514 720)	(359 507)	(1 275 850)	17 570	26 739	169 718	158 799	(2 251 779)
Amounts attributable to future members	(84 426)	299 467	239 624	876 032	(51 778)	(39 322)	(283 172)	(254 653)	182 634
INSURANCE SERVICE RESULT	(6 256)	(215 253)	(119 883)	(399 818)	(34 208)	(12 583)	(113 454)	(95 854)	(2 069 145)
Other income	11 801	407 303	168 526	500 295	40 244	15 676	159 216	133 960	3 378 968
Investment income	8 456	292 542	120 900	356 991	28 493	11 000	113 633	94 653	2 417 940
Net gain on financial assets	3 217	110 346	45 802	137 916	11 320	4 509	43 866	37 874	924 517
Sundry income	128	4 415	1 824	5 388	431	167	1 717	1 433	36 511
Other expenditure	(5 545)	(192 050)	(48 643)	(100 477)	(6 036)	(3 093)	(45 762)	(38 106)	(1 309 823)
Other administration fees	(2 440)	(84 464)	(34 894)	(59 911)	(2 805)	(1 846)	(32 824)	(27 344)	(648 298)
Other operating expenses	(667)	(23 156)	(9 551)	(28 174)	(2 243)	(866)	(8 992)	(7 478)	(191 266)
Asset management fees	(290)	(10 049)	(4 152)	(12 256)	(977)	(377)	(3 903)	(3 248)	(83 041)
Finance cost	(3)	(112)	(46)	(136)	(11)	(4)	(43)	(36)	(922)
Net finance expense from insurance contracts	(2 145)	(74 269)	–	–	–	–	–	–	(386 296)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

Discovery Health Medical Scheme registration number 1125

26. Surplus/(deficit) from operations per benefit plan continued

2022	Executive Plan R'000	Classic Comprehensive R'000	Classic Smart Comprehensive R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comprehensive R'000	Essential Saver R'000	Essential Core R'000
Insurance revenue	906 665	9 800 213	43 570	2 494 614	16 626 490	4 693 862	971 546	6 772 639	2 171 537
Insurance service expense	(1 220 137)	(11 273 216)	(28 447)	(2 512 911)	(16 363 545)	(4 841 055)	(1 100 385)	(5 983 833)	(2 096 134)
Claims incurred	(1 163 276)	(10 506 917)	(24 982)	(2 182 590)	(13 978 113)	(4 302 035)	(1 011 090)	(4 825 821)	(1 737 280)
Risk claims	(1 166 078)	(10 533 133)	(25 045)	(2 187 463)	(14 009 634)	(4 311 991)	(1 013 586)	(4 836 994)	(1 741 415)
Third-party claim recoveries	2 802	26 216	63	4 873	31 521	9 956	2 496	11 173	4 135
Other incurred insurance service expenses	(56 861)	(766 299)	(3 465)	(330 321)	(2 385 432)	(539 020)	(89 295)	(1 158 012)	(358 854)
Insurance acquisition cash flows (broker fees)	(10 519)	(143 111)	(616)	(54 846)	(439 042)	(101 093)	(16 782)	(194 096)	(56 650)
Accredited managed healthcare services (no risk transfer)	(12 272)	(165 580)	(751)	(71 686)	(506 333)	(114 471)	(19 120)	(250 098)	(78 555)
Attributable expenses incurred – administration fees	(33 237)	(446 171)	(2 045)	(198 807)	(1 403 861)	(315 397)	(51 999)	(695 772)	(218 162)
Attributable expenses incurred – operating expenses	(183)	(2 716)	(12)	(1 098)	(8 840)	(1 898)	(378)	(4 518)	(1 228)
Changes in expected recoverability of member and service provider claims receivables	(650)	(8 721)	(41)	(3 884)	(27 356)	(6 161)	(1 016)	(13 528)	(4 259)
Net income/(expense) from risk transfer arrangement/reinsurance	(246)	(3 310)	(2)	740	(1 038)	(552)	(292)	(1 271)	(119)
An allocation of premiums paid	(1 919)	(29 254)	(89)	(3 223)	(22 818)	(8 371)	(2 583)	(7 572)	(2 954)
Amounts recovered from risk transfer arrangements/reinsurance	1 673	25 944	87	3 963	21 780	7 819	2 291	6 301	2 835
INSURANCE SERVICE RESULT BEFORE DISTRIBUTION OF AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS	**(313 718)**	**(1 476 313)**	**15 121**	**(17 557)**	**261 907**	**(147 745)**	**(129 131)**	**787 535**	**75 284**
Amounts attributable to future members	309 495	1 420 368	(15 577)	(26 651)	(442 247)	108 634	122 610	(879 502)	(124 561)
INSURANCE SERVICE RESULT	**(4 223)**	**(55 945)**	**(456)**	**(44 208)**	**(180 340)**	**(39 111)**	**(6 521)**	**(91 967)**	**(49 277)**
Other income	12 718	169 985	779	75 676	539 217	119 739	19 813	269 848	83 809
Investment income	12 546	168 430	773	75 100	530 158	119 109	19 631	262 874	82 443
Net gain on financial assets	(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 expenditure	(8 495)	(114 040)	(323)	(31 468)	(358 877)	(80 628)	(13 292)	(177 881)	(34 532)
Other administration fees	(3 638)	(48 834)	(224)	(21 760)	(153 655)	(34 521)	(5 691)	(76 153)	(23 878)
Other operating expenses	(1 032)	(13 865)	(63)	(6 184)	(43 616)	(9 814)	(1 617)	(21 597)	(6 779)
Asset management fees	(582)	(7 804)	(36)	(3 481)	(24 609)	(5 518)	(910)	(12 226)	(3 828)
Finance cost	(7)	(99)	–	(43)	(302)	(68)	(11)	(149)	(47)
Net finance expense from insurance contracts	(3 236)	(43 438)	–	–	(136 695)	(30 707)	(5 063)	(67 756)	–
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

Discovery Health Medical Scheme registration number 1125

26. Surplus/(deficit) from operations per benefit plan continued

2022	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Start R'000	Classic Smart R'000	Essential Smart R'000	TOTAL R'000
Insurance revenue	289 053	7 849 420	3 296 205	5 790 557	376 825	106 470	2 416 485	1 031 248	65 637 399
Insurance service expense	(229 609)	(8 279 968)	(3 604 682)	(7 054 985)	(375 693)	(82 795)	(2 251 400)	(901 803)	(68 200 598)
Claims incurred	(192 521)	(7 051 105)	(3 095 485)	(6 051 930)	(317 151)	(55 817)	(1 829 429)	(583 332)	(58 908 874)
Risk claims	(192 896)	(7 067 103)	(3 102 757)	(6 066 403)	(317 989)	(55 964)	(1 833 832)	(584 891)	(59 047 174)
Third-party claim recoveries	375	15 998	7 272	14 473	838	147	4 403	1 559	138 300
Other incurred insurance service expenses	(37 088)	(1 228 863)	(509 197)	(1 003 055)	(58 542)	(26 978)	(421 971)	(318 471)	(9 291 724)
Insurance acquisition cash flows (broker fees)	(6 822)	(218 625)	(83 411)	(174 930)	(11 598)	(3 392)	(64 733)	(32 189)	(1 612 455)
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)
Attributable expenses incurred – administration fees	(21 834)	(728 499)	(307 187)	(487 037)	(20 386)	(13 868)	(258 070)	(206 901)	(5 409 233)
Attributable expenses incurred – operating expenses	(133)	(4 321)	(1 660)	(4 750)	(324)	(142)	(1 586)	(1 353)	(35 140)
Changes in expected recoverability of member and service provider claims receivables	(426)	(14 209)	(6 004)	(17 534)	(1 369)	(498)	(5 017)	(4 015)	(114 688)
Net income/(expense) from risk transfer arrangement/reinsurance	(18)	(128)	(122)	74 423	–	2 171	(46)	11	70 201
An allocation of premiums paid	(355)	(13 229)	(5 395)	(207 503)	–	(4 340)	(1933)	(683)	(312 221)
Amounts recovered from risk transfer arrangements/reinsurance	337	13 101	5 273	281 926	–	6 511	1 887	694	382 422
INSURANCE SERVICE RESULT BEFORE DISTRIBUTION OF AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS	**59 426**	**(430 676)**	**(308 599)**	**(1 190 005)**	**1 132**	**25 846**	**165 039**	**129 456**	**(2 492 998)**
Amounts attributable to future members	(62 141)	338 803	240 591	942 975	(22 254)	(33 011)	(224 349)	(177 177)	1 476 006
INSURANCE SERVICE RESULT	**(2 715)**	**(91 873)**	**(68 008)**	**(247 030)**	**(21 122)**	**(7 165)**	**(59 310)**	**(47 721)**	**(1 016 992)**
Other income	8 297	278 110	116 632	344 226	26 779	9 934	100 156	80 484	2 256 202
Investment income	8 249	275 122	116 036	339 575	26 506	9 685	97 488	78 262	2 221 987
Net gain on financial assets	(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 expenditure	(5 582)	(186 237)	(48 624)	(97 196)	(5 657)	(2 769)	(40 846)	(32 763)	(1 239 210)
Other administration fees	(2 390)	(79 735)	(33 622)	(53 307)	(2 231)	(1 518)	(28 246)	(22 646)	(592 049)
Other operating expenses	(679)	(22 655)	(9 560)	(27 938)	(2 181)	(795)	(8 011)	(6 427)	(182 813)
Asset management fees	(382)	(12 759)	(5 376)	(15 758)	(1 230)	(451)	(4 534)	(3 646)	(103 130)
Finance cost	(5)	(157)	(66)	(193)	(15)	(5)	(55)	(44)	(1 266)
Net finance expense from insurance contracts	(2 126)	(70 931)	–	–	–	–	–	–	(359 952)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**

27. Reconciliation of movements in the statement of cash flows

R'000	2023	2022
Cash (paid to)/received from members and providers – other	**(428)**	9 300
Movement in sundry accounts receivable (Note 4)	**(428)**	9 300
Cash paid to provider and employees – other administration fees and operating expenses	**(815 950)**	(729 069)
Other administration fees (Note 13)	**(648 298)**	(592 049)
Other operating expenses (Note 14)	**(191 266)**	(182 813)
Add back: non-cash items included in these amounts		
Depreciation (Note 14)	**1 602**	1 486
Unvested Long-term employee benefit (Note 25)	**4 878**	5 454
Movement in accounts receivable (Note 4)	**(3 222)**	–
Movement in accounts payable (Note 8)	**(9 328)**	10 259
Sundry income (Note 21)	**32 398**	29 894
Movement in risk transfer arrangements/reinsurance contracts	**(2 714)**	(1 300)
Purchases of financial assets	**(3 967 570)**	(7 774 847)
Financial assets at fair value through profit or loss (Note 3)	**(4 182 983)**	(7 930 674)
Capitalised income	**215 413**	155 827
Proceeds from disposal of financial assets	**5 383 974**	9 410 317
Financial assets at fair value through profit or loss (Note 3)	**5 460 688**	9 410 317
Derivative financial instruments (Note 7)	**(76 714)**	
Interest received	**1 802 684**	1 588 234
Interest income (Note 19)	**1 974 679**	1 748 669
Movement in interest receivable	**(2 277)**	(4 608)
Capitalised interest	**(169 718)**	(155 827)
Dividends received	**397 566**	473 318
Dividend income (Note19)	**443 261**	473 318
Capitalised dividends	**(45 695)**	–

28. Events after the reporting period

No significant events occurred between the reporting date and the date the Financial Statements were authorised for issue.

29. 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 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 2022 and 2023, as well as the risk claims paid. The risk claims are indexed to a value of 100 for the "<1" age band in 2022. There has been an increase in the proportion of beneficiaries older than 40 over the past year.

Membership distribution and risk claims (risk claims Indexed to age band "<1" 2022 = 100)

29. Insurance risk management report continued

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:

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 (CIB) covers approved medication and treatment for up to 50 listed conditions, including the 27 PMB 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:

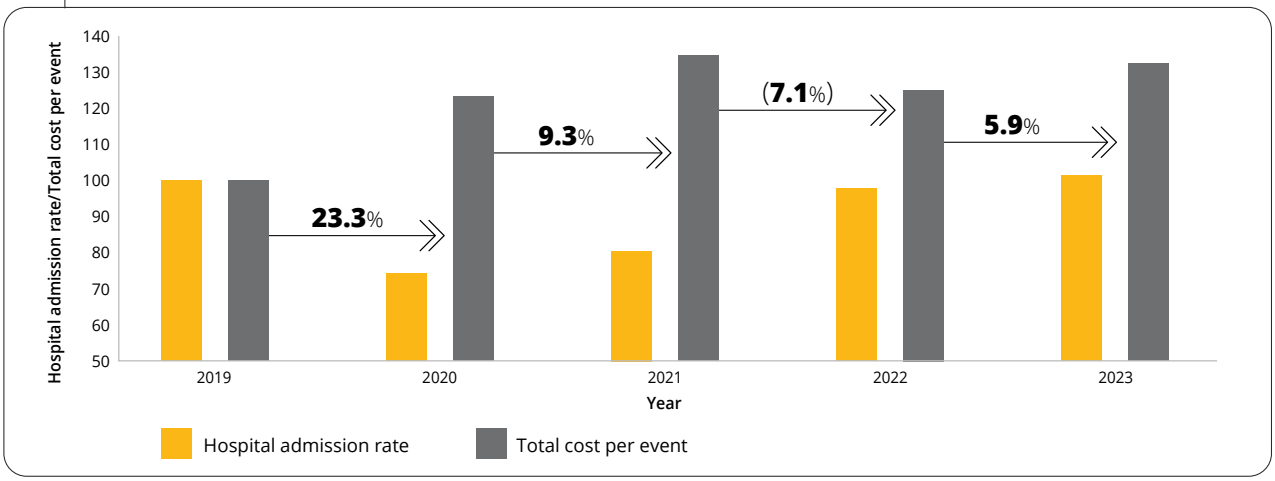
HOSPITAL BENEFIT RISK

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.

Hospital claims experience (Indexed to 2019 = 100)



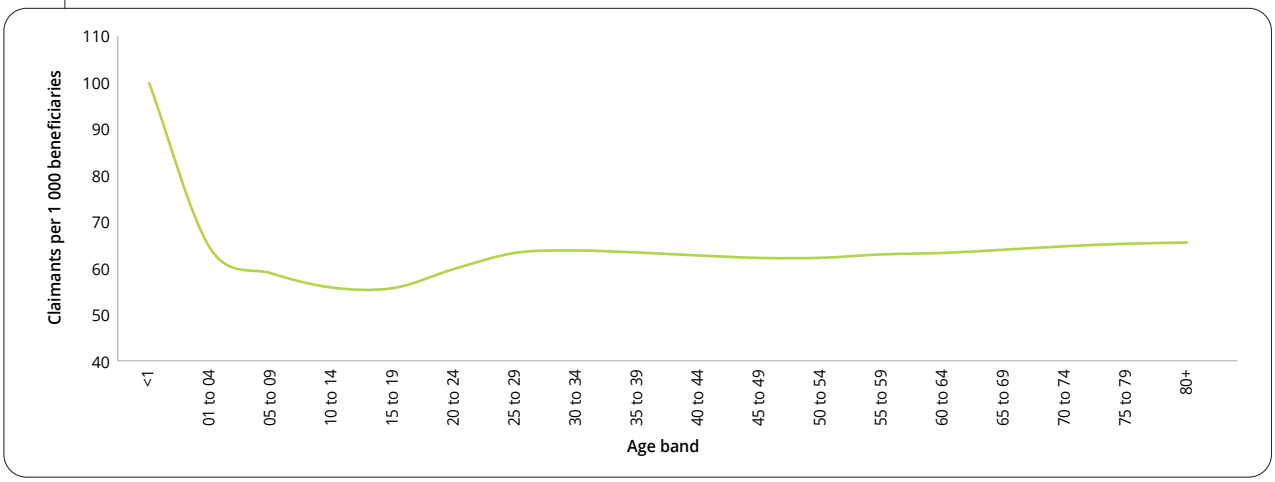
The number of hospital admissions reduced significantly from April 2020 to December 2020. This was due to the 5-stage lockdown imposed by the South African Government in response to the COVID-19 pandemic. This meant that there were minimal elective procedures, and only emergency and high-risk cases were admitted. The number of admissions has increased from 2020 to 2023 with the admission rate in 2023 slightly exceeding pre-COVID levels. 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 and the graph above shows how the admission rate increased further, and also how the total cost per event decreased in 2022. The decrease in cost per event in 2022 is mainly due to the increase (and return to "normal") in the number of lower cost admissions. In 2023, the cost per event increased in line with inflation.

29. Insurance risk management report continued

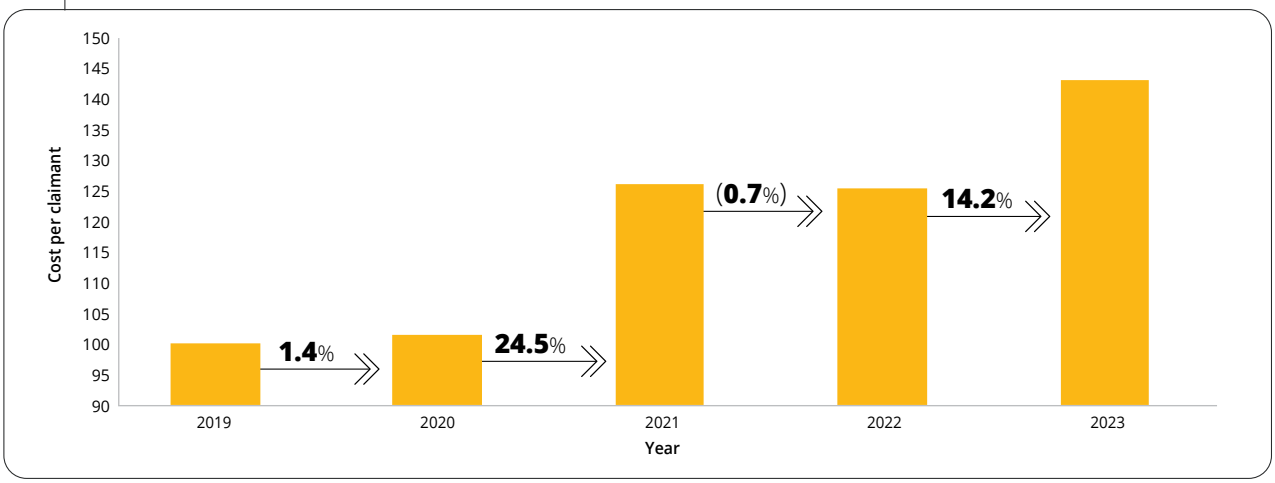
DAY-TO-DAY BENEFITS RISK

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 PMB 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.

2023 claimants per 1 000 beneficiaries from OH risk benefits (indexed to age band "<1" 2023 = 100)



Cost per OH claimant (Indexed to 2019 = 100)



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.

29. Insurance risk management report continued

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.

The OH claims increased once again from 2022 to 2023. This was predominantly due to the introduction of the WELLTH Fund as well as a significant increase in the limits of the oncology benefit.

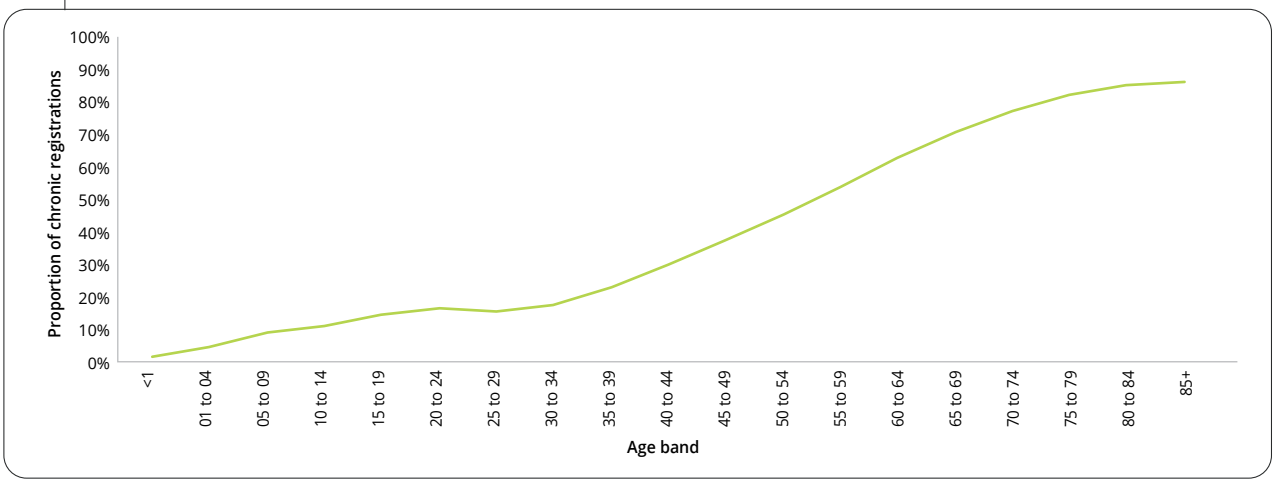
CHRONIC BENEFITS RISK

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.

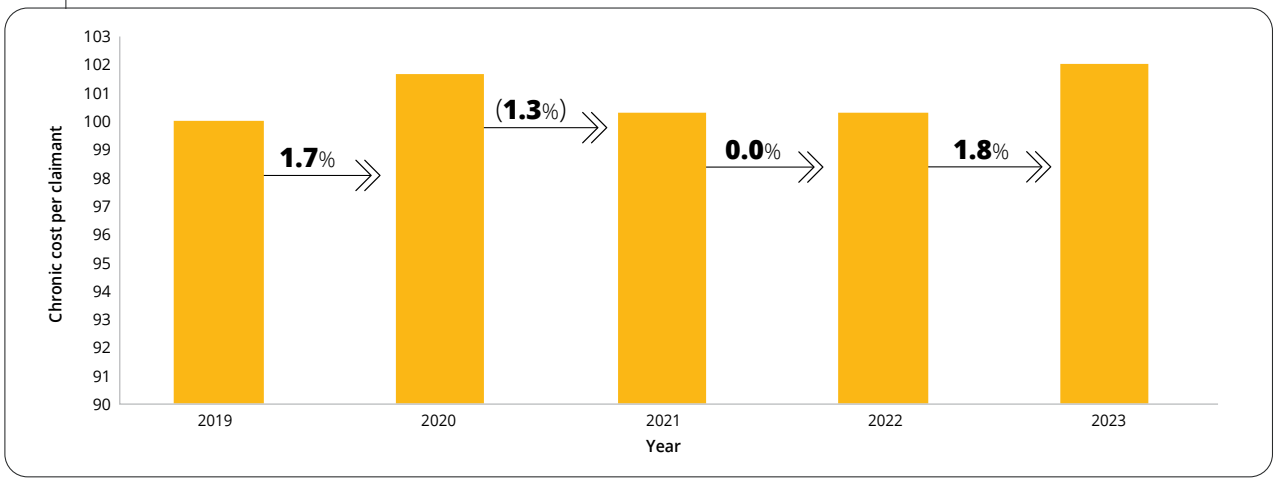
The following graphs indicate the percentage of chronic registrations by age band for 2023, as well as the change in the cost per claimant over the past five years. The cost per claimant graph is indexed to a value of 100 as at 2019.

Proportion of chronic registrations by age band



29. Insurance risk management report continued

Cost per chronic claimant (Indexed to 2019 = 100)



The Scheme's extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, has assisted in keeping the increases in the chronic cost per claimant below the published Single Exit Price increases in medication year-on-year.

SENSITIVITY ANALYSIS

The following table shows the impact on profit or loss reported caused by reasonable possible changes in key variables by the end of the reporting period. One of the main assumptions affecting the Liability for Incurred Claims (LIC) estimate is the claims development period used in calculating the run-off factors. The impact of using different claims development periods is shown in the table below.

Change in variable	Change in LIC 2023 R'000	Change in LIC 2022 R'000
Using 3-month development experience	**47 733**	(93 556)
Using 6-month development experience	**174 834**	70 143
Using 12-month development experience	**241 243**	137 528
Assuming 1% reduction in claims processing	**781 017**	725 518

This analysis is prepared for a change in a specified variable with other assumptions remaining constant. The change in liability also represents the absolute change in income/(expense) for the period.

RISK MANAGEMENT

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include, but are not limited to:

- Members must be referred by a doctor prior to an elective admission.
- All hospital admissions must 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.

29. Insurance risk management report continued

RISK MANAGEMENT continued

- 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 (CCP). 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 PMBs. 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.

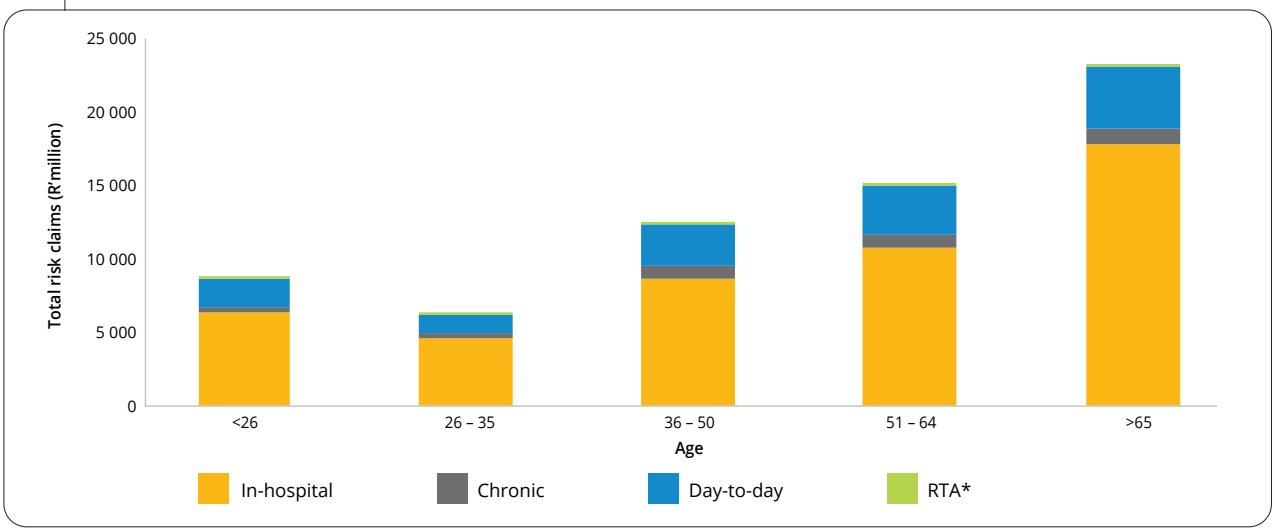
CONCENTRATION OF INSURANCE RISK

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.

The following graph summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred (before and after risk transfer arrangements) by age group and in relation to the type of risk covered/ benefits provided.

2023 DHMS claims by age



* *Risk transfer arrangements/reinsurance contracts.*

29. Insurance risk management report continued

CONCENTRATION OF INSURANCE RISK continued

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 Scheme cedes insurance risk to limit exposure to underwriting losses in terms of risk transfer arrangements where the third-party agrees to reimburse the ceded amount in the event the claim is paid. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to all Scheme members, as and when required by the members. The Scheme does, however, remain liable to its members with respect to ceded insurance if any reinsurer (or supplier) fails to meet the obligations it assumes.

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.

The following table summarises the concentration of insurance risk reinsured, with reference to the amount of the insurance claims incurred by option and in relation to the type of out-of-hospital risk covered/benefits provided:

	Medical practitioners	Dentistry	Optometry	Other
KeyCare options	0%	100%	100%	0%
Non-KeyCare options	4%	0%	0%	0%

Assessment of contribution increases

Similar to the delayed increase implemented in 2022, it was decided to implement a 0.0% contribution increase across all options from 01 January 2023 with a proposed contribution increase of 9.9% for Executive, Comprehensive and Priority benefit options and 7.9% for all other benefit options from 01 April 2023, in order to balance the economic pressures faced by members and the longevity of the Scheme. This translates to an effective average increase of below 6.2% for 2023 off the December 2022 contributions. Due to this lower increase, a larger increase has been implemented in 2024 for the solvency of the Scheme to remain above 25% in the medium term.

In 2024, a weighted average risk contribution increase of 10.5% and a weighted average gross contribution increase to members of 7.5% was applied from 01 January 2024. The lower gross contribution increase is due to a decrease in the PMSA portion on the Saver benefit options. The decision was also made to close the Essential Comprehensive, Classic Delta Comprehensive, and Essential Delta Comprehensive options since they were loss-making. The remaining loss-making options were given higher increases to improve their financial position, thereby reducing the cross-subsidisation required from the other options on the Scheme, which results in an improved overall financial position at a Scheme level.

In addition to the consolidation of the Comprehensive options and the reduction of the PMSA portion on the Saver benefit options, a PMSA of 15% was added to the Classic Smart Comprehensive option. There is a risk that these changes to the benefit options may have an adverse effect on solvency in the future, as well as reputational risk. Should these risks materialise, the Scheme will manage them in the course of the annual benefit design and contribution review exercise.

29. Insurance risk management report continued

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 most cases within three months. At year-end, a provision is made for those claims that have not yet been reported.

The methodology followed in setting the outstanding claims provision is the 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 2023 probability weighted best estimate of future cash flows for claims incurred but not yet reported 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.

Based on the processing patterns and claims development up to the end of December 2023 in respect of treatment dates during the year, the recommended provision for outstanding claims as at December 2023 is R1 978 million (2022: R1 901 million). Note that any changes in case mix are automatically accounted for in the methodology. A sensitivity test is shown further below.

R'000	2023	2022
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	**48 347 310**	43 634 520
Chronic claims incurred	**3 342 558**	3 161 541
Out-of-hospital risk claims incurred	**13 749 748**	12 165 065

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.

	Change in variable %	**Impact on probability weighted best estimate of future cash flows for claims incurred but not yet reported 2023 R'000**	Impact on probability weighted best estimate of future cash flows for claims incurred but not yet reported 2022 R'000
In-hospital claims incurred	1% slower claims processing	**576 422**	517 894
Chronic claims incurred	1% slower claims processing	**5 290**	8 064
Out-of-hospital risk claims incurred	1% slower claims processing	**174 884**	184 187

29. Insurance risk management report continued

Claims development continued

The table below outlines the impact of different risk confidence levels on the risk adjustment.

Risk confidence level	Risk margin percentage of outstanding claims
75% Confidence level	3.1%
70% Confidence level	1.9%
80% Confidence level	4.5%

LIQUIDITY RISK

Members of the Scheme are required to submit their claims within four months of the service date. Therefore the liability attributable to current members is expected to be settled within 12 months.

The members' PMSA contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's PMSA 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' PMSA are deemed to be equal to their fair values, which is the amount payable on demand.

The remaining 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.

The Scheme has budgeted a loss for the period ending 31 December 2024 of R1.7 billion. Of the R28.7 billion total insurance liability to future members, it is expected that future members would use R1.7 billion within the next 12 months.

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.

CREDIT RISK

Credit risk is the risk of financial loss resulting from a counterparty's failure to meet their contractual obligations. The Scheme does not have significant credit risk arising from reinsurance contract assets or insurance assets.

The capitation agreements are used to manage insurance risk. This does not, however, discharge the Scheme's liability as the primary insurer. If a reinsurer fails to pay a claim for any reason, the Scheme remains liable for the payment to the members.

Exposures to individual members are managed by adhering to the requirements of Section 26 (7) of the PMSA i.e actively pursuing all contributions not received within three days of becoming due, suspending benefits for all members where contributions have not been received for 30 days and terminating benefits for all members where contributions have not been received for 90 days. The credit risk is taken into account when the expected contribution is calculated.

30. 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 the establishment and oversight of 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 the 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.
- The Scheme has appointed an external asset consulting company, RisCura Solutions (Pty) Ltd, to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the external asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- An Independent assessment of the 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 which 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
2023				
INVESTMENTS	**32 869 897**			
Offshore cash and bonds	**2 340 515**	✓		✓
Equities	**9 565 664**		✓	
Short duration bonds	**5 353 666**			✓
Flexible fixed income bonds	**9 719 048**			✓
Money market instruments	**5 229 427**			✓
Property	**661 577**		✓	
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		✓	

The Scheme's insurance contract liabilities to current members are settled within one year and the Scheme does not discount insurance contract liabilities. Consequently, changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability. The PMSA, that is included in the insurance contract liabilities, is not exposed to credit interest risk. Interest is allocated to positive PMSA balances greater that R5 000 based on a sliding scale. The interest rates used are fixed interest rates as per the approved Scheme Rules and the Policy for Interest on PMSA.

30. 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 (USD)). 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 2023, R2.3 billion (2022: R2.2 billion) (Note 3) was invested in these portfolios.

- **CURRENCY DERIVATIVES FINANCIAL INSTRUMENT (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.

			2023		
Contract	**Expiry date**	**Nominal USD value $'000**	**USD put ("floor")**	**USD call ("cap")**	**% above floor**
1	22/02/2024	$16 000	**R 18.28**	**R 18.80**	**2.84%**
2	20/08/2024	$32 000	**R 19.01**	**R 19.65**	**3.38%**
3	10/09/2024	$16 000	**R 19.12**	**R 19.69**	**3.03%**
4	11/10/2024	$16 000	**R 19.39**	**R 20.01**	**3.19%**

			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 Net gains/(losses) on financial assets (Note 20).

30. Financial risk management report 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 Statement of Comprehensive Income. 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 R0.91) or 15% (increase or decrease of R2.74) from a spot level of R18.29 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
2023				
(Loss)/gain arising from currency appreciation/depreciation before synthetic forwards	**(351 077)**	**(117 026)**	**117 026**	**351 077**
(Loss)/gain arising from currency appreciation/depreciation after synthetic forwards	**(70 409)**	**21 286**	**112 982**	**204 678**
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

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 R10.2 billion (2022: R9.5 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.

30. Financial risk management report continued

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 Statement of Comprehensive Income. 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
2023				
(Loss)/gain arising from price decrease/increase	**(1 434 849)**	**(478 283)**	**478 283**	**1 434 849**
2022				
(Loss)/gain arising from price decrease/increase	(1 340 652)	(446 884)	446 884	1 340 652

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 Statement of Comprehensive Income. 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
2023				
(Loss)/gain arising from price decrease/increase	**(99 237)**	**(33 079)**	**33 079**	**99 237**
2022				
(Loss)/gain arising from price decrease/increase	(89 647)	(29 882)	29 882	89 647

30. 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 2023				
Cash and cash equivalents	**4 335 736**			**4 335 736**
Money market instruments carried at fair value through profit or loss		**5 229 427**		**5 229 427**
Short duration bonds carried at fair value through profit or loss		**1 356 815**	**3 996 850**	**5 353 666**
Flexible fixed income bonds carried at fair value through profit or loss		**1 278 912**	**8 440 136**	**9 719 048**
Offshore cash and bonds carried at fair value through profit or loss			**2 340 515**	**2 340 515**
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 cash and bonds carried at fair value through profit or loss			2 196 242	2 196 242

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 Statement of Comprehensive Income. 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
2023				
Local portfolios	**1 817 291**	**908 645**	**(908 645)**	**(1 817 291)**
Foreign portfolios	**219 159**	**109 580**	**(109 580)**	**(219 159)**
2022				
Local portfolios	1 229 652	614 826	(614 826)	(1 229 652)
Foreign portfolios	203 830	101 915	(101 915)	(203 830)

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 2023 49% of the investments were invested in variable interest rate instruments, 23% in fixed rate instruments, and the remaining 28% 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.

30. Financial risk management report continued

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 the contractual obligations are clearly defined and not ambiguous. At 31 December 2023, the Scheme considered there to be no significant concentration of legal risk and no provision has been raised.

INVESTMENT RISK

Investment risk is the risk that the investment returns on accumulated assets will be lower than anticipated resulting in solvency reducing below 25%.

The Scheme's Investment Committee oversees that the 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. The Scheme's return goals, as well as the risk associated with each asset class are considered. Diversification is across securities, issuers, asset classes and geographic regions, as well as managers within asset classes where practical. The Scheme invests 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 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 and projected operating surplus.
- 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
2023				
INVESTMENTS	**28 807 391**	**2 340 515**	**1 721 991**	**32 869 897**
Offshore cash and bonds	**–**	**2 340 515**	**–**	**2 340 515**
Equities	**9 565 664**	**–**	**–**	**9 565 664**
Short duration bonds	**3 631 675**	**–**	**1 721 991**	**5 353 666**
Flexible fixed income bonds	**9 719 048**	**–**	**–**	**9 719 048**
Property	**661 577**	**–**	**–**	**661 577**
Money market instruments	**5 229 427**	**–**	**–**	**5 229 427**
CASH AND CASH EQUIVALENTS	**3 671 972**	**663 764**	**–**	**4 335 736**
	32 479 363	**3 004 279**	**1 721 991**	**37 205 633**

30. Financial risk management report continued

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 bonds	–	2 196 242	–	2 196 242
Equities	8 937 682	–	–	8 937 682
Yield-enhanced bonds	4 076 746	–	1 411 987	5 488 733
Inflation-linked 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**

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 16% (2022: 22%) 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 one 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.

30. Financial risk management report continued

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 16% (2022: 17%) 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 (SOFR) plus 400 basis points.

The second portfolio is actively managed on a discretionary basis investing 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% (2022: 7%) of the Scheme's financial assets at fair value through profit or loss.

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 managers 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 30% (2022: 26%) 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 29% (2022: 27%) of the Scheme's financial assets at fair value through profit or loss.

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% (2022: 2%) of the Scheme's financial assets at fair value through profit or loss.

30. Financial risk management report continued

The following table compares the fair value and carrying amounts of financial assets and liabilities per class of assets and liabilities.

	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
2023					
INVESTMENTS					
− Offshore bond portfolio	**2 340 515**	**–**	**–**	**2 340 515**	**2 340 515**
− Equities	**9 565 664**	**–**	**–**	**9 565 664**	**9 565 664**
− Short duration bond portfolio	**5 353 666**	**–**	**–**	**5 353 666**	**5 353 666**
− Flexible fixed income bond portfolio	**9 719 048**	**–**	**–**	**9 719 048**	**9 719 048**
− Property	**661 577**	**–**	**–**	**661 577**	**661 577**
− Money market portfolios	**5 229 427**	**–**	**–**	**5 229 427**	**5 229 427**
CASH AND CASH EQUIVALENTS	**–**	**4 335 736**	**–**	**4 335 736**	**4 335 736**
DERIVATIVE FINANCIAL INSTRUMENTS	**65 826**	**–**	**–**	**65 826**	**65 826**
LEASES	**–**	**–**	**(6 476)**	**(6 476)**	**(6 476)**
TRADE AND OTHER RECEIVABLES	**–**	**11 967**	**–**	**11 967**	**11 967**
TRADE AND OTHER PAYABLES	**–**	**–**	**(81 732)**	**(81 732)**	**(81 732)**
	32 935 723	**4 347 703**	**(88 208)**	**37 195 218**	**37 195 218**

30. Financial risk management report continued

	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	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
DERIVATIVE FINANCIAL INSTRUMENTS	38 525	–	–	38 525	38 525
LEASES	–	–	(9 833)	(9 833)	(9 833)
TRADE AND OTHER RECEIVABLES	–	6 040	–	6 040	6 040
TRADE AND OTHER PAYABLES	–	–	(91 060)	(91 060)	(91 060)
	33 212 197	**3 630 174**	**(100 893)**	**36 741 478**	**36 741 478**

30. 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.

Exposure to credit risk

The carrying amount of insurance contract 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 Scheme conducts a comprehensive assessment of credit risk for various debtor categories, drawing insights from historical data to estimate fulfilment of cash flows. For insurance revenue past due and outstanding for less than 90 days, the Scheme discerns no indication of non-recoverability, reflecting the accuracy of the premiums' expected collection.

Similarly, for member and service provider claims debtors, as well as broker fee debtors, past due and outstanding for less than 180 days, the Scheme recognises non-recoverability indications based on the accuracy of the estimated fulfillment cash flows for claims.

Furthermore, for forensic debtors past due and outstanding for less than three years, the Scheme's estimation process indicates no evidence of non-recoverability.

It is crucial to highlight that the Scheme has not initiated any re-negotiation of receivables terms. Additionally, the absence of collateral or guarantees as security is considered in the estimation process, ensuring a thorough assessment of fulfillment cash flows. The Scheme remains committed to regular reassessment and adjustment of these estimates, thereby upholding the accuracy of its financial reporting.

Other receivables

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 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 with these receivables is negligible and no provision is raised. No further analysis is presented.

CASH AND CASH EQUIVALENTS

For cash and cash equivalents, these amounts are short dated on demand deposits and money market funds 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.

30. Financial risk management report continued

R'000	Current	Total
2023		
Expected loss rate	**0%**	
GROSS CARRYING AMOUNT – OTHER RECEIVABLES	**11 967**	**11 967**
Sundry accounts receivable	**699**	**699**
Prepaid expenses	**3 013**	**3 013**
Interest receivable	**8 046**	**8 046**
Balance due from related party	**209**	**209**
Gross carrying amount – cash and cash equivalents	**4 335 736**	**4 335 736**
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

CREDIT QUALITY

The credit quality of insurance contract receivables can be assessed by reference to historical information about counterparty default.

Insurance revenue debtors

The Scheme collects over 92% (2022: 99%) of outstanding insurance revenue in the month following their due date. This robust collection pattern signifies a high credit quality for insurance revenue. No further disclosure regarding the credit quality is deemed necessary, given the strong historical performance of insurance revenue collections.

Active member insurance service debtors

The Scheme estimates that 56% of the active member insurance service debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

Withdrawn member insurance expense debtors

It is observed that these amounts are receivable from members who have withdrawn from the Scheme. The Scheme estimates that 77% (2022: 78%) of the withdrawn member insurance expense debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

Service provider insurance expense debtors

The Scheme estimates that 77% (2022: 78%) of the service provider insurance expense debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

Insurance acquisition cash flow (broker fee) debtors

The Scheme estimates that 52% (2022: 79%) of the insurance acquisition cash flow debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

30. Financial risk management report continued

Forensic debtors

Forensic debt recovery mechanisms primarily include Acknowledgement of Debts (AODs), reversals, and cost adjustments. AOD amounts are recovered through various means such as debit orders, Electronic Fund Transfers (EFTs), or direct deposits into the bank account, which undergo continuous monitoring. It's crucial to note that forensic debt is only written off in the event of the debtor's death or insolvency.

The Scheme estimates that 10% (2022: 8%) of the forensic debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts. This estimate specifically applies to forensic debt instances where there have been no recoveries over a three-year period.

Other insurance 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.

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	2023	2022
− Offshore cash and bonds	**2 340 515**	2 196 242
− Short duration bonds	**5 353 666**	5 488 733
− Flexible fixed income bonds	**9 719 048**	8 639 881
− Money market instruments	**5 229 427**	7 313 485
− Cash and cash equivalents	**4 335 736**	3 624 134
− Derivative financial instruments	**65 826**	38 525
	27 044 218	**27 301 000**

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 177.

Counterparties of derivatives disclosed in Note 7 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 is regularly monitored with a quarterly report back, presented 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.

30. Financial risk management report 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.

30. 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% 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
2023								
AT FAIR VALUE THROUGH PROFIT OR LOSS:	**22 642 656**	**7 329 084**	**884 615**	**11 069 509**	**377 864**	**1 574 143**	**39 211**	**1 368 230**
Offshore bond portfolio	**2 340 515**	**–**	**–**	**813 033**	**–**	**1 527 482**	**–**	**–**
Short duration bond portfolio	**5 353 666**	**230 908**	**398 543**	**3 636 146**	**224 715**	**45 111**	**34 130**	**784 113**
Flexible fixed income bond portfolio	**9 719 048**	**6 967 018**	**394 129**	**1 735 652**	**97 462**	**1 550**	**5 081**	**518 156**
Money market portfolios	**5 229 427**	**131 158**	**91 943**	**4 884 678**	**55 687**	**–**	**–**	**65 961**
CASH AND CASH EQUIVALENTS	**4 335 736**	**–**	**–**	**4 335 736**	**–**	**–**	**–**	**–**
DERIVATIVES	**65 826**	**–**	**–**	**–**	**–**	**–**	**65 826**	**–**
TOTAL	**27 044 218**	**7 329 084**	**884 615**	**15 405 245**	**377 864**	**1 574 143**	**105 037**	**1 368 229**
% per rating band	**–**	**27.10%**	**3.27%**	**56.96%**	**1.40%**	**5.82%**	**0.39%**	**5.06%**
2022								
AT FAIR VALUE THROUGH PROFIT OR LOSS:	23 638 341	5 960 939	1 135 636	13 281 855	500 365	11 181	1 454 127	1 294 238
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**	**16 905 989**	**500 365**	**11 181**	**1 492 652**	**1 294 238**
% per rating band		21.83%	4.16%	61.92%	1.83%	0.04%	5.47%	4.74%

30. 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:

				Fair value hierarchy		Debt ranking		Credit rating		Underlying assets	
Name and description	**2023 R'000**	**Authorised programme size**	**% of Authorised programme size**	**Level**	**%**	**Ranking**	**%**	**Rating**	**%**	**Asset**	**%**
Residential mortgage-backed securitisations	**115 378**	R10 Billion	1.15%	Level 1	91%	Senior secured	59%	AA- to AA+	91%	Residential mortgages	100%
				Level 2	9%	Secured	41%	NR	9%		
Asset-backed securitisations	**221 912**	R125 Billion	0.18%	Level 1	100%	Senior secured	100%	AA- to AA+	100%	Vehicle loans	100%
Commercial mortgage-backed securitisations	**47 869**	R2 Billion	2.39%	Level 1	100%	Secured	100%	AA- to AA+	100%	Commercial mortgage loans	100%

Name and description	**2023 R'000**	**Portfolio size R'000**	**% of Portfolio size**	**Fair value hierarchy**	**Credit rating**	**Fund**
Collective investment schemes	**638 446**	26 590 460	2.40%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	13 310	43 411 534	0.03%	Level 2	AA+	Nedgroup Investments Corporate Money Market F. C2
	8 915	52 889 524	0.02%	Level 1	AA	Nedgroup Investments Core Income Fund Class C2
	201	21 060 772	0.00%	Level 2	AA+	Ninety One Corporate Money Market Class A
	1 288	44 629 164	0.00%	Level 2	AA+	Ninety One Money Market Fund Class A
	1 174	63 922 067	0.00%	Level 2	AA+	STANLIB Corporate Money Market Fund Class B5
	813 071	250 500 000	0.32%	Level 2	AA+	Legg Mason Brandywine Global Opportunistic Fixed Income Fund
	1 527 482	16 141 383	9.46%	Level 2	BBB	Ninety One ga Multi-asset Credit

30. Financial risk management report continued

EXPOSURE TO CREDIT RISK continued

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%	Commercial mortgage loans	100%

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

30. 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. In order 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.

Members of the Scheme are required to submit their claims within four months of the service date. Therefore the liability attributable to current members is expected to be settled within 12 months. The PMSA balances are payable on demand when a member exits the Scheme.

The Scheme expects to achieve a net deficit (before taking into account amounts attributable to future members) for the period ending 31 December 2024 and therefore expects to utilise a portion of the liability attributable to future members within the next 12 months.

	2023		2022	
R'000	**0 – 12 Months**	**>12 Months**	0 – 12 Months	>12 Months
Insurance contract balances				
Liabilities attributable to current members	**8 525 966**	**–**	7 886 759	–
Liabilities attributable to future members	**1 770 435**	**26 919 793**	3 588 451	25 284 429

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 2023			
Trade and other payables (Note 8)	**81 732**	**–**	**–**
Leases (Note 2)	**1 654**	**1 770**	**3 052**
	83 386	**1 770**	**3 052**
At 2022			
Trade and other payables (Note 8)	41 496	–	–
Leases (Note 2)	2 098	2 245	5 490
	43 594	**2 245**	**5 490**

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.

30. 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**
2023				
Current assets				
– Offshore cash and bonds	**2 340 515**	**96 483**	**2 244 032**	**–**
– Equities	**9 565 664**	**9 521 211**	**44 453**	**–**
– Short duration bonds	**5 353 666**	**3 307 325**	**2 046 341**	**–**
– Flexible fixed income bonds	**9 719 048**	**8 552 258**	**1 166 790**	**–**
– Property	**661 577**	**661 577**	**–**	**–**
– Money market instruments	**5 229 427**	**1 662 848**	**3 566 579**	**–**
– Derivative financial instruments	**65 826**	**–**	**65 826**	**–**
	32 935 723	**23 801 702**	**9 134 021**	**–**
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	–

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.

30. 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:

R'000	Fair value at 2023	Fair value at 2022	Valuation techniques	Observable input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**5 457 163**	5 010 331	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**3 566 579**	4 707 261	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	**44 453**	63 237	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
Derivative financial instruments	**65 826**	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
	9 134 021	**9 819 354**		

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	2023	Restated 2022
Insurance contract liability to future members per Statement of Financial Position	**28 690 246**	28 872 880
Less: cumulative unrealised net gain on re-measurement of investments to fair value	**(1 508 826)**	(1 002 934)
Accumulated funds per Regulation 29	**27 181 420**	27 869 946
Gross annual contribution income	**88 816 184**	79 542 906
Solvency margin = Accumulated funds/gross annual contribution income x 100	**30.60%**	35.04%

At 2023, the Scheme's regulatory capital level of 30.60% (2022: 35.04%) was R5 billion (2022: R8 billion) more than the statutory capital requirement of 25%.

31. 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 to be material or not.

During 2023, 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.

Section 33 (2) of the Act pertains to specific financial requirements applicable to medical schemes and outlines the statutory reserves that medical schemes are required to maintain. However, IFRS 17 provides a comprehensive framework for accounting for insurance contracts, including the recognition, measurement, presentation, and disclosure of insurance contracts. In this context, amounts attributable to future members, as determined under IFRS 17, are not subject to the specific provisions of Section 33 (2) of the Act, and are excluded from the non-compliance testing related to Section 33 (2) of the Medical Schemes Act.

For the year ended 2023 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	**(301 978)**	**(292 395)**
Classic Comprehensive	**(1 462 107)**	**(1 335 117)**
Essential Comprehensive	**(135 661)**	**(120 781)**
Coastal Core	**(359 507)**	**(239 624)**
Coastal Saver	**(514 720)**	**(299 467)**
KeyCare Plus	**(1 275 850)**	**(876 032)**

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 01 December 2022.

31. Non-compliance matters continued

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 01 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.

Duplicate transactions for the same commission month resulted an overpayment to the broker that resulted in the maximum amount payable to a broker being exceeded. The quantification of the overpayment represents less than 0.05% of the total broker fees paid for the year.

In the instances where more than one broker was paid; the value is negligible. 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 instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims are being re-processed 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 two 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.

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 14 identified instances (2022: two) where brokers earned commission on their own health policies after 30 June 2022. These represent less than 0.001% of total broker fees paid for the year. The identified policies were correctly assigned to non-commissionable status and additional quality assurance measures implemented to prevent recurrences in the future.

BINDING FORCE OF RULES

Section 32 of the Act states that the rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.

Rule 7.1.2.2.2 states that the member must pay the requisite contribution in respect of such child as from the first day of the month following the birth or adoption.

The addition of the newborn rule was incorrectly applied on the policy administration system resulting in an additional month of free cover. The incorrect application of the Scheme Rule was based on the incorrect underwriting guideline stating that if the newborn is registered within 30 days, the member's contribution will be up to date.

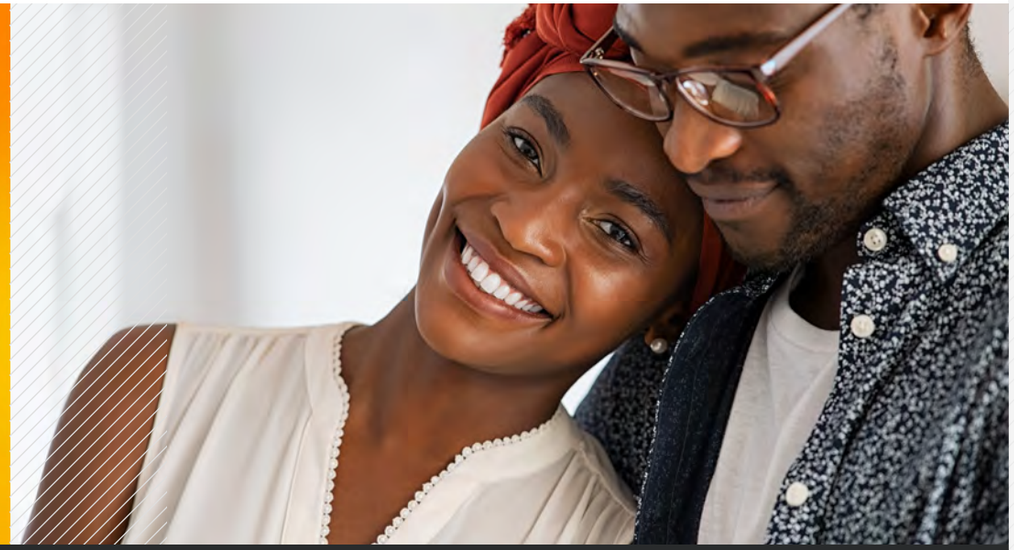
The System rule was updated to align with the Scheme billing rule.

A monitoring and oversight exception report was created (which will validate the date of birth against the cover start date and billing date) and will run for three months post the implementation of the system enhancement.

The value of the uncorrected contributions is negligible.

Resources

SECTION 9



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 / 012 431 0500 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:

Please follow the process outlined on the website

Member support

- Need something? Here's how you can reach us
- Choose the best plan for you and your family
- Plan and benefit information for 2024
- Benefits and cover; understanding your plan
- About DHMS and Scheme Rules
- Medical scheme terminology
- Looking for something else?

IMPORTANT SOURCES OF INFORMATION

We include various useful links below. You may need to log into the website to view some information.

Other information

- The Medical Schemes Act
- The Council for Medical Schemes
- The King IV Report
- The International Integrated Reporting Framework

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[1] 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 request that we investigate your concerns

1 *Deloitte Touche Tohmatsu Limited.*

Discovery Health Medical Scheme registration number 1125

Registered addresses

PRINCIPAL OFFICER
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Sandton
2146

REGISTERED OFFICE
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PO Box 786722, Sandton, 2146

ADMINISTRATOR AND MANAGED CARE PROVIDER
Discovery Health (Pty) Ltd
1 Discovery Place
Sandton
2146
PO Box 786722, Sandton, 2146

AUDITORS
PricewaterhouseCoopers Incorporated
4 Lisbon Lane
Waterfall City
Jukskei View
2090
Private Bag X36, Sunninghill, 2157

PRINCIPAL BANKERS
Rand Merchant Bank, a division of FirstRand Bank Ltd
1 Merchant Place
Corner of Fredman Drive and Rivonia Road
Sandton
2196

Investment managers

Investment managers for the Scheme in 2023 included the following:

ABAX INVESTMENTS (PTY) LTD
Coronation House, The Oval,
1 Oakdale Road, Newlands, 7700

ALLAN GRAY INVESTMENTS (PTY) LTD
1 Silo Square, V&A Waterfront,
Cape Town, 8001

ALL WEATHER CAPITAL (PTY) LTD
9th Floor Katherine Towers, 1 Park Ln,
Wierda Valley, Sandton, 2196

ALUWANI CAPITAL PARTNERS (PTY) LTD
EPPF Office Park, 24 Georgian Crescent East, Bryanston East, 2152

BRANDYWINE GLOBAL INVESTMENT MANAGEMENT LLC
London EC4N 6HL, United Kingdom

FAIRTREE CAPITAL (PTY) LTD
Willowbridge Place, Cnr Carl Cronje Dr & Old Oak Rd, Bellville 7530

FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD
3rd Floor, Great Westerford Building,
240 Main Road, Rondebosch, 7700

MAZI ASSET MANAGEMENT (PTY) LTD
4th Floor North Wing, 90 Rivonia Road,
Sandton, 2196

NINETY ONE SA (PTY) LTD
36 Hans Strijdom Avenue, Foreshore,
Cape Town

155 West Street, Sandown, Sandton

The Arch, 1 Ncondo Place, Cnr Ncondo Place & Ntusi Road, Umhlanga

SESFIKILE CAPITAL (PTY) LTD
2nd Floor, 18 The High Street,
Melrose Arch, Johannesburg, 2076

STANLIB ASSET MANAGEMENT (PTY) LTD
17 Melrose Boulevard, Melrose Arch,
Johannesburg, 2076

TAQUANTA ASSET MANAGERS (PTY) LTD
5th Floor, Draper on Main, 47 Main Road, Claremont, Cape Town, 7708

Acronyms and abbreviations used in this Report

AGM	Annual General Meeting
AOD	Acknowledgement Of Debt
ATB	Above Threshold Benefit
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
EFT	Electronic Funds Transfer
EID	Employee intelligence dashboard
ESG	Environmental, social and governance
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
HQA	Health Quality Assessment
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
NDoH	National Department of Health
NGOS	Non-Government/al Organisations
NHI	National Health Insurance
NHI Bill	National Health Insurance Bill
NomCo	Nomination Committee
OH	Out-of-hospital
PCR	Polymerase Chain Reaction
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
SGM	Special General Meeting
STeFI	Short-Term Fixed Interest
SREC	Stakeholder Relations and Ethics Committee
TCF	Treating Customers Fairly
TEI	The Ethics Institute
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

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Discovery Health Medical Scheme registration number 1125