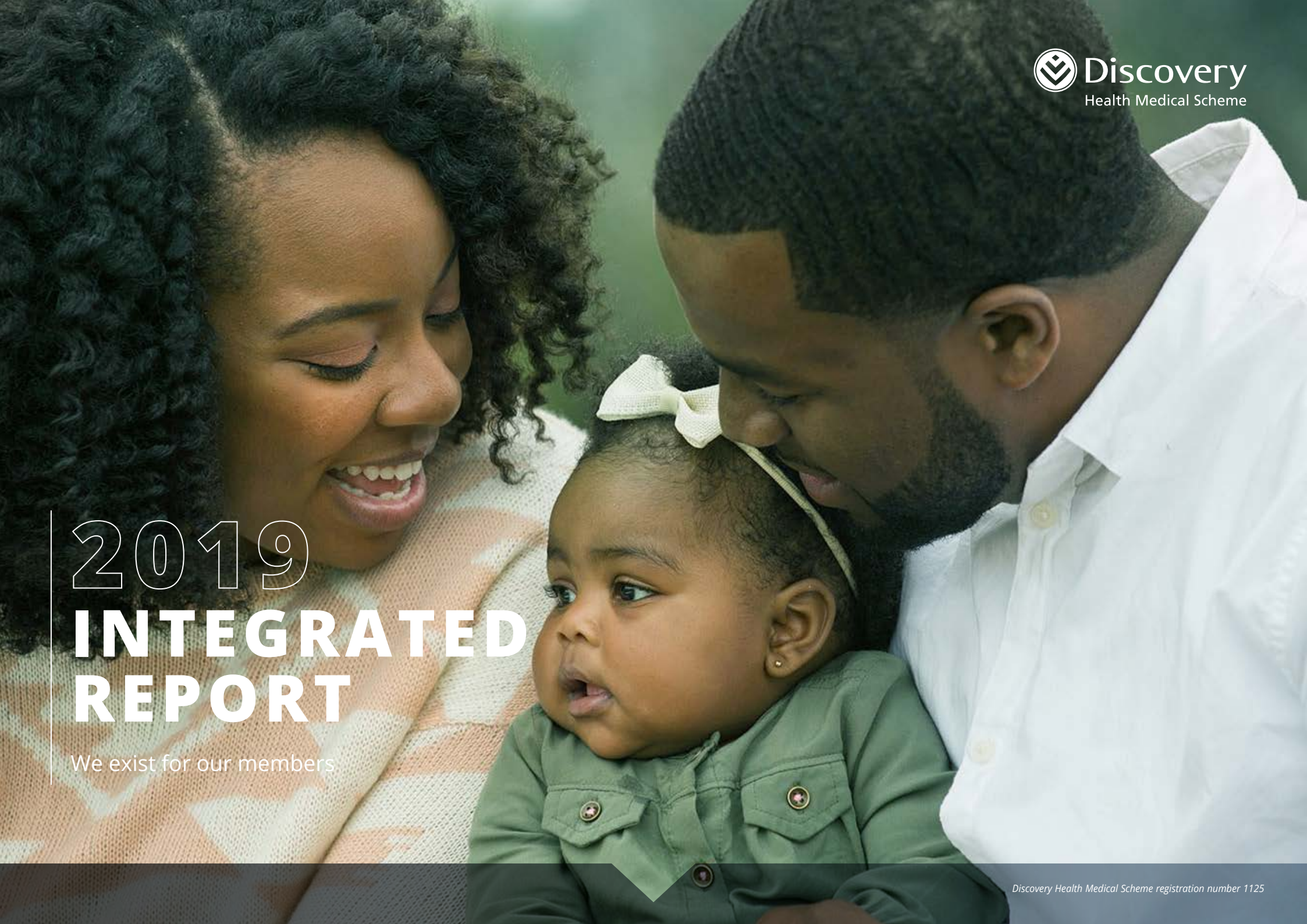

Discovery
Health Medical Scheme

2019 INTEGRATED REPORT

We exist for our members

Discovery Health Medical Scheme registration number 1125

IN THIS REPORT

Why join DHMS? We exist for our members.

We place members at the centre of care and ensure that it is their health outcomes that matter.

We engage in many quality of care initiatives and ongoing monitoring, striving to ensure our members have access to the safest, most efficient and effective healthcare available in South Africa.

In 2019, 87.3% (2018 87.9%) of contributions received were used for the direct funding of healthcare.

DHMS is a non-profit organisation governed by an independent Board of Trustees with robust governance structures and processes to protect members' interests and ensure that the Scheme creates outstanding value for them and our other stakeholders, through our business model.

Our context, material matters, strategy and risks

How we create value for our members is largely determined by our operating context and the needs of all our stakeholders, from which we derive our material matters. These inform the development of our strategic themes and the management of our key risks.

HEALTHCARE FOCUS: CORONAVIRUS

We closely monitor guidance from the National Department of Health and the World Health Organisation and consider this in assessments, modelling and plans in order to formulate our response to the outbreak.

OUR PLACE IN SOCIETY

As an industry leader, we take our corporate social responsibility seriously. We take great care in engaging with all our key stakeholders and partners, including members, healthcare providers, financial advisers, employees and regulatory bodies.

How we measure our performance

The Scheme's financial strength, its ability to pay claims, and its sustainability over the long term, are of critical importance to our members. We monitor key outcomes metrics, and report on a range of other performance factors in addition to providing our full Financial Statements.

INDUSTRY FOCUS: Fraud, waste and abuse (FWA)

Managing FWA saves our members some R1 billion per year. We estimate that this activity has resulted in our members' contributions being 14% lower today than they otherwise would be. Read about the industry inquiry and some examples of FWA behaviour.

The Council for Medical Schemes (CMS)

Our regulator, the CMS, is mandated to protect the interests of all scheme members. DHMS engages regularly with the CMS for guidance, and we participate actively in the industry initiatives undertaken by the CMS.

WE PRICE CONTRIBUTIONS FOR SUSTAINABILITY AND AFFORDABILITY.

In pricing contributions for each year, the Scheme's objective is to ensure sufficient contribution income to pay all claims and to return a modest surplus, required to meet regulatory requirements, and maintain a cushion against unexpected cost increases.

Contribution increases are driven by healthcare inflation, made up of CPI plus tariff increases, utilisation of healthcare services, demand-side factors (such as age, gender, chronic status and anti-selection[1]) and supply-side factors (such as technology and provider driven increases in utilisation).

NATIONAL FOCUS: National Health Insurance (NHI)

The NHI Fund is intended to support South Africa's move to providing universal healthcare. Universal healthcare is a social good and human right, as per the United Nations' Universal Declaration of Human Rights and the South African Constitution, which we fully support in line with our social responsibility mandate. Our position is explained in the FAQs and other views on our website.

1 *In a legislative environment where underwriting is extremely limited, and mandatory membership is not required, medical schemes are prone to anti-selective behaviour by members. An example would be a young family that joins a scheme from pregnancy to shortly after birth, and then leaves the scheme. This disadvantages other members of the scheme who fund the care of a short-term member and do not receive reciprocal contributions.*

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More information in this Report

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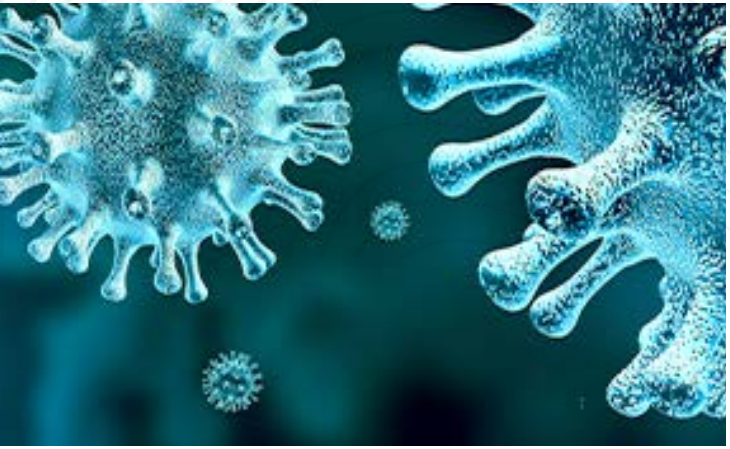
OUR RESPONSE TO CORONAVIRUS



Our overarching concern for 2020 is the impact of the COVID-19 outbreak on the Scheme and our members, our other stakeholders within the healthcare system, and on the people of our country and our economy. We support our government's wide-ranging health and economic measures to mitigate and contain the impact of the pandemic, and will continue working to find ways to contribute to these initiatives.

At the time of publishing this Report, we are monitoring the situation closely and, alongside Discovery Health, we have provided additional support to certain stakeholders to the extent possible. Our priority remains to keep the Scheme stable, financially sound and sustainable, to enable us to continue funding the healthcare needs of all our members.

The extraordinary measures put in place for these unprecedented circumstances have required close consultation with the Council for Medical Schemes. We thank our Regulator for their rapid response and support in caring for our members and the national healthcare system.

Members

Soon after the World Health Organisation (WHO) declared COVID-19 a global emergency and as the first case was diagnosed in South Africa, the Board of Trustees approved the introduction of the WHO Global Outbreak Benefit to fund healthcare services for members diagnosed with COVID-19. In recognition of the economic impact of the pandemic, qualifying members with positive balances in their Personal Medical Savings Accounts can apply to use those funds to pay their monthly contributions for up to three months.

WHO Global Outbreak
Benefit information

In support of the public health measures to reduce community transmission of the virus, the Scheme and Discovery Health have made isolation hotels available to members who are infected with COVID-19 but have mild or no symptoms, and may not be able to effectively isolate themselves at home. These hotels offer access to nursing care, supportive over-the-counter medicine and virtual doctor consultations. Members get a significantly reduced daily rate when staying at these isolation hotels.

Healthcare providers

Many healthcare providers are facing significant challenges with regards to continued practice, and are at high risk of exposure to the virus. The Scheme has facilitated increased virtual consultations to provide support and protection, with higher rates payable to providers for these where appropriate.

Given their high risk of exposure, especially considering that flu season is coinciding with the COVID-19 pandemic, the Scheme is also funding flu vaccines for healthcare professionals that are members of the Scheme. Other measures to support healthcare professionals include up-to-date, evidence-based clinically oriented information on the pandemic provided by Discovery Health through the healthcare professionals' section on the website. In addition, in partnership with experts and professional bodies such as the South African Medical Association, Discovery Health continues to facilitate live webinars and podcasts on the pandemic.

Small- and medium-sized enterprises

Relevant and up-to-date information and support on the epidemic is provided to members and other key stakeholders such as health professionals through various dedicated platforms, including the website and a call centre for member enquiries.

Keeping stakeholders informed

Continually updated information on COVID-19 is made available to members and other key stakeholders.

COVID-19 information
on the website

The Trustees, supported by its Committees and Scheme management, will continue to monitor the impact of the outbreak, and will assess the attendant risks as well as the opportunities to support our members and the healthcare system.

In particular, we will closely monitor the impact on the Scheme's claims, investments and solvency, as well as on healthcare inflation. Board Committees will, in accordance with their mandates, continue to assess the impact on our stakeholders; clinical best practice and risk management; changes required to benefit plan design and any other areas required; and how the economic ramifications of the pandemic will affect the Scheme's investment strategy.

Our Financial Statements include our current assumptions of the impact of COVID-19.

Financial Statements

01
ABOUT
OUR REPORT

Our Integrated Report demonstrates, both in our aspirations and in our performance, the accountability of the Board of Trustees of Discovery Health Medical Scheme to our members and to the Scheme's other stakeholders.

This Report provides an overview of Discovery Health Medical Scheme (DHMS or the Scheme) and a holistic assessment of our governance, business model, strategy, performance and outlook in the context of key risks and opportunities in the South African private healthcare sector. With increasing economic pressure on our members, above-inflation increases in healthcare costs and the regulatory and policy uncertainty that currently characterises the South African healthcare context, this Report sets out the Scheme's efforts to balance the needs and expectations of our various stakeholders. Achieving this balance underpins the Scheme's financial and operational sustainability which in turn, as the largest open medical scheme in the country, supports the overall capacity and viability of the private healthcare sector.

Board of Trustees responsibilities and approval

The Board of Trustees (the Board or 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 131 of 1998, as amended, the Scheme Rules, International Financial Reporting Standards, and all additional financial reporting requirements of the Council for Medical Schemes. 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

Neil Morrison
Chairperson

Johan Human
Trustee

Charlotte Mbewu-Sanqela
Acting Principal Officer

8 April 2020

SCOPE AND BOUNDARY

This Report covers the benefit year from 1 January 2019 to 31 December 2019, also referred to as the 2019 financial year (the year). In addition, this Report touches on some events in early 2020 that occurred prior to the date of approval of this Report by the Trustees.

The Scheme takes guidance from the King IV™ Report on Corporate Governance for South Africa 2016 (King IV), the SAICA Medical Schemes Accounting Guide, and uses the International Integrated Reporting Framework of the International Integrated Reporting Council as the basis for preparing and improving its reporting, which is applied insofar as it is relevant and applicable to medical schemes in South Africa.

The Report discusses how we manage our relationships and our resources responsibly. The boundary of the report therefore includes our interactions with entities outside the organisation that underpin our ability to create value for our members and other stakeholders.

In line with our Vested® outsourcing model, the Scheme contracts with Discovery Health (Pty) Ltd (Discovery Health) as its Administrator and Managed Care Provider. Using a specific methodology, the Scheme reviews and monitors the value that Discovery Health delivers to the Scheme and our members. Assessing the value added and work performed by Discovery Health is an important aspect of this Report.

The terms 'the Scheme', 'DHMS', 'we' and 'our' refer to Discovery Health Medical Scheme. The terms 'Discovery Health' and 'the Administrator and Managed Care Provider' refer to Discovery Health (Pty) Ltd.

More about **how we operate**

MATERIALITY DETERMINATION

The Trustees are responsible for determining and effectively managing the matters that materially impact the Scheme's ability to create value for our members and ensure the sustainability of the Scheme over time. The Trustees review material matters formally on an annual basis.

The Trustees scan the broader environment and consider Board and Scheme Office reports, the Scheme's risk register, and product and benefit enhancement opportunities to determine material matters. Both formal (stakeholder engagement activities) and informal (emails and calls to the Scheme) stakeholder feedback is also considered. Where appropriate, the Trustees adapt the Scheme's strategic objectives to ensure that all material matters are considered in implementing the Scheme's strategy.

Material matters for the year

How we **create value** for our stakeholders

Our business model

How to submit a **complaint or compliment**, **report fraud or unethical behaviour**, and how to give feedback on this Report.

COMBINED ASSURANCE

The Scheme uses a combined assurance model based on three lines of defence:

- **First line:** Scheme management provides the Trustees with assurance that risk management is integrated into the day-to-day running of the Scheme and that it is monitored on an ongoing basis.
- **Second line:** the outsourced Group Risk Management, Compliance, and Forensics 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, external audit and an independent actuarial firm.

Scheme management prepares the Integrated Report. Following a detailed review, the Audit Committee recommends the Integrated Report to the Board for approval. External auditors provide independent assurance of the Financial Statements.

AUDITOR INDEPENDENCE

PricewaterhouseCoopers Inc have audited the Scheme's Financial Statements. Rotation of the designated partner forms part of the independence assessment. The Audit Committee is satisfied that the auditor is independent of the Scheme.

Details of fees paid to the external auditors for audit and non-audit services 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 have been disclosed to, and agreed with, the Audit Committee.

02
ABOUT DHMS

- **Scheme Rules**
- **The Medical Schemes Act**
- **The CMS website**
- **A snapshot of the Scheme** and the **key stakeholders in our world**

1 *Medical Schemes Act 131 of 1998, as amended.*
2 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 June 2019 (www.medicalschemes.com/Publications.aspx).*

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules.

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

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd through a formal contractual arrangement.

Covering
2 808 106
BENEFICIARIES
at 31 December 2019

DHMS is the
LARGEST OPEN MEDICAL SCHEME
in South Africa

With an open medical scheme
MARKET SHARE OF
56.7%[2]

Why join DHMS?

Quality of care is key to our membership proposition

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

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

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 Administrator and Managed Care Provider, and the industry to shape an inclusive and complete healthcare system in South Africa.

The Scheme's support of Discovery Health's shared value model, which engages stakeholders in working together towards better healthcare access and affordability, also contributes to positive regulatory reform and extends the Scheme's influence in driving beneficial change in our sector.

We'll be here for you

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

Key outcomes metrics for ensuring the Scheme's sustainability

We make sure your investment in membership takes care of you

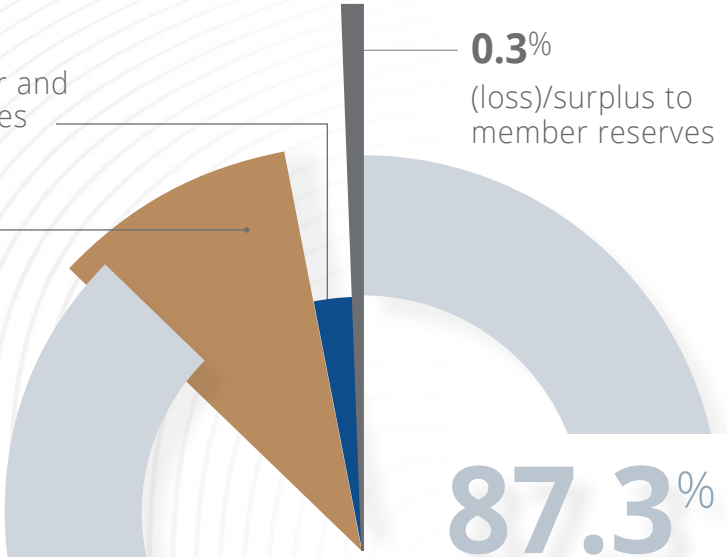
The Scheme's income is derived only from member contributions and investment returns. The Scheme pools all contributions to fund members' claims, and any surplus funds are transferred to Scheme reserves for the security and benefit of members.

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

A portion of DHMS's 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 reserves and these activities, the Scheme's entire income is used to fund claims.

2019 EXPENSE BREAKDOWN



Our Chairperson's Statement

The slow growth of medical scheme membership[1] is evidence of the mounting economic pressure on South Africans. Unemployment has risen and living costs are squeezing disposable household income. The priority for the Trustees is therefore to maintain affordable member contributions in the face of a growing burden of disease, aging Scheme population, the introduction of new technologies and increasing demand-side utilisation.

In this challenging environment, DHMS continues to enhance risk management initiatives aimed at meeting the care needs of our members at the most affordable cost possible. Notwithstanding the pressures, the Scheme delivered an operating result above our forecast for 2019. In addition, the Scheme continues to pursue opportunities that allow us to extend benefits for members. With this objective in mind, the Scheme enhanced medicine benefits and introduced a mental health management programme in 2019. We also enhanced our screening and prevention benefit for 2020.

Our commitment to being there for our members has guided our response to the outbreak of COVID-19. In early March 2020, the Trustees approved the WHO Global Outbreak Benefit to support members who become infected, as well as putting other measures in place to support certain stakeholder groups insofar as we are able. Discovery Health has actively collaborated with the National Department of Health, the National Institute of Communicable Diseases and private sector stakeholder forums convened in response to the outbreak. We have launched an extensive communication campaign aimed at all our stakeholders.

More about our **response to COVID-19**

The prevalence of fraud, waste and abuse (FWA) is currently a topic of much concern and alarm in the medical schemes industry. Discovery Health's investment in and efforts to curb its incidence, and recover funds for our members, are of significant value to the Scheme. We estimate that our efforts to combat FWA activity have resulted in our members' contributions being 14% lower[2] today than would otherwise be the case.

More about **fraud, waste and abuse**

In the past year, allegations of industry-wide racial discrimination, related to the combatting of FWA, resulted in the CMS launching an investigation into complaints in relation to Section 59 of the Medical Schemes Act. This legislation empowers schemes to recover funds and other losses due to fraud, theft, negligence or other misconduct. The Scheme, together with Discovery Health, co-operated fully with the investigation. The Trustees also examined independent assessments of Discovery Health's policies and practices, and reviewed detailed reports on the Administrator's activities. We are satisfied that there is no evidence of racial discrimination. We encourage the authorities to prosecute providers who misappropriate our members' money.

Our commitment to being there for our members has guided our response to the outbreak of the novel coronavirus, referred to as COVID-19. In early March 2020, the Trustees approved the WHO Global Outbreak Benefit to support members who become infected.

The Scheme welcomed the publication of the final Health Market Inquiry (HMI) report. The report has provided recommendations for addressing the fragmented private healthcare sector, creating a cost-effective private healthcare sector, and implementing the medical schemes regulatory framework more comprehensively. As a first step, we are participating in the work of Health Quality Assessment (HQA) as it expands its measurement of health quality to include providers, in its interim role towards the establishment of an independent Outcomes Monitoring and Reporting Organisation (OMRO).

1 *Source: CMS Annual Report 2018/19.*
2 *Taking into account the last seven years.*

Our Chairperson's Statement *continued*

The Scheme supports the aim of universal health coverage to give all South Africans access to a standard level of healthcare. In our NHI submission, we emphasised that contributing to the NHI Fund need not and should not preclude the choice to maintain comprehensive private medical scheme cover, as opposed to cover that is only complementary to the NHI. The Scheme will continue to engage with the National Department of Health and the parliamentary process, in support of the objectives of NHI while also protecting the interests of our members.

Our constructive engagement with the CMS, our primary regulator, continues as a matter of course. During the year, the Scheme engaged with the CMS on Scheme Rules, benefit plans, and the Primary Healthcare (PHC) and Prescribed Minimum Benefits (PMBs) frameworks. The Scheme will also continue to participate in discussions on the development of a Low-cost Benefit Option (LCBO) framework, which if implemented will expand access to medical scheme cover to low-income households.

Every year, the Trustees conduct an independent assessment of the value delivered to the Scheme and our members by Discovery Health in providing Administration and Managed Care services to the Scheme. For every R1.00 spent by DHMS on administration and managed care fees in 2018, the Scheme received value of R2.12 (2017: R2.02)[1]. We recognise Discovery Health's market-leading innovation and service capabilities and thank them for their continued excellence, transparency and accountability to the Trustees.

Value for money provided by Discovery Health

In 2019, the Board of Trustees reviewed our governance structures to identify opportunities for efficiency and cost saving. We dissolved the Non-healthcare Expenses (NHE) Committee as its workload was relatively small outside of contractual re-negotiation periods with Discovery Health. The NHE Committee's responsibilities were apportioned to other Board Committees as appropriate; primarily the Risk, Audit, and Stakeholder Relations and Ethics Committees.

In 2020, the first terms of two elected Trustees, Adv Joan Adams SC and Dr Susette Brynard, come to an end and elections will be held to fill these vacancies. We also said farewell to Independent Committee Members Ms Phililе Maphumulo (who served as a Member on the Audit, Risk and Investment Committees), Mr Barry Stott (who was Chair of the Audit and Risk Committees and a Member of the Investment Committee) and Mr Steven Green (who was a Member of the Audit and Risk Committees). On behalf of the Board, I thank them all for their diligence, care and expertise in service to the Scheme.

We welcomed two new Independent Committee Members, Mr Eric Mackeown, who has been appointed Chair of the Audit Committee and Member of the Risk and Investment Committees, and Dr Alewyn Burger, appointed to the Audit and Risk Committees, who joined us at the start of 2020.

We also welcomed Ms Lusani Nelufule-Mugivhi to the Scheme Office team as our new Head of Compliance and Governance. Ms Nelufule-Mugivhi is an admitted attorney of the High Court of South Africa with extensive experience both in practice and as an in-house counsel. We have great confidence in her abilities and wish her well at the Scheme.

On behalf of the Trustees, I thank Dr Nozipho Sangweni, our outgoing Principal Officer for the passion and diligence she brought to the role. We wish her well in her future endeavours. The Board appointed Ms Charlotte Mbewu-Sanqela, the Scheme's Chief Financial Officer, to the position of Acting Principal Officer. We thank Ms Mbewu-Sanqela for her willingness to take the helm during this transition period and are confident that her experience will benefit the Scheme.

> The Scheme continues to enhance existing and develop new risk management initiatives aimed at meeting the care needs of our members at the most affordable cost possible.

Finally, the Scheme could not continue to operate effectively without the Scheme Office team, Independent Committee Members and Trustees. My thanks to you all for your dedication to discharging the responsibilities our members entrust to us, with due care and unfailing diligence.

N Morrison
Chairperson

1 *As the assessment uses industry information, results are only available for the preceding year.*

Our operating context

The CMS was established through the Act to regulate registered medical schemes and to protect the interests of scheme members, among other objectives. The registration of medical schemes is subject to compliance with the provisions of the Act and the promotion of public interest.

The CMS is responsible for, among other things, ensuring that:

- Medical schemes are financially sound, with a sufficient number of members contributing to them.
- Schemes do not unfairly discriminate against any person on arbitrary grounds.

The CMS interacts frequently with the industry and publishes regular circulars to guide medical schemes on interpreting and implementing the Act. It also 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, and undertakes vetting of trustees and principal officers[1].

The CMS accredits medical scheme administrators and managed care providers, as well as the financial advisers who provide advice to the public on private healthcare cover. All fees paid by medical schemes to financial advisers are prescribed by the Minister of Health.

All medical schemes in South Africa are non-profit entities that operate in a complex, changing and tightly regulated sector. Schemes price their benefit plans for the following year based on industry factors, utilisation of healthcare services, financial performance, and financial and actuarial forecasts. Pricing contributions is a function of balancing affordability with other imperatives. These include holding sufficient reserves to weather times of economic difficulty and unexpected claims, making provision for increased utilisation and escalation in the cost of treatment, optimising benefits, and equitable treatment of all scheme members.

An incomplete regulatory framework also affects the pricing of contributions. Medical schemes operate under the principle of social solidarity: schemes must accept all members who wish to join; members are community risk rated so there is no differentiation of pricing based on, for example, the status of individuals' health; and members' funds are pooled to provide healthcare funding for members in an equitable manner. However, other key elements of a social solidarity framework such as mandatory membership and risk equalisation have not been implemented.

At the end of 2018 there were 81 medical schemes registered with the CMS, consisting of 21 open schemes and 60 restricted schemes, covering over 8 916 000 beneficiaries. These schemes paid out approximately R173.3 billion in total healthcare benefits[2] in 2018 (2017: R160.5 billion). The average age of scheme members in 2018 decreased by 0.1 years to 33.1 from 33.2 in 2017, and the proportion of pensioners increased to 8.5% from 8.4%[3]. Aging scheme membership and stagnant membership growth, reflecting economic and demographic trends, are factors that have been evident over several years, with negative implications for cross-subsidisation within scheme risk pools and for the industry as a whole.

DHMS acknowledges the important part we play in South African society and our responsibility as a corporate citizen, given our leading share of the open schemes market of 56.7%[4]. Through our Administrator and Managed Care Provider, Discovery Health, and in partnership with healthcare providers, we strive for a seamless integration of services, quality care for our members, and cost efficiency in the context of a fragmented and inflationary healthcare system. This fragmentation has a significant impact on health outcomes as healthcare providers frequently operate in silos, which means private healthcare consumers experience barriers to integrated health information, difficulty in navigating the healthcare system and poor co-ordination of care across disciplines and processes. The development of managed care programmes that target specific conditions, supported wherever possible by innovative reimbursement mechanisms, serve to reduce fragmentation and improve cost management, making this an essential way forward for our industry and for the healthcare sector as a whole.

More about how we partner with **healthcare providers**

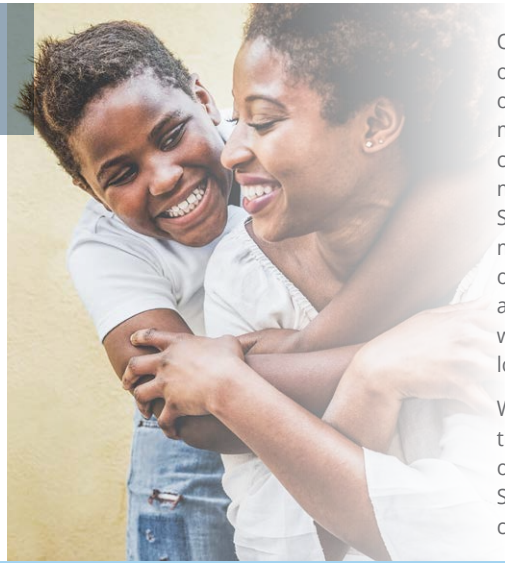
The Scheme works closely with regulatory authorities, including the National Department of Health, as necessary. Engagements in the past few years related to Prescribed Minimum Benefits, primary healthcare and Low-Cost Benefit Option reforms by the CMS, proposed amendments to the Medical Schemes Act, the development of National Health Insurance (NHI) and the Competition Commission's Health Market Inquiry (HMI) into private healthcare in South Africa.

More about **our regulatory engagements**

1 *In addition to the process undertaken by the Scheme's Nomination Committee in respect of nominated trustees.*
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 for industry information: CMS Annual Report 2018–2019 (www.medicalschemes.com/Publications.aspx), which does not include data for 2019.*
4 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Reports for the Period ending 30 September 2018 (www.medicalschemes.com/Publications.aspx).*

Our material matters

The Scheme's material matters are the most important factors affecting our ability to create sustainable value for our members and other stakeholders, and which underpin the financial, operational and reputational wellbeing of the Scheme in a complex operating environment. The material matters are the overarching context for ongoing Board discussions and are formally reviewed by the Trustees on an annual basis.



Our material matters are informed by our risks, opportunities and strategic objectives, and the key concerns of our members and other stakeholders. With careful management, our material matters present opportunities for the Scheme to create value for our members, differentiate our service offering, protect our market position and enhance our reputation – all of which contribute to the Scheme's long-term sustainability.

We exist for our members, which puts their health and wellness at the heart of what is most important for the Scheme. To ensure that we can continue to fund the healthcare needs of our members, Scheme sustainability 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 the prevalence of fraud, waste and abuse in the sector.

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

MEMBER NEEDS

- Balancing our membership's health, wellness and access needs with quality of appropriate care imperatives and affordability, in the face of medical inflation well in excess of CPI.
- Promoting a patient-centred, value-based healthcare model and reducing fragmentation and variability in the quality of care.
- Empowering our members to participate actively in their healthcare, leveraging digital health platforms and tools.
- Deterioration of population health and an aging membership base, resulting in high levels of utilisation and increasing costs, together with the longer-term impact of climate change on health.

ETHICAL BUSINESS AND KEY STAKEHOLDERS

- The need for proactive and inclusive engagement to support the quality of key stakeholder relationships.
- Stakeholders' misperceptions of the Scheme constraining the achievement of strategic objectives.
- Ethical leadership, fairness and social responsibility towards a better society.
- The impact of inadequate governance and controls in the broader business and political environment.

MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- The future of private healthcare in South Africa, including opportunities to innovate, compete effectively and support the journey towards universal healthcare
- Regulatory complexity affecting member protection, the delivery of quality healthcare, affordability and social solidarity.

THE VESTED OUTSOURCING MODEL

- Obtaining best possible value from our Administrator and Managed Care Provider through Vested outsourcing, together with best practice governance and oversight.
- Benefiting members through innovation, efficiency and excellence.

DIFFICULT ECONOMIC CONDITIONS

- Slow economic growth, increasing cost of living and rising unemployment exacerbated by the reduction of available jobs in the formal sector, potentially increasing the burden on the public healthcare system.
- The impact of the COVID-19 outbreak on the South African healthcare system as well as the economic environment.
- The impact of slow or stagnant membership growth on Scheme stability and sustainability.

Mitigating our residual risks

The Scheme continually scans the internal and external environment to assess risks and opportunities associated with our strategy, and related to the capitals used and affected by the Scheme in conducting our business. The Scheme is also closely attuned to the highly regulated and ever-changing landscape of both the local and international healthcare industries.

We assess risks according to a Board-approved enterprise risk management framework as well as a risk appetite framework and statement. Risks are rated according to impact and likelihood on a five-point scale that ranges from low to catastrophic. The assessment covers the Scheme's dependence on resources and relationships represented by the various forms of capital. This process targets identification of risks capable of negatively affecting organisational objectives, as well as opportunities made available by effectively managing these risks.

Risk responses and mitigation plans are developed and monitored by Scheme management, who conduct regular reviews and report to the Risk Committee, to other relevant Board Committees where appropriate, and to the Board.

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

AFFORDABILITY OF CONTRIBUTIONS AND MEDICAL INFLATION

The risk that contributions to the Scheme become unaffordable due to the impact of demand-side factors (such as age, gender, chronic status, epidemics and anti-selective behaviour) and/or supply-side factors (such as technology and provider-driven increases in utilisation), as well as fraud, waste and abuse, which drive above-inflation increases to healthcare costs.

This risk is exacerbated by a weak economy and wage increases below contribution increases, placing financial pressure on members. Worsening chronic disease profiles in the population also hamper the Scheme's ability to keep contribution rates low, while competing short-term insurance products can discourage people from joining medical schemes and negatively affect schemes' risk profiles.

- Each year, the Trustees critically assess the benefit plans offered by the Scheme to ensure that the full spectrum of member needs are met, within the bounds of affordability and sustainability. Consideration is given to interventions that may lower healthcare costs while ensuring members have access to quality healthcare through value-based contracting.
- The Trustees also satisfy themselves that value for money is obtained from Discovery Health, along with other providers and suppliers.
- Risk management interventions are implemented by Discovery Health on behalf of the Scheme. These include close management of hospital admissions, sophisticated fraud prevention and recovery services, and clinical funding policy design and implementation.
- In keeping with the social solidarity principles according to which the Scheme operates, active marketing and distribution strategies are developed and implemented to attract and retain members to enable effective cross-subsidisation.

More about **healthcare inflation**

Our range of **benefit plans**

Value for money from Discovery Health

COMPLIANCE

The risk of being assessed as not completely compliant with laws, regulations, rules and self-regulated Scheme standards and codes of conduct, including those related to our values and ethics. This may impact the Scheme's ability to operate effectively and efficiently, and may damage our reputation.

- Operating in a highly regulated environment requires extensive controls to ensure ongoing compliance with complex legislated obligations. The Scheme is acutely focused on ensuring compliance in all areas and has appropriate operational, oversight and assurance processes in place.
- Regulatory change is monitored closely and plans are made well ahead of implementation dates to ensure that requirements are incorporated ahead of time.
- Proactive engagement with regulatory bodies provides confidence relating to changes that the Scheme must make, as do discussions regarding changes in progress.
- Active engagement with all industry stakeholders assists in building consensus on effective and enabling regulatory and legislative frameworks.
- Review and interrogation of existing processes to ensure continued compliance and responsiveness to external changes, with independent assessments commissioned as necessary, are undertaken as a matter of course.

Our engagement with **regulatory matters**

Our engagement with **our stakeholders**

POLICY AND REGULATORY CHANGE

Changes in the regulatory environment may have an adverse impact on the operations, competitive advantage, strategy and sustainability of the Scheme. This includes the challenge of navigating a potentially contradictory or incomplete regulatory environment, where reforms currently underway can influence changes to the structure and operating requirements of the industry.

- Regular, detailed and proactive engagement with relevant regulators at all stages of the regulatory change process.
- Proposed amendments are subject to close assessment, including detailed research and analysis regarding potential impact on the Scheme, our members and other key stakeholders, the healthcare industry, and the regulatory framework as a whole, to provide comprehensive submissions. Where appropriate, collaborative submissions are made with industry partners and/or representatives.
- The Scheme's views and positions are developed taking into account input from independent advisers and Discovery Health's extensive policy and regulatory capabilities.
- Participation in public and industry forums, both individually and through industry associations, detailed review of publications and the submission of considered and well-supported responses to support positive change in the sector.

Our engagement with **regulatory matters**

TECHNOLOGY AND INFORMATION

In a world heavily reliant on information technology for storage, communication, business processes and management, the Scheme embraces technology and the beneficial opportunities it presents for members by facilitating access to healthcare and information, as well as by creating better co-ordinated healthcare journeys. Technology, however, brings with it risks of system outages, data leakage or loss, financial loss and business disruption, all of which can impact the integrity and availability of information assets and the security of personal information.

- Robust information security measures enable us to ensure the protection of Scheme information, particularly the personal information of our members. Discovery Health's related systems add a further level of protection.
- Cyber and information risk, including global trends of attacks by malicious third parties, is closely monitored by the IT Governance Forum, consisting of representatives from the Scheme and Discovery Health.
- New processes, systems and controls offering improved risk mitigation are continually assessed and implemented where appropriate.

STAKEHOLDER MANAGEMENT

The risk of inadequate stakeholder engagement and management, resulting in harm to the Scheme's ability to perform optimally, along with our reputation in the eyes of members and other stakeholders, which may ultimately impact sustainability.

- Engaging proactively and frequently with all stakeholder groups to understand their needs and engender better understanding of the Scheme and promote alignment with our objectives.
- The Trustees embrace the Treating Customers Fairly (TCF) principles and framework, and receive regular reports on the performance of Discovery Health on key TCF indicators, as well as other stakeholder engagements conducted on behalf of the Scheme.
- The Scheme conducts ongoing environmental scanning 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 needs, access to healthcare, awareness of quality outcomes, regulatory changes, and the non-profit status of the Scheme.

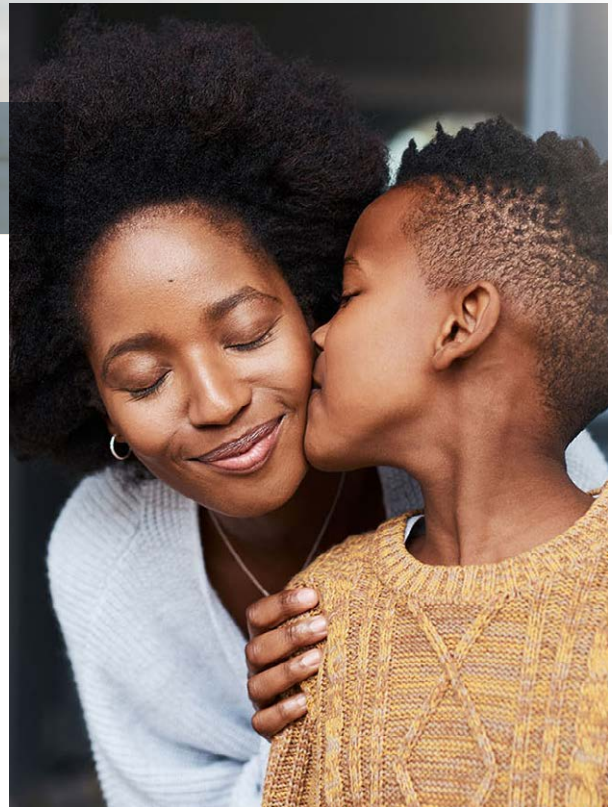
Our engagement with **our stakeholders**

Treating Customers Fairly

Our strategic themes

Our purpose and vision guide the development of the Scheme's strategy. Within this framework of aspirations and objectives, the Scheme's strategy remains adaptive and is tailored to the demands of our operating environment and the evolving needs of our members and other stakeholders, from which we derive our material matters. We continually review internal and external factors, and identify, mitigate and manage the associated risks to ensure the long-term sustainability of the Scheme and optimise value for our members.

DHMS has a holistic view of member value that considers the health and wellness of members, quality of care and appropriateness of healthcare services, together with overall cost efficiency and financial sustainability. The Scheme's limited sources of financial capital (only member contributions and returns on the investment of member funds) requires a careful balancing of the resources required to meet our strategic objectives and the financial sustainability and solvency requirements of the CMS.



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

The Scheme has a fiduciary obligation to maximise investment returns with due regard for the related risks, which requires that we consider issues that can impact the longer-term sustainability of investment performance. The Trustees have adopted a framework for responsible investment that encompasses both strategic and tactical elements while remaining cognisant of legislative requirements.

A formal strategy planning session is held annually. The Trustees and Scheme Office review the material matters, which inform the Scheme's strategic objectives for the coming year. High-level objectives are broken down into work streams, with key performance indicators set to measure progress and assess associated outcomes. Work streams are not necessarily tied to a specific benefit year and may be carried over several years or longer; the lifespan of these work streams depends 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 the relevant Board Committees, according to their terms of reference. The Scheme Office interfaces with these Committees and the Board, and reports regularly on operational oversight and monitoring as well as the mitigation of emerging risks.

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

The strategic themes discussed last year remain largely unchanged, but remain forward looking and have been updated to reflect Scheme priorities and recent changes in our operating context. Our strategic themes respond to our material matters and delivering on the related objectives will help to mitigate our material risks.

Performance against our strategic themes in 2019

CARING FOR OUR MEMBERS

Superior quality of care for members

The Scheme ensures its members have access to quality healthcare by funding healthcare services, technology and products that are scientifically proven to be efficacious and cost-effective. This is enabled by robust health technology assessment and clinical policy development functions provided by Discovery Health's Centre for Clinical Excellence.

In the prevailing environment of unprecedented healthcare innovation, the Scheme has a robust framework for designing pilot programmes and projects to investigate the feasibility of new technological and clinical developments. These are then assessed by the Clinical Governance Committee as potential additional benefits.

Through Discovery Health, the Scheme continues to collaborate with healthcare providers, including clinical societies, hospital providers and all categories of healthcare professionals, to co-develop and implement value-based care initiatives. These are aimed at rewarding healthcare professionals for improving health outcomes and service delivery efficiencies. This is enabled by the wealth of claims and other data collected through Discovery Health's digital platforms such as HealthID and the clinical, actuarial and data capacity of Discovery Health's Strategic Risk Management and Risk Intelligence units. The Scheme also uses global standards for benchmarking quality data and reporting through the Health Quality Assessment, which provides reporting at both industry and Scheme level, facilitating a continual focus on, and improvement in, healthcare quality.

The Scheme is also focused on evidence-based preventative care, demonstrated by the rich prevention and screening benefits available to members. In early 2020, this was expanded to include screening for colorectal cancer as well as an enhanced screening programme for members over the age of 65.

In addition, the Scheme uses population management strategies to identify high-risk members (complex clinical cases with multiple co-morbidities and fragmented care with multiple admissions) who are at risk of sub-optimal care and health outcomes. We place these members into care co-ordination programmes such as the out-of-hospital based Member Care Programme. Other successful care co-ordination programmes include the Advanced Illness Benefit Programme which co-ordinates care of the terminally ill by providing palliative resources outside of hospital, and the provision of facility-based care co-ordinators that ensure appropriate care from acute to sub-acute and rehabilitation centres.

Care initiatives for our members

Lowest healthcare costs

Affordability for members remains one of the Scheme's greatest concerns in an environment of high healthcare inflation, economic pressure and the increasing chronic disease profile of the population. A focus on healthcare costs allows DHMS to keep contribution increases as low as possible while innovative risk management and network strategies reduce out-of-pocket expenses for members.

The Scheme continues to ensure that our range of plans allows sufficient choice to our members, including lower-cost options, and we continue to optimise benefits and plan design.

Using Discovery Health's analytics capability, the Scheme monitors claims cost drivers, utilisation and clinical trends on an ongoing basis, to identify risks early and respond quickly. This includes:

- Price negotiations with pharmaceutical and surgical device companies to ensure our members have access to evidence-based treatment at an affordable price;
- Care management programmes such as DiabetesCare;
- Regularly reviewing new high-cost treatments and diagnostic tools;
- Implementing value-based contracting and other alternative reimbursement arrangements with providers; and
- Fraud prevention and recoveries.

DHMS contributions are lower

Our range of **benefit plans**

Care initiatives for our members

Personalised, predictive and preventative approach

Engaging members in their own care is important to the Scheme, and leveraging data and technology enables us to provide relevant and tailored information to our members. Discovery Health's increasing capabilities in artificial intelligence and big data analytics allow us to continually refine and improve this focus area.

Besides the extensive preventative and health screening benefits we offer, our members may elect to join Vitality[1], a world-leading science-based wellness programme.

Member-centric servicing

Ease of access to excellent service from Discovery Health and healthcare providers – where this can be facilitated by the Scheme – is an ongoing objective. Digital technologies and networks allow the Scheme to provide our members with convenient access to their healthcare providers through video consultations via the Dr Connect platform, as well as other third-party providers partnering on the enhanced Day-to-day Extender Benefit pathways.

Client journeys in 2019

EXCELLENCE IN GOVERNANCE

As a centre of medical scheme excellence, the Scheme Office's core activities are best practice governance and oversight. As such, the Trustees closely monitor the work of the Scheme Office, and Discovery Health, to fulfil their accountability to our members. The Scheme's robust governance structures and processes are compliant with the Act, take guidance from the Companies Act where appropriate, and incorporate King IV principles, recognised as global best practice in governance. 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 reported in the Scheme's Business Model, Performance chapter and in the Governance and Leadership chapter.

In 2018, the Scheme reported that an enterprise-wide ethics risk assessment would be undertaken; this has since been postponed. The Scheme Office's ongoing focus on ethics is supported by an experienced executive responsible for legal and ethics matters. In line with our approach to continual development and learning, additional ethics skills and qualifications are being developed within the Scheme Office and assessments of specific Scheme processes and functions will be carried out.

Our business model

Performance

Governance and leadership

1 *Provided by Vitality, which members may elect to join. Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate science-based wellness programme, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.*

STAKEHOLDER ENGAGEMENT

The Scheme seeks to engage stakeholders on an ongoing basis. In some instances, Discovery Health undertakes stakeholder engagements on the Scheme's behalf; this is overseen by the Scheme Office and the relevant Board Committees.

Our approach and framework for stakeholder engagement, and our engagements with key stakeholder groups, are reported in Creating Stakeholder Value.

Creating stakeholder value

GROWTH AND SUSTAINABILITY

The Scheme's growth, demographics, financial strength, ability to pay claims, and sustainability over the long term are of critical importance to our members. The Scheme closely monitors and measures its performance on these and other metrics to ensure that critical performance levels are met.

Scheme performance

ACTIVE ENGAGEMENT WITH REGULATORY AND POLICY MATTERS

Significant development of the policy and regulatory environment affecting medical schemes and their members is underway. The Scheme continues to monitor these developments and to conduct extensive and detailed work in responding to them, to promote the best outcomes for members. Engagement with the relevant regulators and other stakeholders in this respect pertain to the draft NHI Bill; the HMI's final report and its recommendations; Low-Cost Benefit Options and a relevant framework to govern these in future; the development of a primary healthcare package; the review of prescribed minimum benefits; the further development of a framework to address fraud, waste and abuse in the industry; and an updated solvency framework for medical schemes, among others. The Scheme also continues to engage closely and actively with its primary regulator, the CMS.

Regulatory and industry matters dealt with in 2019

BEST PRACTICE OUTSOURCING AND A FOCUS ON INNOVATION

The Scheme makes use of a best practice outsourcing model, Vested Outsourcing, to govern its relationship with Discovery Health as its Administrator and Managed Care Provider. The performance of Discovery Health against contractually agreed metrics is regularly reported to the Scheme, and the value it delivers to the Scheme and our members is assessed by the Trustees on an annual basis.

How we operate

How we operate

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

In accordance with the Act and the Scheme Rules, the Trustees have appointed an accredited administrator and managed care provider to deliver these services to the Scheme and our members.

We elect to use a single provider as the Trustees believe that an integrated model (as opposed to a fragmented model using multiple service providers) delivers best value for money and optimal efficiency. Based on the measures applied to evaluating the services Discovery Health provides to the Scheme, the Trustees are satisfied that we contract with the best administrator and managed care provider in the sector.

The outcomes our **business model** achieves

Administration and managed care agreements specify the defined and measured outcomes the Scheme expects from Discovery Health. Service level agreements set out performance expectations across a wide range of measures. Discovery Health reports formally to the Scheme on these contractually agreed key performance indicators on a monthly, quarterly and annual basis. In addition, Discovery Health raises any operational or strategic concerns with the Scheme Office.

Discovery Health provides leading capabilities to our members, including initiatives to combat fraud, waste and abuse.

Robust relational governance practices underpin the Scheme's relationship with Discovery Health. From time to time, the Board will commission independent assessments of these practices, benchmarked against local and international governance practice, contracting principles, independence requirements, and the ability to meet members' needs. These assessments provide the Trustees with assurance that the Scheme is applying best practice in governing this outsourced relationship, and any areas identified for improvement are actively implemented and monitored.

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 the best outcomes.

We use the Vested outsourcing model to govern our working relationship

The Vested outsourcing model aligns the transactional and relational governance elements of this relationship with global outsourcing best practice.

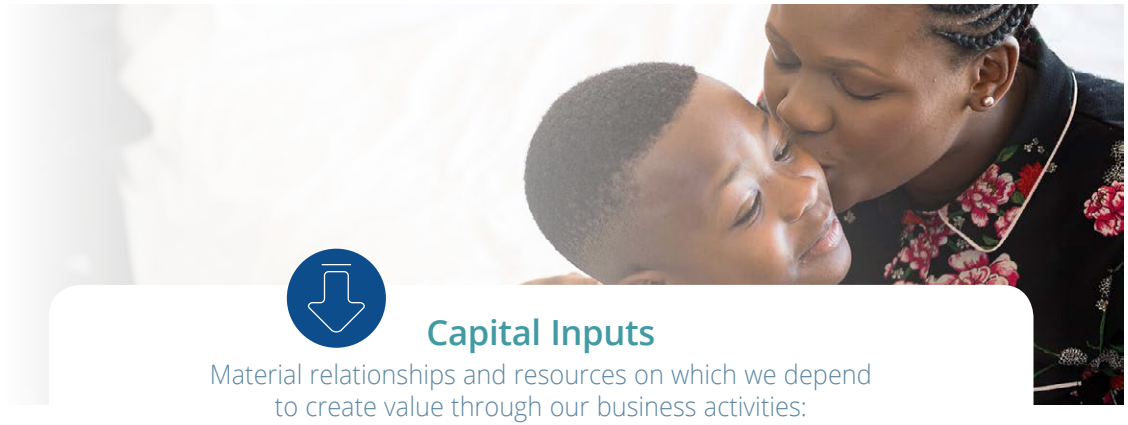
The principles of the model strengthen the strategic alignment between organisations and encourage a value-driven relationship. In effect, Vested frees both organisations to do what they do best by contracting for results and not activities – which allows for innovation, improved service and continuous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

With respect to the Scheme's relationship with Discovery Health, the Vested model operationalises the Scheme's governance and oversight role and embeds its independence. It also allows 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 Relationship Management and Innovation Committees, which are mandated to monitor, review and improve the relationship and the innovation that the Vested model promotes.

The commercial arrangements and scope of the agreement that give effect to the integrated (single provider) model and these Vested principles provide the certainty that Discovery Health needs to be able to invest significantly in innovation and new technologies. It also means that both organisations can take a longer-term view in driving positive changes to the healthcare system, which in turn supports the outstanding value we strive to deliver to our members.

> The Vested model operationalises the Scheme's governance and oversight role and embeds its independence.

Our business model



The Scheme exists for the benefit of our members, and we place them at the centre of care, as expressed in our purpose and vision.

Sustaining the Scheme's financial, operational and reputational wellbeing ensures our ability to continue funding quality healthcare for individual members, which requires equitable consideration of the interests of our whole membership base. As a funder that connects our members into the private healthcare value chain, the quality of our relationships with all our stakeholders is essential to how we create sustainable value for our members in line with our purpose, and to realising our vision of market leadership in a better healthcare system.

The Scheme's business model, shown on these five pages, ensures effectiveness and efficiency in fulfilling our purpose and realising our vision.

The business model depicts our material and capital inputs; this excludes manufactured and natural capital as these are not core inputs. However, given its potential impact on population health, climate change is considered a longer-term emerging watchlist item. The business model also sets out the value outcomes of our propositions to each of our key stakeholder groups, which in turn secure access to inputs.

Capital Inputs

Material relationships and resources on which we depend to create value through our business activities:

FINANCIAL CAPITAL

The Scheme's income is derived only from member contributions and investment returns.

- Member contributions of R69.9 billion (2018: R64.6 billion).
- Investment income of R1 698 million (2018: R1 512 million) generated from members' funds.

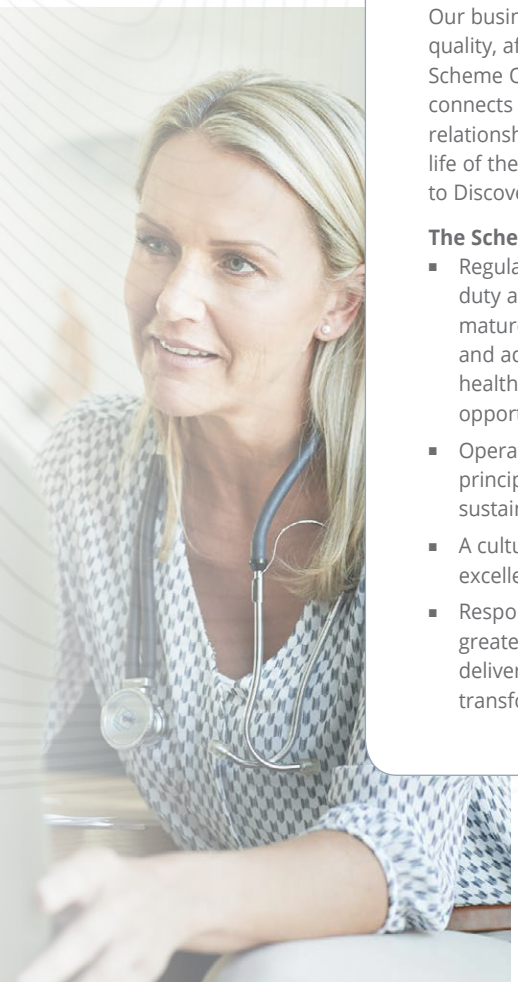
SOCIAL AND RELATIONSHIP CAPITAL

- Maintaining our social licence to operate in the best interests of our members.
- Attracting and retaining a substantial membership base.
- Maintaining collaborative partnerships with all our stakeholders.
- Balancing the need for constructive relationships with our Vested outsource partner and other suppliers, with our oversight role.
- Reputation as a stable and accessible medical scheme with integrity.
- Reputation as a responsible and involved corporate citizen.
- Supporting healthcare reform towards an effective and equitable healthcare system.

HUMAN AND INTELLECTUAL CAPITAL

- Skilled, knowledgeable, independent Board of Trustees accountable for effective oversight and delivery of the Scheme's mandate.
- Mature governance framework, processes and structures.
- Effective, efficient and agile business model with optimised outsourcing.
- 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.

BUSINESS ACTIVITIES



Business Activities

The Scheme's business model centres on delivering excellence in our core activities, which are primarily effective medical schemes governance, oversight and thought leadership.

Our business is to enable funding for and access to quality, affordable healthcare for our members. The Scheme Office manages the Scheme's resources and connects and co-ordinates the stakeholder relationships that give effect to the operational life of the Scheme and the work outsourced to Discovery Health.

The Scheme Office has a specific focus 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.
- A culture of learning that acts as a catalyst for excellence in all areas of the business.
- Responsible corporate citizenship: we support greater quality, efficiency and value in healthcare delivery, healthcare system reform, and transformation in South Africa.

Activities supporting excellence

SET STANDARDS FOR EXCELLENCE

- Vested outsource partner oversight, and performance and customer management
- Terms of reference, policies and procedures

EXECUTE FOR EXCELLENCE

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

Continuous learning and improvement

MONITOR AND REPORT FOR EXCELLENCE

- Clinical governance compliance
- Stakeholder requirements
- Risk management
- Legal risk and compliance
- Financial reporting compliance
- Investment asset performance
- Regulatory compliance
- Product development

EVALUATE AND REFINE FOR EXCELLENCE

- Standards
- Execution requirements

VALUE OUTCOMES

Value Outcomes

The sector leadership contemplated in our vision is served by not only satisfying the needs of our members and other stakeholders, but by exceeding them. Value created for our key stakeholders through our business activities:

MEMBERS AND EMPLOYER GROUPS

The Scheme provides members and their families with access to the highest-quality healthcare at every stage of their lives, at the lowest possible cost.

Quality and value-based healthcare

- Better health outcomes achieved through a value-based approach to partnering with providers, a focus on efficiency and quality of care, the ongoing development of managed care programmes, innovation and integration.

Discovery Health's **initiatives for the Scheme**

Affordability

- Average contributions for our members in 2020 are 16.7% lower than the next eight largest open medical schemes.

Value for money

The Trustees conduct a formal evaluation of the value for money Discovery Health provides to the Scheme every year. The results are expressed as the value added by Discovery Health for each rand paid to it. Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2018, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.12 (2017: R2.02) in value from the activities of Discovery Health[1]. This is equivalent to nominal added value of R7.34 billion in 2017 (2017: R6.24 billion).

2018: **R2.12** | 2017: **R2.02**[2] | 2016: **R2.00** | 2015: **R1.85** | 2014: **R1.73**

Our members benefit when our Administrator and Managed Care Provider adds more value than the fees paid to it by the Scheme. The value for money 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 eight open schemes.

Our contributions are lower

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the latest results were reported to the Trustees. The assessment takes account of value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members, any additional services offered, and innovation.

The Scheme engaged Deloitte to review the reasonability of the data, revised methodology and results. Deloitte concluded that the methodology is appropriate, that the increase in value added from 2017 to 2018 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed.

1 *As the assessment uses industry information, results are only available for the preceding year.*
2 *Discovery Health's value-adding initiatives for the Scheme constantly evolve, and new initiatives that have proven their value-add are included in the calculation, which was the case for the 2018 calculation. Applying this updated methodology for 2017, the figure would have been R2.09 value received by the Scheme for every R1.00 spent.*

VALUE OUTCOMES continued

Value Outcomes *continued*

MEMBERS AND EMPLOYER GROUPS

Value of benefits[1]

- On average, **R1 651 per beneficiary** collected in risk contributions each month. Members receive substantial value in terms of their healthcare benefits, when they need to claim. For instance, the largest hospital claim made would require 326 years of contributions by the member to cover that single claim.
- **R59.5 billion paid in claims including, on average:**
  - **R5 052 per beneficiary** with a chronic condition (697 769 beneficiaries)
  - **R46 538 per admission** (668 767 hospital admissions)
  - **R97 229 per beneficiary** undergoing oncology treatment (39 436 beneficiaries)
- **16.1% of beneficiaries** claiming more than their contributions.

Plan choice

- Our full spectrum of **23 plan options** offers our members sufficient choice to meet their medical and financial needs.

Service

- Member perception score of **8.77 out of 10.**
- Service metrics exceed international best practice benchmarks[2]:
  - Customer effort score of **72% vs 47%**
  - Member-based feedback score of **89% vs 64%**
  - First call resolution score of **80% vs benchmarks of 65%** for digital assistance and **75%** for telephonic assistance

Digital capabilities[3]

- The member app gives our members easy access to their health plan information, and provides seamless access to high-quality medical information via Dr Connect. Approximately **56 000 members** have downloaded DrConnect, with around **7 686 unique member** logins each month.
- HealthID, the only comprehensive payor electronic health record in South Africa, allows members to consent to the sharing of their health records with their doctors, improving quality of care and reducing administration for doctors. An average of **2 025 doctors** regularly used HealthID in treating our members during 2019, and **2.37 million members** have given their doctors consent to access their records on HealthID.

Sustainability

- Largest open medical scheme, with **2 808 106 beneficiaries** and **56.7% market share.**
- Favourable demographics, with an **average age of 35.33** and a **pensioner ratio of 10.35%** (versus 35.8 and 11.4% respectively across all other open medical schemes[4]).
- Financial strength, with **R19.2 billion in member funds**, a **27.5% solvency level**, and an AAA credit rating confirming the Scheme's ability to meet large, unexpected claim variations.

Full Scheme **performance information**

1 Note: All figures for the period October 2018 to September 2019, 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 2019.
2 Compared with benchmarks from the NTT 2020 Global Customer Experience Benchmarking Report (previously branded Dimension Data), which was published on 17 April 2020, based on data obtained in 2019.
3 For members of all schemes administered by Discovery Health.
4 Source: CMS Annual Report 2018–2019; values are for 2018.

Value Outcomes continued

FINANCIAL ADVISERS

Financial advisers play a critical role in connecting the Scheme to existing and prospective members, and ensuring their cover is best suited to their health and affordability needs. The Scheme reimburses them for their services according to legislated fees and provides ongoing training and support through Discovery Health.

Engagements with **financial advisers**

EMPLOYEES

The Scheme is committed to protecting the dignity, safety and health of our employees, providing decent work, fair remuneration, training and development opportunities, and treating them equitably and ethically. The Scheme is a diverse workplace with a focus on transformation. Employees' satisfaction with the Scheme's employee value proposition is regularly assessed and informs our people management priorities.

More about **our approach to our employees**

ADMINISTRATOR AND MANAGED CARE PROVIDER

The Vested model focuses on outcomes for the ultimate benefit of our members. Discovery Health is a global leader in healthcare administration and managed care, with a strong reputation for excellent service and innovation. This contractual relationship has allowed DHMS to become the largest open medical scheme in South Africa.

Measured against our competitors:

- High efficiency resulted in **87.3% of contributions** used for members' direct benefit (2018: 87.9%).
- DHMS gross administration expenditure is the seventh lowest out of **21 schemes in the open scheme market** (2018: sixth lowest).
- **94.27% of members** did not change their plan for 2020 (2019: 94.07%), reflecting member satisfaction, stability in benefit design and appropriate pricing.

HEALTHCARE PROVIDERS AND FACILITIES

The Scheme, with the support of Discovery Health, partners with medical professionals and contracts with facilities to meet the challenge of increasing access to quality, cost-effective healthcare services. Our support of Discovery Health's shared value approach to healthcare creates a virtuous cycle in which patients, their doctors and funders work together to optimise the outcomes for each party as well as the broader healthcare system.

More about how **we engage with healthcare providers**

HEALTHCARE SYSTEM AND OUR REGULATORY BODIES

We work with our regulatory bodies and relevant stakeholders, advocating for effective regulatory reform to drive positive change in the healthcare sector; this includes contributing towards health policymaking and amendments to legislation by the Department of Health and CMS.

More about how we **engage with our regulatory bodies**

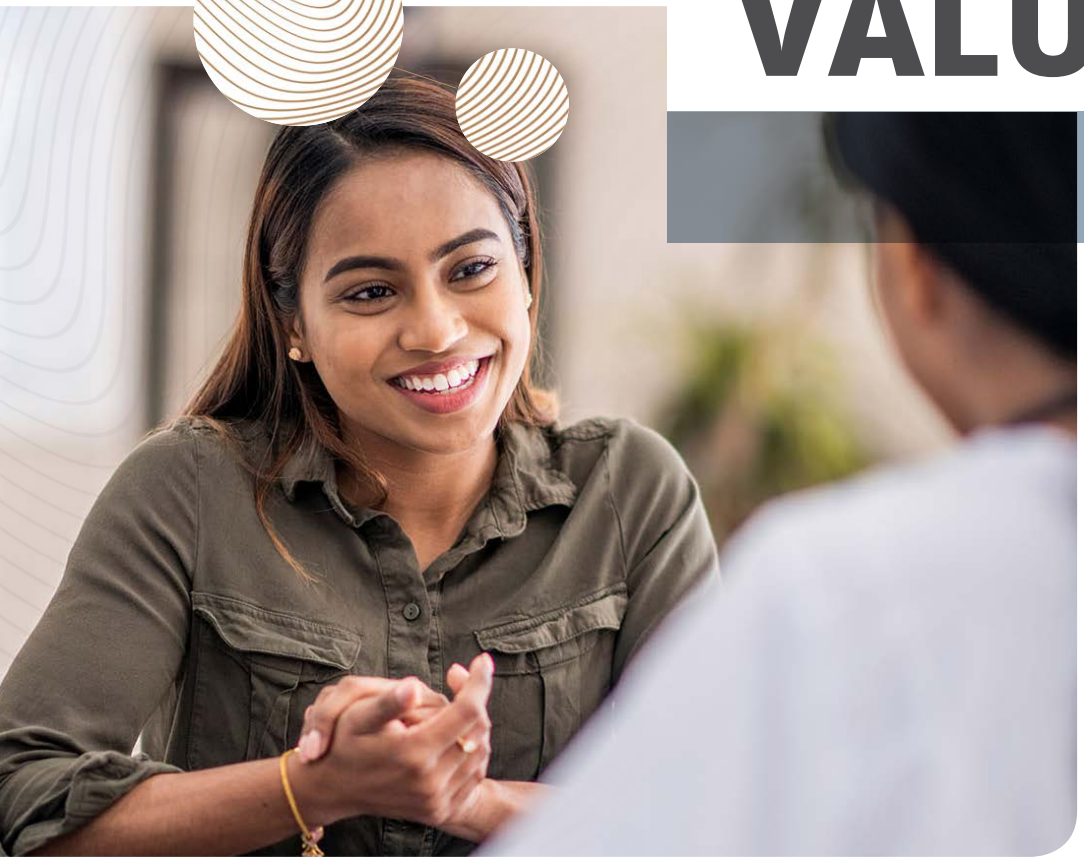
SOCIETY

Private healthcare funding inherently 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 sector. The Scheme seeks to amplify these benefits by working towards an improved healthcare system.

Full **performance** information

03

CREATING STAKEHOLDER VALUE



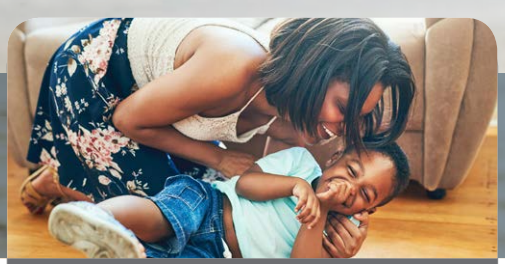
Our approach

The Scheme exists for the benefit of all our members and this guides everything we do. We apply social solidarity principles to balance the needs of individual members with the collective wellbeing of the Scheme.

As a non-profit medical scheme in South Africa, Discovery Health Medical Scheme (DHMS or the Scheme) operates according to social solidarity principles, whereby the Scheme pools member contributions and manages these to fund member healthcare equitably.

The Scheme's commitment to social responsibility, through our corporate citizenship framework, recognises that the support of all our stakeholders and the wellbeing of broader society are essential, both to our licence to operate, and to our ability to achieve the Scheme's purpose and vision.

Ethics, values and culture



The Scheme operates according to the highest ethical standards. Policies set the standard of behaviour expected of our Board of Trustees (the Board or the Trustees) and employees, in areas such as legal compliance, protecting personal information, human rights, employee rights and sound business practices.

These policies are available to all Trustees and employees, and are referenced in employment contracts. Regular assessments are conducted into the effectiveness of the Scheme's governing body; these include considering whether the Scheme's ethics are upheld and identifying any areas of concern.

The Scheme Office has an ongoing focus on ethics, supported by an experienced executive whose portfolio is legal and ethics matters. Last year, the Scheme reported that an enterprise-wide ethics risk assessment would be undertaken; however, this has been replaced by individual ethics risk and opportunity assessments of specific Scheme functions.

Information on King VI

MORAL DUTIES AND ETHICAL VALUES

The Scheme's standards of behaviour are aligned with the outcome of an ethical culture as defined in the King IV Report on Corporate Governance for South Africa 2016 (King IV) and the expectations of the Council for Medical Schemes (CMS), and are articulated in our governance framework.

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.

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

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.

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

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.

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

TEAM WORK, SUPPORT AND CARE
We will support and care for ourselves and others. When working together, we will share the load and work interdependently.

Treating Customers Fairly

The Treating Customers Fairly (TCF) framework is founded in sound business principles and good governance. The Scheme voluntarily embraces the TCF principles and recognises their relevance to the quality of service we provide to our members.

As a registered Financial Service Provider in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS), our Administrator, Discovery Health has implemented the TCF framework.

THE DESIRED OUTCOMES OF TCF:

- Customers must feel confident that they are dealing with an institution where TCF is at the core of their culture.
- Products and services in the retail market which are sold and marketed are designed according to the needs of the customers identified and targeted accordingly.
- Customers are provided with clear information and kept appropriately informed before, during and after point of sale.
- Advice is suitable and according to the customer's circumstances.
- Service is of an acceptable standard and products perform as customers have been led to expect.
- Customers do not face unreasonable post-sale barriers when they want to change a product, switch providers, submit a claim or make a complaint.

TO ASSESS ITS TCF PERFORMANCE, DISCOVERY HEALTH MONITORS:

- Plan movements;
- Opportunities for process improvement;
- Communication, and the completion of interactions, with members;
- The total number and content of complaints received; and
- The perception scores of members, financial advisers, healthcare providers and employer groups.

The Stakeholder Relations and Ethics Committee reviews and considers regular reports on Discovery Health's performance relative to the objectives of TCF.

More about **TCF**

Member Disputes and **CMS Complaints**

Awards

Sunday Times Top Brands

In 2019, DHMS was once again awarded top medical aid in the Sunday Times Top Brands awards. The Scheme's Administrator, Discovery Health, placed eighth for top business overall.

The Sunday Times Top Brands survey measures consumer sentiment towards brands, and this award recognises the strong relationship the Scheme has developed with our members.

Customer Satisfaction Index 2019

In 2019, the Scheme was awarded joint first place in the medical schemes category of the South African Customer Satisfaction Index, a comprehensive national benchmark of customer satisfaction levels in South Africa.

Social responsibility

While the Scheme's non-profit status and governing regulations constrain our investment in specific social responsibility activities, we nonetheless work with relevant stakeholders on improving the effectiveness of the healthcare system in South Africa.

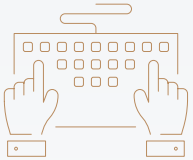
In particular, the Scheme's support of Discovery Health's shared value model – which engages stakeholders in working together towards better healthcare access and affordability, and contributing to positive regulatory reform – extends the Scheme's influence to drive positive change in our sector. This 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.

In line with the requirements of King IV, the Stakeholder Relations and Ethics Committee is mandated to oversee the Scheme's social responsibility. To help it fulfil its mandate, the Committee employs a corporate citizenship framework that is adapted from The Ethics Institute and incorporates King IV requirements[1]. The Committee receives regular reports and presentations on areas covered by the framework, enabling it to monitor progress and provide input on the Scheme's social responsibility activities.

The Scheme considers all items in the framework to be important but, given the nature of the Scheme's business, we prioritise those that are most material to realising the Scheme's purpose, vision and strategic objectives. We also believe that a strategic approach to responsible corporate citizenship must be long-term, as it requires extensive stakeholder engagement and the alignment of organisations and bodies with the intent of the Scheme.

Economy

- *Economic transformation*
- *Fraud and corruption detection and response*
- Broad-based black economic empowerment
- *Responsible and transparent tax practices*

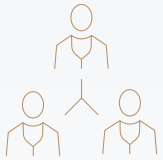


Workplace

- *Employment equity*
- Decent work
- *Employee dignity, safety and health*
- Employee relations
- *Development of employees*
- *Fair remuneration*
- *Organisational ethics*

Natural environment

- Environmental impact
  - *Pollution*
  - *Waste disposal*
  - *Biodiversity*



Social environment

- *Community development*
- Donations and sponsorships
- *Public health and safety*
- Advertising
- *Consumer protection*
- Consumer relations
- *Protection of human rights*

RESPONSIBLE CORPORATE CITIZENSHIP FRAMEWORK

1 *Crane, Matten & Spence (2008); The Ethics Institute material from 2017. Areas specified in King IV are shown in italics.*

Engaging with our stakeholders

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

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. The Committee seeks to ensure that appropriate management and engagement plans are in place while monitoring their effectiveness, and attending closely to the resolution of specific incidents and stakeholder concerns.

As the Scheme's Administrator and Managed Care Provider, Discovery Health conducts some stakeholder engagement work on behalf of the Scheme; this is in accordance with the agreements between the Scheme and Discovery Health. The Committee receives regular reports from Discovery Health on stakeholder engagement and perceptions, supplemented by presentations and discussions on matters of significant concern to the Scheme.

DISCOVERY HEALTH'S STAKEHOLDER ENGAGEMENT ACTIVITIES ON BEHALF OF THE SCHEME INCLUDE:

- Responding to member queries via call centres, e-mail, the member app and website.
- Developing innovative managed care programmes to increase quality of care, decrease fragmentation and control costs for our members and the Scheme.
- Engaging with health professionals to discuss new initiatives.
- Providing training and support to financial advisers on the Scheme's products.

Discovery Health reports to the Scheme on all such interactions and, where necessary, items are escalated to the Scheme Office for its direct involvement.

As we carefully consider the impact of our material matters and risks on our stakeholders, the emphasis of stakeholder engagements changes from year-to-year to ensure that these remain responsive to our operating context as well as our own activities in the healthcare sector. For example, in 2019 the Scheme implemented a day surgery network which required extensive engagement, both with healthcare providers to develop appropriate guidelines and procedure lists, and with facilities to negotiate cost-appropriate contracts.

Our members

We exist for our members, who entrust us with their healthcare funding needs. Keeping this top-of-mind, the Scheme aims to manage long-term affordability of contributions in a challenging economic context with high healthcare inflation, to ensure our members have continued access to private healthcare of the highest standard. Building and maintaining strong relationships with our other stakeholders is fundamental to our ability to achieve these objectives.

One of the Scheme's key strategic priorities is to drive value-based healthcare, a delivery model placing members at the centre of care. In such a model, providers are reimbursed based on health outcomes rather than inputs. This ensures that health results are prioritised over the volume of services delivered, giving our members access to facilities, programmes and providers 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. In 2019, we focused on growing our day surgery network to provide members with access to more facilities that enable them to go home on the same day as receiving treatment.

Find a **network facility** for your health plan

Through Discovery Health, the Scheme is deeply engaged in many quality of care initiatives which are monitored to strive to ensure that our members have access to the safest, most effective and efficient healthcare available in South Africa. The Scheme also empowers our members with information that is relevant to their needs, when they need it.

Discovery Health's infrastructure and member support systems provide a range of engagement options for our members. This includes comprehensive information on the website, which also has virtual agent capability using artificial intelligence to respond to member questions. Members can also make contact via call centre, website, the member app, or by visiting one of five client service centres in South Africa. If being admitted to hospital, members have access to benefit specialists in many hospitals throughout the country who can support and advise them on their plan entitlements, facilitating their healthcare journeys. Members are also able to contact the Principal Officer directly if needed.

These support systems provide members with easy access to accurate information about their benefits, claims and other plan information. The Scheme ensures that our members are continuously 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 option best suited to their healthcare and affordability needs, even as these change.

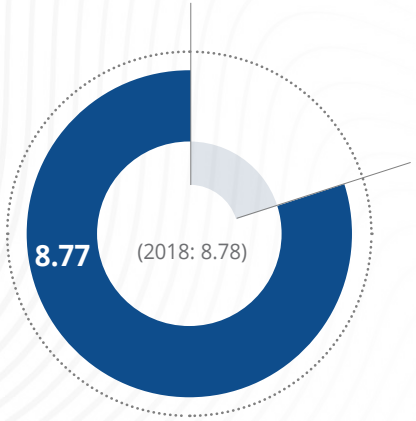
Information is also made available on an ad-hoc basis in response to specific healthcare concerns:

COVID-19 information

Various customer satisfaction and operational metrics are monitored to assess whether our members' service expectations are being met. Dissatisfied members have access to a complaints and disputes process. The escalation process culminates in the option to have a hearing before an independent Disputes Committee in terms of the Scheme's Rule 27. Alternatively, members may choose to take a complaint to the CMS in terms of section 47 of the Medical Schemes Act (the Act).

THE SCHEME MAINTAINED A HIGH AVERAGE MEMBER PERCEPTION SCORE IN 2019:

8.77
out of 10



DHMS has many innovative programmes and initiatives to support members in their healthcare journey:

- More about **our initiatives**
- **Contact us through the website**
- **Contact us through client service centres**
- **Complaints and disputes process**

Measuring member satisfaction

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.

Employer Groups

Many employers offer their employees the opportunity to join a medical scheme as part of their benefit package. Employers can fund membership through a specified subsidy or a structured salary package. Publicly available information suggests that DHMS remains the most popular open medical scheme among employers, with more than 70% of individuals belonging to an open medical scheme as part of an employer group, being DHMS members[1].

Providing employer groups with an integrated health and wellness solution

Discovery Health offers DHMS employers and their employee members a fully integrated corporate health and wellness solution. This includes onsite wellness days for Scheme members where a range of key health metrics are assessed, allowing wellness specialists to identify members at risk and refer them to appropriate care where necessary. It also includes executive wellness screenings and onsite healthcare clinics where required by employers, as well as making Discovery Healthy Company (a proactive, digitally enabled employee assistance programme) available.

IN 2019, ENGAGEMENT ACTIVITIES INCLUDED:

- Corporate wellness days were held to encourage interaction by employer group members.
- Focused service and engagement strategies, tailored to suit workforce servicing needs, were developed with employer groups.
- In a national rollout, the Scheme's product and benefit enhancements for 2020 were presented to key decision makers of employer groups; this was followed by employee training sessions.

In 2020, information regarding **COVID-19** was made available for key stakeholders on the website

1 *Based on annual Global Credit Ratings reports for the seven largest open medical schemes that subscribe.*

Healthcare providers and professional societies

The current environment is characterised by a steady increase in the average age of members and a corresponding increase in members with chronic illnesses. In open schemes like DHMS, these trends are exacerbated by anti-selection and are accompanied by increasing demand-side utilisation. Coupled with supply-side factors, the effect is an unabated escalation in claims costs. This results in member contribution increases that consistently exceed consumer inflation.

On the other hand, healthcare providers find themselves in a fast-paced and rapidly changing health systems landscape, with uncertainty regarding how the proposed changes in national health policy (particularly the National Health Insurance Bill) will impact them. They also serve more empowered patients who wish to actively participate in decisions related to their healthcare needs, and must balance this with the delivery of high-quality, affordable care. Discovery Health and the Scheme seek to partner with and support healthcare professionals to thrive in this dynamic context.

DHMS and Discovery Health have adopted shared value principles to accelerate the development of innovative funding models that sustain medical practice and assure access to high-quality services for Scheme members. A value-based approach to healthcare creates a virtuous cycle in which patients, their healthcare providers and funders work together to optimise the outcomes for each party as well as for the broader healthcare system. The Scheme is aware that effective partnership strategies and support are required to ensure that healthcare providers are actively involved in, and in fact champion, value-based care initiatives.

The Scheme supports the framework employed by Discovery Health to engage with health professionals. This consists of the four pillars of shared value, administration, remuneration, and communication. Ongoing engagements with healthcare providers and professional services include:

- Extensive communication to update health professionals on pertinent Scheme and Discovery Health changes.
- Ongoing engagement with societies and representative bodies in the sector.
- Articles published in medical journals and the press to showcase quality of care improvement initiatives as well as collaboration with doctors.

More about the **National Health Insurance Bill**

Our **NHI FAQ**

Healthcare providers and professional societies continued

Key shared value project activities during 2019

Building on the extensive list of successful shared value projects and benefit innovations implemented in recent years, 2019 saw further gains in enhanced care delivery and cost-efficiency outcomes for all stakeholders. Examples of active new projects include:

ONSITE HOSPITAL BENEFIT SPECIALIST INITIATIVE

Hospital benefit specialists, first implemented in 2016, support the delivery system by making funding decisions pertaining to non-emergency, medical admissions. This initiative has enhanced Scheme member and provider experiences, replacing telephonic benefit authorisation with in-person, on-the-ground interaction at the front desk of the hospital. The accuracy of benefit approval has been shown to enhance the experience of scheme members and the sustainability of the Scheme.

DISCOVERY DAY SURGERY NETWORK

In keeping with our aspiration to address the high costs of healthcare, there is a clear need for medical schemes to consider alternative healthcare delivery models that provide affordable cover, without compromising on quality of care.

Day surgery in an appropriate ambulatory setting has been proven to be clinically safe with exceptional patient satisfaction levels. The use of these centres is backed by evidence and is a widespread global practice. In the US, approximately 84% of all same-day procedures are performed in day surgery centres. In contrast, prior to 2019, only 14% of these procedures were performed at day surgery centres in South Africa. Given the infrastructure limitations, intensive stakeholder engagement and change management required, the launch of the Discovery Day Surgery Network in 2019 has already demonstrated significant gains in increasing access to day surgery treatment for appropriate procedures.

DISCOVERY HEALTH MEDICAL SCHEME (DHMS) NEW DIABETES PROGRAMME

In November 2019, Discovery Health launched a new focused diabetes care capitation initiative to supplement the existing Premier Plus Chronic Disease Management Network. Discovery Health engaged extensively with diabetes doctor groups to better understand the nuances and individual needs of various practices caring for diabetic patients. Numerous operating models and approaches were explored with the aim of achieving excellent clinical outcomes for members, while meeting the economic and clinical requirements of the treating Doctor and the Scheme.

The new programme takes an integrated approach to diabetes care, where the doctor, the patient and the Scheme work closely together to improve clinical outcomes and reduce downstream costs. Since launch, all eligible practices have joined the programme. Discovery Health plans to work alongside these practices in 2020 to build on the components of the programme including:

- Increased patient engagement.
- Enhanced rewards for doctors that demonstrate superior clinical outcomes.
- Refined patient navigation and co-ordination of care.

Healthcare providers and professional societies continued

Looking forward to 2020

NEW TECHNOLOGIES ENABLING ACCESS AND VALUE-BASED CARE

New technologies are changing many industries, including healthcare. Digital technology is particularly relevant to improving care co-ordination by facilitating the sharing of critical aspects of care delivery to the health professional team. Gaining efficiencies through high-value activity is particularly helpful for extending access to quality care to underserved communities as this provides medical professionals with the tools needed to offer better care to more people.

DIGITAL TOOLS HAVE BEEN SHOWN TO:

- Enhance administrative efficiency.
- Connect healthcare providers and patients for easily accessible, earlier care.
- Provide important patient information to inform healthcare providers' clinical decisions.
- Facilitate better co-ordination of care.
- Enable enhanced measurement and visibility of clinical outcomes.

We are committed to working with the profession in building a shared value healthcare ecosystem that uses digital tools, in line with global trends and best practice. This ecosystem is one in which patients, doctors and the funder can unite to sustainably improve healthcare outcomes.

One important innovation during the period under review involved providing enhanced access to telemedicine consultations between healthcare providers and patients, and was accomplished by building on our existing digital platform. Telemedicine, and virtual consultations in particular, are now globally established as a quality, cost-effective and convenient channel to manage specific medical problems.

The initiative is supported by the Day-to-day Extender Benefit, which provides access to additional GP consultations when members have exhausted their Personal Medical Savings Account. In 2020, this benefit will be aligned with global telemedicine trends, and funding will be available for virtual consultations between members and their GPs, or members consulting GPs through the pharmacy wellness networks.

Limiting exposure to highly infectious diseases

Apart from providing ease of access to patients, virtual consultations and other digital tools provide significant support for both patients, providers and the communities in which they operate, by limiting the need for physical contact during the infectious stages of diseases.

In 2020, information regarding **COVID-19** was made available for stakeholders, including healthcare providers, on the website.

SPINAL CARE INITIATIVE

Back pain is universally recognised as the leading contributor to years lived with disability, placing strain on even well-resourced healthcare systems[1]. The high volumes of spinal care claims received by Discovery Health provide a valuable data repository that, with careful analysis, could identify potential system enhancements.

The SA Spine Society (SASS) and Discovery Health are collaborating on the issues faced in the South African spinal care environment with the common goal of achieving the best possible clinical outcomes for patients, while unlocking additional funding support for spinal surgeons.

The Spinal Care Initiative will commence with the sharing of data via a personal practice profile. It is intended that the information in the practice profile report will:

- Support healthcare providers in understanding DHMS patients' use of the healthcare system.
- Enable healthcare providers to compare their practices with relevant anonymised peers.
- Facilitate peer-to-peer conversations where indicated.

We believe this partnership with SASS will make a positive impact on spinal care in South Africa.

Our programmes and initiatives for working with healthcare providers in **caring for their patients**

1 *Traeger, AC et al. 2019. Care for low back pain: can health systems deliver? Bulletin of the World Health Organization 2019; 97:423-433.*

Financial advisers (brokers)

The private healthcare sector in South Africa is complex, encompassing different types of providers, facilities, funding structures and mechanisms, as well as individual patient needs. Financial advisers play a critical role in helping existing and prospective members navigate this complexity by providing comprehensive and independent advice about the healthcare cover best suited to their specific health and affordability needs. The HMI's final report agreed that "brokers play an important role within the current complex benefit option environment" and recommended that their assistance to members continue, albeit with additional transparency[1].

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, weaknesses, and service levels of competing medical schemes. Consumers are then able to match their needs with the most appropriate medical scheme and plan offering. Once consumers have joined a scheme, financial advisers provide ongoing information through annual reviews and also update members and employers on product and service changes.

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

Discovery Health engages extensively with financial advisers on the Scheme's behalf. In-depth training and assessment sessions are supplemented by annual product launches and updates to support advisers. The Scheme specifically focuses on ensuring that our health plan information is written in an easily understood and accessible manner, for the benefit of both members and advisers.

Perception surveys were conducted to establish how satisfied financial advisers are with Discovery Health. The overall perception score by brokers of Discovery Health for the year was 8.92 out of 10, slightly up from 8.77 for 2018.

Engagements in 2019 included:

The annual update on the Scheme's product and benefit enhancements for the coming year was provided in a national rollout to over 200 business consultants and agents. It was also presented and broadcast to more than 8 200 financial advisers from the annual product launch event. Following the product update, approximately 70 sessions were held with business consultants and financial advisers across the country.

National presentations to corporate brokerages at three different times during the year provided information on the Scheme's strategies, industry position, financial results and risk management initiatives.

Broker consultants received training and were assessed on their knowledge of the Scheme's products, the private healthcare sector, and sales and presentation skills.

1 *The Competition Commission's Health Market Inquiry Final Findings and Recommendations Report, September 2019.*

Discovery Health (Pty) Ltd

Providing services to over 3.5 million lives, Discovery Health is a leading administrator and managed care provider for medical schemes in South Africa. They administer DHMS, the largest open scheme in South Africa, 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. The working relationship between the two organisations is governed by the outcomes-based Vested® model. The relationship is characterised by a shared vision and aligned objectives, ensuring that both organisations work for the ultimate benefit of members.

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

The agreement between the Scheme and Discovery Health contains extensive service level requirements against which the Trustees monitor and measure Discovery Health's performance.

ENGAGEMENT 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.

During 2017, DHMS renewed its Administration and Managed Care contracts with Discovery Health, which took effect in 2018. The agreements provided for the formation of the new Relationship Management and Innovation Committees, to support enhanced governance and relational dynamics relating to the Vested relationship between DHMS and Discovery Health and provide scope for continued innovation. These committees met during 2019 and continued to function as effective mechanisms to enhance the working relationship and maintain a joint focus on innovation for the benefit of our members.

More about **how we operate**

Our employees

The Scheme is committed to protecting the dignity, safety and health of our employees, providing decent work, fair remuneration and opportunities for training and development. In line with the corporate citizenship framework we have adopted as part of our strategy, we are also strongly committed to treating our employees equitably and ethically, in accordance with good employer practices.

A comprehensive set of Board-approved human resources, ethics and codes of conduct policies are available on the Scheme's intranet and are embedded in the Scheme's daily operations. The Principal Officer is accountable for resolving all employee-related matters.

The Scheme employs a small team who must be agile in responding to industry developments and challenges to ensure the Scheme's effective operation and sustainability. It is imperative that all employees are nurtured and developed to ensure that they are engaged and fulfilled and therefore able to consistently deliver their best efforts. Training and development opportunities are regularly identified, and all staff members attend training, conferences and industry events relevant to their work and their potential within the Scheme. Periodic assessments of the Scheme's value proposition to employees support interventions to promote staff satisfaction and retention, and regular performance discussions help employees to maintain focus on their role objectives, alignment with the objectives of the Scheme, and career development.

During 2019, the Scheme implemented a revised performance management framework, which will be fully implemented in 2020. This will be supported by values and culture interventions to support the team's continued alignment with the Scheme's strong ethical and values-driven culture.

Regulatory bodies

The Scheme and Discovery Health are required to adhere to strict legislation. The Scheme is primarily governed by the Medical Schemes Act.

Maintaining constructive relationships with 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 relevant authorities.

The Scheme and Discovery Health continue to engage the National Department of Health, the CMS and the Competition Commission on matters affecting the sustainability of the broader industry, including advocating for access to more affordable health technology, managing fraud, waste and abuse, and in promoting innovative regulatory change such as the implementation of the Health Market Inquiry's (HMI's) recommendations.

Council for Medical Schemes

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

- Protecting and educating the public regarding their medical scheme cover;
- Assessing and registering schemes' rules and benefits;
- Handling complaints and disputes between the public and medical schemes;
- Ensuring that schemes comply with the Act and maintain 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 policy, application and interpretation of rules, benefit design, Scheme finances and resolution of disputes with members.

In 2019, the CMS published 84 circulars and the Scheme submitted responses to these where required, as well as to other ad hoc and formal enquiries from the CMS. The CMS also publishes an annual report covering activity across the private healthcare industry.

The CMS website

The National Department of Health

The Scheme interacts with the National Department of Health whenever needed. In October 2019, the Scheme and Discovery Health submitted a joint response on the revised NHI Bill (published in August 2019) to the Portfolio Committee for Health; we have subsequently continued to engage in discussions on the Bill at industry level, directly and through the Health Funders Association (HFA). The Portfolio Committee held public hearings in various provinces and continues to gather stakeholder input; this includes having a presentation made to it on the recommendations of the HMI.

The Scheme supports the objectives of universal health coverage as well as the need for the healthcare sector to respond to the needs of its patients, within our social, economic and demographic context. In the interests of our members, we will continue to engage with the Ministry whenever opportunity allows.

More about **regulatory matters**

More about the **National Health Insurance Bill**

Our **NHI FAQ**

The Competition Commission

In September 2019, the final report of the Inquiry by the Competition Commission into the private health sector was published. The Inquiry investigated whether aspects of the market distort, restrict or prevent competition. In its report, the HMI has identified the need for improved competition across all sectors of the private healthcare market and has made wide-ranging recommendations encompassing many factors and stakeholders.

The report was presented to the Minister of Trade and Industry and the Deputy Minister of Health at the launch. Minister Patel committed to closely scrutinising its contents and engaging with his counterparts at the Department of Health accordingly.

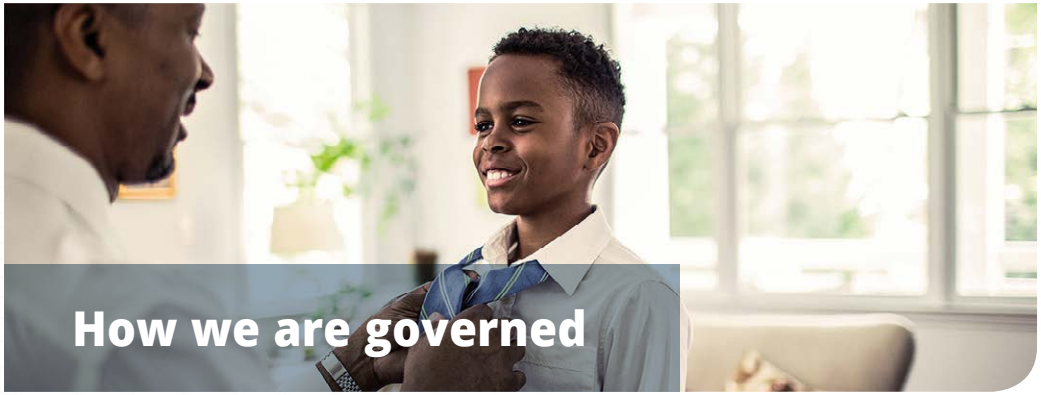
In addition, Commissioner Bonakele announced the establishment of a special unit within the Competition Commission that will advocate for the implementation of the HMI recommendations and contribute to the debates on NHI and the proposed health system reforms.

The Scheme supports the implementation of the HMI's many constructive recommendations and looks forward to engaging with stakeholders in this regard.

The HMI website

04

GOVERNANCE AND LEADERSHIP



How we are governed

All medical schemes in South Africa are governed by the Medical Schemes Act (the Act). The Scheme Rules are developed in accordance with the Act and approved 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). King IV 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 the following outcomes:

- **An ethical culture**
- **Effective control**
- **Good performance**
- **Legitimacy**

The Trustees embrace the principles of King IV in achieving optimal governance outcomes for the Scheme and within the Scheme environment. The Trustees are required to lead ethically and effectively, and each Trustee (individually and collectively as part of the Board) is expected to cultivate the characteristics of integrity, competence, responsibility, accountability, fairness and transparency, exhibiting these in their conduct.

The Board of Trustees

DHMS is governed by an independent Board of Trustees, which is responsible for overseeing the business of the Scheme. The Trustees hold the decision-making power of the Scheme and are ultimately responsible for oversight of the Scheme's material matters, the development and implementation of the Scheme's strategy and the sound management of its business, including Scheme policies.

The Board's overriding objective is to ensure that the best interests of Scheme members are served equitably while ensuring the sustainability of DHMS. The Trustees are accountable to the Scheme's members.

According to the Scheme Rules, the affairs of the Scheme must be managed according to these Rules by a Board of fit and proper members (i.e. with the requisite character, integrity, skill, competence, financial soundness and ability to exercise a fiduciary duty) of at least five and at most eight Trustees.

Trustees serve a three-year term after which they are eligible for re-election or re-appointment. However, they may not serve more than two consecutive terms.

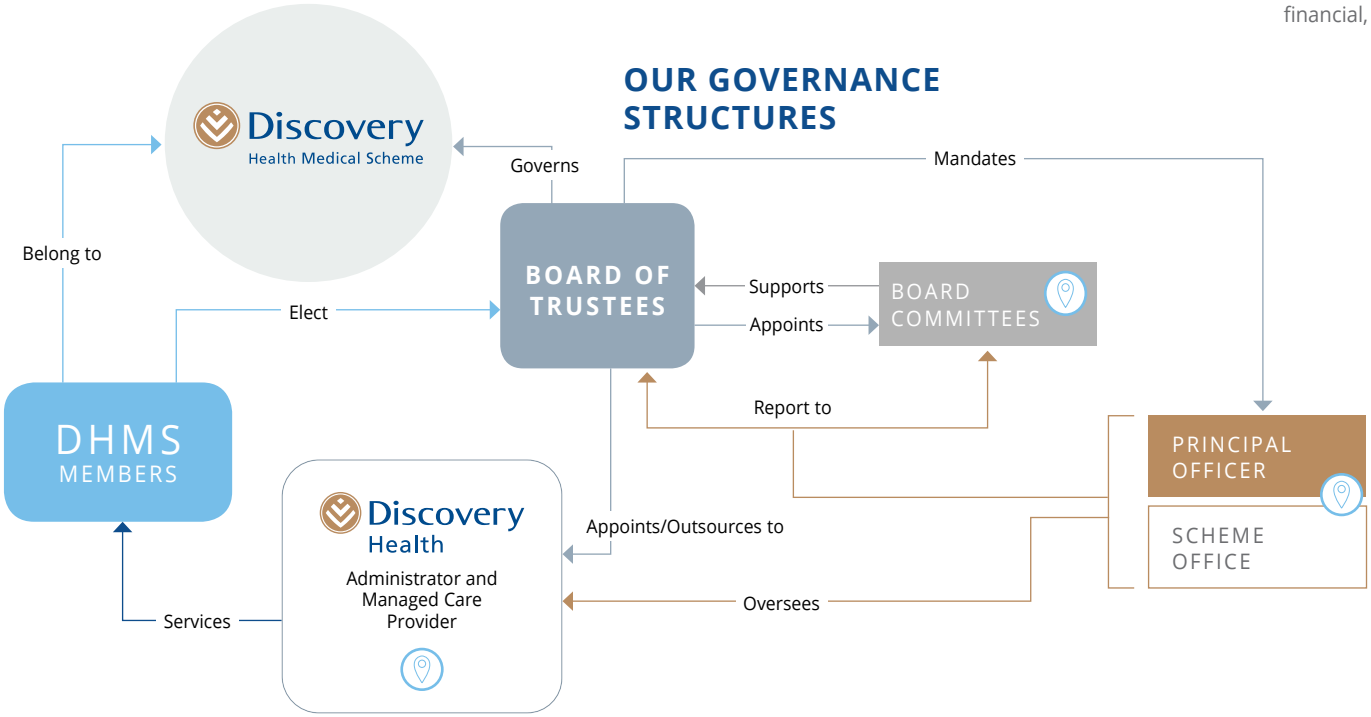
At any given time, at least half of the Trustees must be elected by members, meaning that the Scheme has no influence over the re-election of these Trustees or of the composition of the Board in respect of the elected Trustees. Due to its limited succession planning ability in this regard, the Board may also appoint additional Trustees to fill knowledge, experience and skills gaps if required, and may re-appoint such Trustees (subject to the requirement that a Trustee may only serve two consecutive terms).

In addition, the Trustees have access to professional advice, both inside and outside of the Scheme to inform the proper execution of their duties, and may obtain such external or other independent professional advice as they consider necessary.

To ensure effective leadership, the Trustees dedicate a significant amount of time and effort to their fiduciary duties; this extends well beyond meeting attendance.

The Board comprises independent, highly skilled professionals with a diverse range of specialisms, experience, background and gender. This brings 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, clinical, financial, financial reporting, investment and human resources.

OUR GOVERNANCE STRUCTURES



- **The Scheme Rules** on the website
- **King IV** on the web
- More about our **material matters**
- **Constitution of our Board and Committees** on the website

THE ROLE OF THE TRUSTEES

- Evaluate, direct and monitor the Scheme's strategy, ensuring alignment with the purpose and value drivers of the Scheme, alongside the legitimate interests and expectations of stakeholders;
- Review the sustainability of the Scheme and evaluate whether the services offered by the Administrator and Managed Care Provider meet the needs of, and offer value for money to, the Scheme and its members;
- Monitor innovation and oversee the improvement of all levels of the Scheme's operations;
- Monitor adherence to the 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 act with reference to best practice governance and any relevant legal requirements to manage these.

THE DUTIES OF THE TRUSTEES, SET OUT IN THE ACT AND THE SCHEME RULES

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

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 non-profit status of medical schemes.

Board evaluations

The Board is assessed at least every two years either by external independent parties, or through self-appraisals. The last Board evaluation was conducted by the Institute of Directors in South Africa (IoDSA) in 2018 with highly satisfactory results reported in the 2018 Integrated Report. The next evaluation will be conducted in 2020.

The Board is satisfied that the diversity of skills and experience of the Trustees enables it to competently execute its duties, fulfilling 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 has carried out its duties in an ethical, responsible and equitable manner during the year.

Our Trustees[1]

MR NEIL MORRISON (63)

BSc (Hons) Physics; MA (Economics)

Chairperson

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

Mr Morrison was elected as a Trustee in 2016 and currently serves on the Remuneration, Investment, Non-healthcare Expenses[2], and Stakeholder Relations and Ethics Committees. He was elected Chairperson of the Board on 14 August 2017.

MS JOAN ADAMS SC (56)

B.IURIS LLB; (FP) SA[3]

Ms Adams SC has been an advocate for 31 years. She was previously a Senior State Advocate and Senior Family Advocate. She 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 a full and accredited forensic practitioner (Institute for Commercial Forensic Practitioners, RSA) and a member of the Gauteng Society of Advocates.

Ms Adams SC has considerable experience in medical law and ethics, and has chaired numerous professional conduct inquiries. She was elected as a Trustee in 2017 and serves on the Clinical Governance, Audit[4], Risk, and Stakeholder Relations and Ethics[5] Committees.

DR SUSETTE BRYNARD (63)

BSc (Sciences); PhD (Education)

Dr Brynard is a 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. She is currently a director of SAMBA, a co-operative buy-aid. She has held this position for the last 25 years. She attained her post-graduate degrees cum laude and is doing ground-breaking work on the education and development of learners with Down syndrome internationally.

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

MR JOHN BUTLER SC (53)

B.Comm, LLB, MA (Senior Counsel, Member of the Cape Bar)

Mr Butler SC is a practising advocate. He was appointed a Senior Counsel in 2008. He specialises in commercial practice, including in 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 SC was appointed as a Trustee on 14 June 2017. He serves on the Stakeholder Relations and Ethics, Audit[6], Non-healthcare Expenses[7] and Remuneration Committees.

1 All ages as at 31 December 2019.
2 The Non-healthcare Expenses Committee was dissolved as of 31 August 2019.
3 Forensic Practitioner, South Africa.
4 Term as a member of the Audit Committee ended effective 01 September 2019.
5 Appointed to the Committee by the Board on 02 August 2019.
6 Appointed to the Audit Committee by the Board as of 02 August 2019.
7 The Non-healthcare Expenses Committee was dissolved as of 31 August 2019.

Our Trustees *continued*

MR JOHAN HUMAN (49)

B.Bus.Sc; FIA[1]; FASSA[2]

Mr Human has more than 20 years' experience in actuarial and healthcare consulting to large corporate organisations and medical schemes. He is currently a director and co-founder of LifeHouse Finance (Pty) Ltd, with interests in private equity, infrastructure fund management and structured finance.

Mr Human was appointed to the Board on 14 August 2017 after being co-opted as an Independent Co-opted Member to the Board on 5 September 2016. He currently chairs the Product Committee and serves on the Investment, Audit and Risk[3] Committees. He previously served on the Non-healthcare Expenses Committee[4].

MR DAVID KING (56)

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

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

Mr King was elected as a Trustee in 2016 and currently chairs the Remuneration and Risk[5] Committees and serves on the Non-healthcare Expenses[6] and Stakeholder Relations and Ethics Committees. He previously served as an Independent Member on the Audit, Risk and Stakeholder Relations Committees.

DR DHESAN MOODLEY (57)

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

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

Dr Moodley served the Scheme as Chairperson and a member of the Board between 2001 and 2011. In 2016, he was re-elected as a Trustee and currently chairs the Clinical Governance and Investment Committees while serving on the Product and Stakeholder Relations and Ethics Committees.

MS DAISY NAIDOO (47)[7]

CA(SA); Masters in Accounting (Taxation); BCom Postgraduate Diploma in Accounting

Ms Naidoo is a Chartered Accountant. She is a professional independent non-executive director and currently serves on a number of listed and non-listed company boards, investment and credit committees. She has extensive knowledge in finance, accounting, banking, investment, risk and general business. She was a dealmaker at Sanlam Capital Markets for almost a decade where she headed the Debt Structuring Unit. Prior to this, she was a tax consultant at Deloitte, consulting mostly to financial services companies. She was also a financial planner at South African Breweries.

Ms Naidoo was elected as a Trustee in 2016 for a second term. She served on the Audit, Risk, Investment and Product Committees, and chaired the Non-healthcare Expenses Committee[8].

1 *Fellow of the Institute of Actuaries UK.*
2 *Fellow of the Actuarial Society of South Africa.*
3 *Term as a member of the Risk Committee ended effective 01 September 2019.*
4 *The Non-healthcare Expenses Committee was dissolved as of 31 August 2019.*
5 *Appointed as Chairperson of the Risk Committee on 02 August 2019.*
6 *The Non-healthcare Expenses Committee was dissolved as of 31 August 2019.*
7 *Term ended on 22 June 2019.*
8 *The Non-healthcare Expenses Committee was dissolved as of 31 August 2019.*

Board independence, composition, rules and attendance[1]

The affairs of the Scheme are managed by a Board of at least five and at most eight persons. At least half of such Trustees must be principal members of the Scheme that are elected by members of the Scheme.

The balance of the Trustees may be elected by members of the Scheme, or appointed by the Trustees provided that the number of these Trustees shall at any given time not exceed two[2].

Name of Trustee or Board Committee Member	Designation	Appointed/Elected	Start of Term	End of Term
Daisy Naidoo	Trustee	**Elected 1st term**	20 Jun 13	19 Jun 16
	Trustee	**Elected 2nd term**	23 Jun 16	22 Jun 19
David King	Trustee	**Elected**	23 Jun 16	22 Jun 19
	Trustee	**Elected**	20 Jun 19	22 Jun 22
Dhesan Moodley	Trustee	**Elected**	23 Jun 16	22 Jun 19
	Trustee	**Elected**	20 Jun 19	22 Jun 22
Joan Adams SC	Trustee	**Elected**	22 Jun 17	21 Jun 20
Johan Human	Independent Co-opted Member	**Appointed**	05 Sep 16	13 Aug 17
	Trustee	**Appointed**	14 Aug 17	13 Aug 20
John Butler SC	Independent Co-opted Member	**Appointed**	05 Sep 16	13 Jun 17
	Trustee	**Appointed**	14 Jun 17	13 Jun 20
Neil Morrison	Trustee – Chair of the Board	**Elected**	23 Jun 16	22 Jun 19
	Trustee – Chair of the Board	**Elected**	20 Jun 19	22 Jun 22
Susette Brynard	Trustee	**Elected**	22 Jun 17	21 Jun 20
Barry Stott	Trustee	**Elected**	24 Jun 10	20 Jun 13
	Chair of the Audit and Risk Committees, Independent Investment Committee Member	**Appointed**	04 Jul 13	31 Aug 19
Eric Mackeown	Chair of the Audit Committee, Independent Risk and Investment Committee Member	**Appointed**	01 Sep 19	31 Aug 22
Imtiaz Ahmed	Chair of the Investment Committee	**Appointed**	20 Jan 16	19 Jan 19
Ndumiso Luthuli	Independent Remuneration Committee Member	**Appointed**	18 Apr 18	17 Apr 21
Nonkululeko Mlaba	Independent Clinical Governance Committee Member	**Appointed**	28 Aug 18	27 Aug 21
Philile Maphumulo	Independent Audit and Risk Committees Member	**Appointed**	19 Jan 16	18 Jan 19
		Reappointed	20 Jan 19	01 Sep 19
	Independent Investment Committee Member	**Reappointed**	12 Sep 17	29 Feb 20[3]
Selma Smith	Independent Clinical Governance Committee Member	**Appointed**	01 Jan 16	31 Dec 18
		Reappointed	01 Jan 19	31 Dec 21
Steven Green	Independent Audit and Risk Committees Member	**Appointed**	11 Dec 01	31 Dec 19
Susan Ludolph	Independent Audit and Risk Committees Member	**Appointed**	19 Jan 16	19 Jan 19
		Reappointed	20 Jan 19	19 Jan 22
Zephne van der Spuy	Trustee	**Elected 1st term**	24 Jun 10	20 Jun 13
	Trustee	**Elected 2nd term**	20 Jun 13	23 Jun 16
	Independent Clinical Governance Committee Member	**Appointed**	04 Jul 16	03 Jul 19
Peter Goss	Chair of the Nomination Committee	**Appointed**	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	26 Jun 20[4]
Tom Wixley	Nomination Committee Member	**Appointed**	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	26 Jun 20[5]
Royston Shough	Nomination Committee Member	**Appointed**	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	26 Jun 20[6]
2020 Appointment				
Alewyn Burger	Independent Audit and Risk Committees Member	**Appointed**	01 Jan 20	31 Dec 22

1 *Due to the variation of Disputes Committee panellists, members are not listed. Each Disputes Panel consists of three Independent Members drawn from the greater Disputes 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. The Committee can be constituted several times a week if required to attend to increased caseloads.*

2 *An amendment to the Scheme Rules to allow for the appointment of a maximum of three Trustees is pending registration by the CMS.*

3 *Ms Maphumulo resigned to attend to her other commitments.*

4 *Amended from the date of 19 June 2020 shown in the 2018 Integrated Report, due to the requirement that the Committee Members oversee the 2020 elections, and the scheduling, subsequent to the publication of last year's report, of the Scheme's AGM for 25 June 2020. The Board constitutes the Nomination Committee when required by the timing of Trustee elections, in order to oversee Trustee nominations processes. These Committee Member terms are therefore not for a fixed three-year period.*

5 *Amended from the date of 19 June 2020 shown in the 2018 Integrated Report, due to the requirement that the Committee Members oversee the 2020 elections, and the scheduling, subsequent to the publication of last year's report, of the Scheme's AGM for 25 June 2020. The Board constitutes the Nomination Committee when required by the timing of Trustee elections, in order to oversee Trustee nominations processes. These Committee Member terms are therefore not for a fixed three-year period.*

6 *Amended from the date of 19 June 2020 shown in the 2018 Integrated Report, due to the requirement that the Committee Members oversee the 2020 elections, and the scheduling, subsequent to the publication of last year's report, of the Scheme's AGM for 25 June 2020. The Board constitutes the Nomination Committee when required by the timing of Trustee elections, in order to oversee Trustee nominations processes. These Committee Member terms are therefore not for a fixed three-year period.*

Board meeting attendance in 2019

Board meetings attendance in 2019		18 Feb[A]	19 Feb	20 Feb	09 Apr	02 May[A]	07 Jun	31 JulA	01 Aug[A]	02 Aug	29 Aug	02 Oct[A]	14 Nov	28 Nov[A]	06 Dec[A]	09 Dec[A]
Trustees	Mr Neil Morrison (Chair)[#]	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ms Daisy Naidoo[◊]	–	✓	✓	✓	✓	✓	–	–	–	–	–	–	–	–	–
	Mr David King[#]	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dr Dhesan Moodley[#]	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
	Adv Joan Adams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	–	–	✓
	Mr Johan Human	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr John Butler	✓	✓	✓	x	✓	✓	✓	x	x	✓	–	✓	–	–	✓
	Dr Susette Brynard	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	–	–	✓
Chairperson: Audit and Risk Committee	Mr Barry Stott[□]	–	✓	✓	✓	✓	✓	–	–	–	✓	–	–	–	–	–
Chairperson: Audit Committee	Mr Eric Mackeown[∞]	–	–	–	–	–	–	–	–	–	✓	–	✓	–	–	–

A Ad hoc meetings:

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

- *The meeting of 18 February 2019 was to discuss and finalise the pricing strategy.*
- *The meeting of 02 May 2019 was a joint meeting with the Nomination Committee to discuss candidate nominations for the AGM.*
- *A Board effectiveness workshop was held on 31 July and 01 August 2019.*
- *A Board task team was convened to discuss administration and managed care fees. The task team met on 02 October 2019, 28 November 2019 and 06 December 2019.*
  The task team presented its recommendations to the Board on 09 December 2019.

 # Re-elected on 20 June 2019.

◊ Term ended 22 June 2019.

□ Term ended on 31 August 2019.

∞ Requested to attend the Board meeting held on 29 August 2019 and commenced his term as Chairperson of the Audit Committee and as an Independent Committee Member of the Investment and Risk Committees on 01 September 2019.

– Not required to attend.

x Apology tendered.

Board Committees

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

The Board is supported by nine[1] Board Committees which are constituted and structured according to the needs of the Scheme to assist the Board to fulfil its fiduciary and oversight duties effectively. Board Committee Members consist of both Trustees and Independent Members according to each Committee's requirements. Independent Board Committee Members serve three-year terms and are eligible for subsequent re-appointment for a further term but may not serve more than two consecutive terms. Committee Members are remunerated for their services in terms of the Scheme's Remuneration Policy.

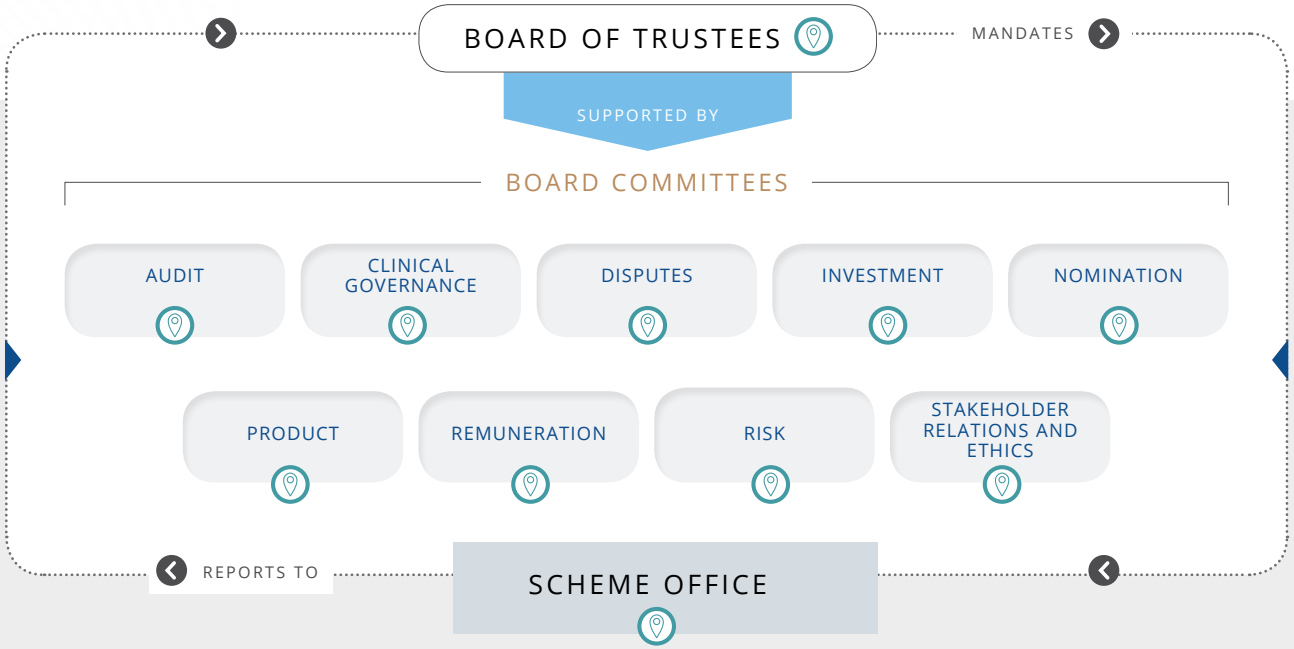
More about our **Remuneration Policy**

The Committees report to the Board regularly, and each has its own terms of reference and clear procedures for reporting. 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 the approval of any decisions to be taken.

Board Committee evaluations

The Board Committees are assessed at least every two years either by external independent parties, or through self-appraisals. The last Board evaluation was conducted by the IoDSA in 2018 with highly satisfactory results reported in the 2018 Integrated Report. The next evaluation will be conducted in 2020.

More on each of our **Board Committees**



1 *The Non-healthcare Expenses Committee was disbanded during 2019, with its functions being absorbed into several other committees, primarily the Risk Committee and the Stakeholder Relations and Ethics Committee.*

Independent Board Committee Members[1]

MR IMTIAZ AHMED (54)[2]

CA(SA)

Chair of the Investment Committee.

Detailed understanding of financial markets with more than 30 years' experience as a portfolio manager and director at various reputable investment houses. Member of various investment committees with a combined asset value in excess of R30 billion.

MR ALEWYN BURGER (68)[3]

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

Member of the Audit and Risk Committees.

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

MR ERIC MACKEOWN (62)[4]

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. Thorough and deep understanding of the health and medical aid industries.

1 Note: all ages as at 31 December 2019.
2 Term ended on 19 January 2019.
3 Appointed as an Independent Member of the Audit and Risk Committees on 01 January 2020.
4 Appointed as Chairperson of the Audit Committee on 01 September 2019.
5 Term ended on 31 December 2019.

PROF PETER GOSS (52)

Professor of Practice (Governance, Fraud Risk, Forensic Auditing): College of Business and Economics, University of Johannesburg; Master of Arts in Criminal Justice; (FP) SA

Chairperson of the Nomination Committee.

Advisor on corporate governance, strategy facilitation, ethics, strategic forensics, training and crisis management. Former governing board member/ managing partner/managing director in two international advisory firms. Author/ publisher of three university textbooks titled: "Corporate Governance and Illicit Conduct"; "Fraud and Corruption Risk Governance"; and "Forensic Investigation Process".

MR STEVEN GREEN (48)[3]

BSc (Hons) Information Systems; BSc Computer Science

Member of the Audit and Risk Committees.

Extensive expertise in IT architecture design and implementation, and IT risk assessment and management, particularly in relation to outsourcing. Gained experience in South Africa and internationally, in a wide range of technology-related areas, including data analytics.

MRS PHILILE MAPHUMULO (38)

BCom (Hons); M.Com Finance; CA(SA)

Member of the Audit, Risk and Investment Committees.

More than 13 years' experience in corporate finance and private equity. Founder of Heritage Capital, a private equity fund focused on funding small to medium enterprises. Served as a non-executive director on company boards in various sectors in South Africa.

MRS SUE LUDOLPH (56)

CA(SA)

Member of the Audit and Risk Committees.

Technical expert in IFRS and financial and integrated reporting, including standard setting for accounting in South Africa. Established and implemented the strategy and work plan for South Africa's first top 100 CFO Forum to guide, influence and lead on issues affecting CFOs and business. Judge for the PwC Building Public Trust Awards from 2014 to 2018. Independent non-executive director of Fortress REIT from December 2018, and a member of their Audit and Risk Committees.

Independent Board Committee Members[1] *continued*

MR NDUMISO LUTHULI (44)

B.Proc; LLB; BCL[2]; MBA

Member of the Remuneration Committee.

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

DR NONKULULEKO MLABA (48)

MBBCh; MPH; PGDHE

Member of the Clinical Governance Committee.

A healthcare professional with a medical degree and post-graduate public health and health economics qualifications. Seasoned professional with a deep understanding of managed healthcare, healthcare regulation and clinical research.

MR ROY SHOUGH (69)

CA(SA); HDip BDP

Member of the Nomination Committee.

Acknowledged as a leading expert in corporate governance, particularly in relation to governance processes as well as the role, responsibilities and effectiveness of boards, directors and board committees, and senior executives in governance and risk management.

PROF SELMA SMITH (58)

MBChB; M Prax Med[3]; FCFP(SA)[4]

Member of the Clinical Governance Committee.

Specialist family physician and expert in family medicine and primary care in the public sector. Has held directorships on the governing bodies of educational institutions focused on improving outcomes in family medicine in South Africa.

MR BARRY STOTT (71)[5]

CA(SA)

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

Deep understanding of the financial services industry. Member of audit, risk and investment committees, and independent nonexecutive director at financial services institutions. More than 40 years' experience in accounting and auditing.

PROF ZEPHNE VAN DER SPUY (72)[6]

MBChB; MRCOG[7]; PhD; FRCOG[8]; FCOG (SA)[9]

Member of the Clinical Governance Committee.

Specialist obstetrician gynaecologist and expert in women's health and reproductive medicine. National Research Foundation-rated scientist with an extensive body of published research.

MR TOM WIXLEY (79)

BCom; CA(SA)

Member of the Nomination Committee.

More than 40 years' experience in accounting and auditing. Former director of numerous public companies. Expert in corporate governance and published author.

1 Note: all ages as at 31 December 2019.
2 Bachelor of Civil Law.
3 Masters in Family Medicine.
4 Fellow of the College of Family Physicians of South Africa.
5 Term ended 31 August 2019.
6 Term ended on 03 July 2019.
7 Member of the Royal College of Obstetricians and Gynaecologists.
8 Fellow of the Royal College of Obstetricians and Gynaecologists.
9 Fellow of the College of Obstetricians and Gynaecologists of South Africa.

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. The Audit Committee is chaired by an Independent Committee Member and comprises of at least five members who are highly skilled and experienced, with extensive actuarial, legal, financial and IT expertise. 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 roles and responsibilities of the Committee include:

- Providing oversight for 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 solvency requirements of the Scheme;
- Reporting to the Board on the acceptability of the Scheme's accounting policies;
- Providing oversight for integrated reporting processes;
- 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;
- Considering, approving and overseeing the external and internal audit plans;
- 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

Second Line – Group Risk Management, Compliance and Forensics

Third Line – Internal audit, external audit and an independent actuarial firm

The combined assurance assessment showed that adequate assurance was provided and received in respect of all significant risks for the 2019 benefit year. The Trustees are comfortable with the level and type of assurance the Scheme obtains.

More about **non-compliance matters**

ACTIVITIES DURING 2019

The Committee continued to support the Trustees in fulfilling their governance and oversight responsibilities during the year. It is satisfied that its activities, reporting and recommendations to the Board during 2019 have fulfilled its responsibilities in accordance with its terms of reference.

The **Audit Committee's report**

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, the Committee comprised two Trustees and three Independent Committee Members, one of whom chaired the Committee.

During 2019, the Committee met four times. The external and internal auditors met regularly with the Committee without the Administrator and Managed Care Provider and Scheme management present. The external auditor, internal auditor, Principal Officer, Chief Financial Officer, Chief Operations Officer, Head of Governance and Compliance, and heads of the outsourced administration functions attend all Committee meetings by invitation to provide information and insight into their areas of responsibility, and have unrestricted access to the Chairperson of the Audit Committee. The Committee may consult any expert or specialist to assist in performing its duties.

Board Committees *continued*

Audit Committee attendance in 2019		20 Mar	15 Aug	22 Aug	10 Oct
Independent Member/ Chairperson	Mr Barry Stott#	✓	✓	✓	–
Committee Members	Mr Eric Mackeown¤	–	✓	✓	✓
	Adv Joan Adams (Trustee)◊	✓	✓	✓	–
	Mr John Butler (Trustee)	–	✓	✓	✓
	Mr Steven Green (Independent Member)	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	✓
	Ms Susan Ludolph (Independent Member)	✓	✓	✓	✓
	Ms Phililе Maphumulo (Independent Member)◊	✓	✓	✓	–
	Ms Daisy Naidoo (Trustee)*	✓	✓	–	–

 # Term ended on 31 August 2019.
¤ Requested to attend the Audit, Risk and Investment Committee meetings held on 15 and 22 August 2019, and commenced his term as Chairperson of the Audit Committee on 01 September 2019.
∞ Term ended on 31 December 2019.
◊ Term as a member of the Audit Committee ended effective 01 September 2019.
** Term ended on 22 June 2019.*
– Not required to attend.

FUTURE FOCUS AREAS

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

Clinical Governance Committee

While there is no statutory requirement for this Committee, it 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 such Board members and other experts as it may deem necessary. In this instance, the Trustees established this Committee to ensure compliance with the Act, and to comply with best practice governance principles. The Committee comprises members with the requisite skills to consider the clinical complexities in healthcare funding.

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

It also oversees engagement strategies with healthcare professionals facilitated by Discovery Health, which foster shared purpose and value, aiming to reduce inefficiencies in healthcare delivery while also improving quality of care and ultimately health outcomes.

The Committee also engages with Health Quality Assessment, an independent industry body that performs an annual assessment of clinical quality offered by medical schemes and reports on specific quality indicators for both the industry and participating schemes.

ACTIVITIES DURING 2019

In accordance with its annual work plan, the Committee met four times during 2019. The Committee's meeting agendas and deliberations are informed by risk intelligence reports provided by Discovery Health's actuarial and statistician teams; these highlight key indicators and trends in the Scheme's demographic and chronic disease profile, claims experience, and utilisation of in- and out-of-hospital benefits. These are further supported by other quantitative and qualitative data reported by a variety of units within Discovery Health including the Centre for Clinical Excellence, the Health Professionals Unit, and the Strategic Provider Contracting and operations units (including ex-gratia and clinical exceptions reports).

The Committee evaluates member-focused reports including those relating to complaints and disputes. This provides the Committee with insight into any trends that may require funding policy or clinical governance interventions.

The Committee considered and gave input into the proposed 2020 product and benefit enhancements. This included enhanced screening benefits for colorectal cancer and senior members, and pharmacy-based primary care services supported by digital health platforms through the Day-to-day Extender Benefit.

The Committee also engages in all relevant policy and regulatory matters of industry and national importance, including ongoing developments related to Prescribed Minimum Benefit (PMB), and the National Health Insurance (NHI) policy.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2019, have fulfilled its responsibilities in accordance with its terms of reference.

Board Committees *continued*

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, Committee Members included two Trustees, one of whom chaired the Committee, two Independent 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. The Committee also hosts occasional external speakers on specific topics of interest to the Committee.

Clinical Governance Committee attendance in 2019

		14 Mar	11 Jul	17 Sep	07 Nov
Trustee/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓
Committee Members	Adv Joan Adams (Trustee)	✓	✓	✓	✓
	Dr Unati Mahlati (Chief Medical Officer)%	✓	✓	✓	✓
	Ms Nonkululeko Mlaba (Independent Member)	✓	✓	✓	✓
	Prof Selma Smith (Independent Member)	✓	✓	✓	✓
	Prof Zephne van der Spuy (Independent Member)#	✓	–	–	–
Attendee	Mr Neil Morrison (Trustee)*	–	–	–	✓

% Scheme Executive. All other Committee Members are non-executive.
– Not required to attend.
 # Term ended on 3 July 2019.
** Attended as an observer, as permitted for all Trustees, and was not remunerated for attendance.*

FUTURE FOCUS AREAS

The Committee continues to grapple with the challenge of unabating medical inflation by continuously reviewing the Scheme's funding policies, especially those pertaining to high-cost health technology innovations, including novel pharmaceuticals used in oncology and rare but life-threatening diseases. Funding such innovations is considered with due regard to ensuring the Scheme's members continue to have sustainable access to evidence-based cost-effective healthcare services and products.

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

Disputes Committee

The Trustees established an independent Disputes Committee to hear and rule on all formally-lodged member disputes transparently and equitably.

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 those contravening applicable legislation and the latest registered Scheme Rules. In the event of a member being dissatisfied with a ruling made by the Committee, they are able to lodge a complaint with the CMS in terms of Section 47 of the Act.

The Committee's responsibilities are to:

- Receive submissions from Scheme members and the Scheme's representatives, which may be made in person, by telephone or in writing;
- Ensure that it has sufficient information regarding the dispute to adjudicate the case objectively;
- Adjudicate the dispute and draft a ruling with due regard for all facts presented at the hearing and in line with relevant legislation and the Scheme Rules; and
- Ensure that the process at hearings and in adjudicating disputes is managed as efficiently as possible and without undue delay.

ACTIVITIES DURING 2019

In 2019, 786 disputes were lodged in terms of Rule 27[1], with 628 or 93% of disputes being settled or withdrawn prior to a hearing. Only 47 cases proceeded to a hearing before the Disputes Committee.

Oversight of the Committee's activities, on behalf of the Board, was moved from the Clinical Governance Committee to the Stakeholder Relations and Ethics Committee. This is because the scope of the Committee's work extends beyond medical matters, covering the full spectrum of stakeholder concerns.

The Committee is satisfied that its activities during 2019 have fulfilled its responsibilities in accordance with its operating framework.

COMPOSITION AND MEETINGS IN 2019

All Dispute Committee panellists have either legal or medical expertise. Each panel consists of three members drawn from the greater Committee according to availability, and must include at least one legal and one medical expert. A practicing attorney is always the Chairperson of each hearing. Dispute Hearings are scheduled as and when required, and the Committee can be constituted several times a week if required.

Committee Members are independent and not employed by the Scheme, but are remunerated for their time and input in objectively hearing and adjudicating cases, regardless of the outcome of the hearings.

During 2019, all hearings 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. Access to the Committee is not only available to members, but also to healthcare practitioners in respect of forensic (fraud, waste and abuse-related) disputes.

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.

Board Committees *continued*

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 and ensuring that investments made are in the best interest of members and within the risk appetite of the Scheme, 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 final approval.

The Committee's responsibilities are to:

- Recommend to the Trustees an investment policy for the Scheme, with due regard to the requirement that the assets invested should maximise returns while maintaining solvency;
- Monitor the effectiveness and implementation of the Investment Policy;
- Make recommendations to the Trustees regarding strategic and long-term asset allocation and approve plans for implementation;
- Approve any short-term asset allocation and plans for implementation;
- Review investment strategies, capital and equity market assumptions, performance of the investment portfolio and of asset managers against established benchmarks, and report to the Trustees quarterly on the performance of the portfolio;
- Monitor the performance of each asset class with a view to maximising the total return, while considering the risk appetite of the Scheme;
- Report to the Trustees annually on overall investment performance;
- Make recommendations to the Trustees on the appointment of asset consultants and asset managers, including fees payable and the terms of appointment;
- Assist the Trustees in deciding whether to withdraw funds from portfolios to support daily operations;
- Supervise the safekeeping and handling of the Scheme's investments;
- Monitor all reported investment activities in line with the Scheme's Investment Policy and statutory requirements, and where there is deviation from the Investment Policy, investigate the reasons and recommend corrective action to the Trustees; and
- Assist the Trustees in preparing their annual report on investment performance and compliance.

ACTIVITIES DURING 2019

- Considered the Scheme's asset allocation across various asset classes, taking into account the prevailing economic outlook.
- Reviewed the performance of asset managers.
- Commenced a process to optimise the allocation of assets across various equity portfolio management styles.
- Oversaw the implementation of the long-term asset allocation plan that commenced in 2018.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included on-site visits by the Scheme. This included due diligence reviews of the Scheme's offshore investment managers.
- Agreed to allocate a portion of the investments to a portfolio that aims to extract returns using multi-asset credit strategies.
- Recommended an updated Investment Policy Document to the Board for approval.
- Reviewed the effectiveness of services provided by the investment consultant.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2019, have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, the Committee consisted of three Trustees and two Independent Members. The Committee receives investment advice and quarterly reports from the Scheme's investment consultants, Riscura, who attend all Committee meetings. Asset managers are invited to attend meetings on a rotational basis to report on their strategy and performance.

Investment Committee attendance in 2019		12 Feb	09 May	08 Aug	30 Oct
Independent Member/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓
Committee Members	Mr Johan Human (Trustee)	✓	✓	✓	✓
	Mr Eric Mackeown (Independent Member)*	–	–	–	✓
	Ms Philile Maphumulo (Independent Member)	✓	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓
	Ms Daisy Naidoo (Trustee)#	✓	✓	–	–
	Mr Barry Stott (Independent Member)▫	✓	✓	✓	–

* *Commenced his term as Chairperson of the Audit Committee and as an Independent Committee Member of the Investment and Risk Committees on 01 September 2019.*
\# *Term ended on 22 June 2019.*
▫ *Term ended on 31 August 2019.*
– *Not required to attend.*

FUTURE FOCUS AREAS

During 2020, 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 asset allocation across the various equity portfolio management styles.

Non-healthcare Expenses Committee

The Committee oversaw the optimisation and management of the Scheme's non-healthcare expenses and the outsourcing of the administration and managed healthcare services based on the Scheme's Vested® outsourcing model. In July 2019, the Board of Trustees decided to disband the Committee and its functions were absorbed into several other committees, primarily the Risk Committee and the Stakeholder Relations and Ethics Committee.

The Committee's responsibilities were to:

- Support and endorse key principles that the Scheme Office uses to negotiate the contractual terms of the outsourced administration and managed services based on Vested® principles, and recommend the contractual terms to the Trustees for consideration and approval;
- Recommend the fee model to be used for the calculation of the outsourced administration and managed care fees to the Trustees for consideration and approval;
- Set and monitor the service levels of the Administrator and Managed Care Provider;
- Monitor the value the Scheme and its members receive from the Administrator and Managed Care Provider relative to the fees paid;
- Monitor and evaluate the investment in innovation by the Administrator and Managed Care Provider for the Scheme;
- Recommend the non-healthcare expenses budget to the Trustees for consideration and approval, and monitor actual non-healthcare expenses incurred against the approved budget; and
- Recommend the Scheme's Procurement Policy to the Trustees for consideration and approval, and monitor procurement decisions.

More about **the Vested model**

ACTIVITIES DURING 2019 (TO JUNE)

- Reviewed and monitored reports on Discovery Health's service levels and approved changes in line with the operating environment.
- Assessed innovations by Discovery Health.
- Reviewed reports on the Scheme's non-healthcare expenses against budget.

At June 2019, the Committee was satisfied that its activities, recommendations and reporting to the Board during 2019 had fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2019

As of June 2019, the Committee comprised four Trustees, one of whom chaired the Committee, and the Principal Officer. Committee meetings were attended by the DHMS Chief Operations Officer, responsible for oversight of the outsourced administration and managed healthcare services, as well as the Head of Legal and Ethics. Executive management of Discovery Health attended when required by the Committee.

Board Committees *continued*

Non-healthcare Expenses Committee attendance in 2019		07 Mar	31 Jul	17 Oct
Trustee/ Chairperson	Ms Daisy Naidoo#	✓	–	–
Committee Members	Mr John Butler (Trustee)	✓	–	–
	Mr David King (Trustee)	✓	–	–
	Mr Neil Morrison (Trustee)	✓	–	–
	Dr Nozipho Sangweni (Principal Officer)%	✓	–	–

 # Term ended on 22 June 2019.

– The NHE Committee meeting of 31 July was cancelled, prior to the Committee being dissolved as of 31 August 2019. Items that had fallen under the mandate of the NHE Committee have since been incorporated into the Risk Committee and the Stakeholder Relations and Ethics Committee or are dealt with directly by the Board of Trustees.

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

Nomination Committee

The Committee oversees the nomination process to elect suitably fit and proper persons as Trustees. In terms of the Scheme Rules, the Trustees may appoint an independent third-party service provider to assist the Nomination Committee in carrying out its functions. For the 2019 election, the Trustees approved the appointment of PricewaterhouseCoopers' (PwC's) Forensic Services division as the independent third-party service provider to assist the Nomination Committee.

ACTIVITIES DURING 2019

The following activities were initiated by the Committee for the 2019 Trustee elections. This process will continue into 2020:

- Oversee the procedural aspects of the nominations process, including approving communications to members.
- Ensure that the Independent Electoral Body (IEB) applies a vetting process ensuring that candidates standing for election are fit and proper. During the process, each nominee is subject to stringent vetting criteria.
- Review and discuss the draft candidate list compiled by the IEB, and provide the final list of candidates for election to the Trustees.
- The Committee reported to the Board on its activities for the 2019 election and fulfilled its responsibilities in accordance with its terms of reference.

Nominations Committee attendance in 2019		21 Jan	28 Jan	08 Feb	25 Feb	11 Mar	26 Mar	2 – 3 Apr	08 Apr	15 & 17 Apr	22 – 26 Apr	02 May^A	25 Oct	29 Oct	22 Nov
Independent Member/ Chairperson	Mr Peter Goss	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee Members	Mr Roy Shough (Independent Member)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓
	Mr Tom Wixley (Independent Member)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓

A Ad hoc meeting:

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

- *The meeting of 02 May 2019 was a joint meeting with the Board to discuss candidate nominations for the AGM.*

– Not required to attend. On 29 October, the Chairperson of the Nomination Committee was requested to meet with the IEB on behalf of the Committee.

COMPOSITION AND MEETINGS IN 2019

The Board, at their meeting on 28 August 2018, approved the reconstitution of the Nomination Committee for the purposes of the 2019 and 2020 nominations and elections processes. The Committee comprises three Members who are independent of the Board and Board Committees. Committee meetings are attended by the IEB and its representatives.

FUTURE FOCUS AREAS

Trustee elections were held in 2019 and will be held in 2020. The Nomination Committee will oversee this process from a governance perspective in terms of its mandate. PwC is the IEB appointed to apply nomination and vetting processes, ensuring that candidates who stand for election are fit and proper.

Product Committee

While there is no statutory requirement for this Committee, it was established in terms of Scheme Rule 19.3, as the Trustees consider it necessary for ensuring compliance with the legislative and regulatory requirements of the Act, as well as compliance with best practice governance principles pertaining to benefit and product development. The Committee comprises members with the requisite skills including actuarial and medical expertise. At the end of 2019, the Committee comprised three Trustees, one of whom is the Chairperson of the Clinical Governance Committee which facilitates the required overlap between the two Committees. The Principal Officer is also a member of this Committee.

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

ACTIVITIES DURING 2019

The Committee met three times during 2019, in accordance with the Committee's annual work plan, at which the following were considered:

- The Scheme's 2018 annual and 2019 quarterly financial performance and related factors.
- Impact of the product and benefit changes implemented in 2018.
- The Scheme's competitive position in the market.
- The 2019 marketing strategy and plan.
- The performance of all benefit plans based on specific performance metrics.
- The Committee collaborated with the Audit Committee and Clinical Governance Committee in considering the member and provider impact, clinical appropriateness and actuarial valuation of the product design and benefit amendments for 2020, prior to making the final recommendations to the Board for approval.
- Changes to the Scheme Rules and related feedback from the Regulator.
- Relevant policy and regulatory matters of industry and national importance, including the final report of the Health Market Inquiry (HMI), the ongoing PMB review, proposals for Scheme consolidation and the development of a framework for Low-Cost Benefit Options (LCBOs), and the NHI policy.

The Committee is satisfied that it has fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, the Committee comprised three Trustees, one of whom chaired the Committee, and the Principal Officer. The Committee obtains regular reports and presentations from Discovery Health, and relevant individuals are regularly invited to Committee meetings for this purpose.

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

Product Committee attendance in 2019		04 Apr	25 Jul	22 Aug
Trustee/ Chairperson	Mr Johan Human	✓	✓	✓
Committee Members	Dr Susette Brynard (Trustee)	✓	✓	✓
	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Ms Daisy Naidoo (Trustee)#	✓	–	–
	Dr Nozipho Sangweni (Principal Officer)%	✓	✓	✓

 # Term ended on 22 June 2019.
– Not required to attend.
% Scheme Executive. All other Committee Members are non-executive.

FUTURE FOCUS AREAS

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

Remuneration Committee

The Committee assists the Board in ensuring that the Scheme's remuneration practices are fair, responsible and transparent. It also assists with overseeing human resources strategies and policies, and ensuring compliance with these policies. Furthermore, it oversees the remuneration of Trustees and Independent Committee Members and makes recommendations to the Board regarding remuneration structures for Trustees and Independent Committee 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 Committee's responsibilities include the following:

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

1 *At least half of the Trustees must be elected by members at any time, which means that succession planning is not possible for these positions.*

ACTIVITIES DURING 2019

- Recommended Trustee and Independent Committee Member remuneration to the Board for approval.
- Considered and recommended the Trustee and Independent Committee Member Remuneration Policy to the Board for approval.
- Considered and recommended employee remuneration to the Trustees for approval.
- Considered and recommended Scheme human resources policies to the Board for approval.
- Reviewed and approved training and development requirements for Scheme employees.
- Tabled the Trustee Remuneration Policy and Trustee remuneration to members at the 2019 annual general meeting (AGM) for a non-binding advisory vote; these received 95.4% approval.

The Committee is satisfied its activities, recommendations and reporting to the Board during 2019 have fulfilled its responsibilities in accordance with its terms of reference.

AGM elections and **voting results**

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, the Committee comprised four Trustees and an Independent Committee Member. The Principal Officer attends Committee meetings by invitation.

The Committee makes regular use of independent remuneration experts from PwC and engaged Spencer Stuart for recruitment assistance during 2019. Individuals from these organisations are occasionally invited to Committee meetings.

Remuneration Committee attendance in 2019		23 May	13 Nov	02 Dec[A]
Trustee/ Chairperson	Mr David King	✓	✓	✓
Committee Members	Mr John Butler (Trustee)	✓	✓	✓
	Dr Susette Brynard (Trustee)	✓	✓	✓
	Mr Ndumiso Luthuli (Independent Member)	✓	x	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓

x Apology tendered.

A Ad hoc meeting:

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

- *The meeting of 02 December 2019 was held to discuss employee remuneration.*

FUTURE FOCUS AREAS

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

- Exercising oversight of the revised performance management approach with the intention of full implementation in 2021;
- 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; and
- Reviewing the Scheme's remuneration practices, where appropriate, and ensuring these comply with changing legislative and regulatory requirements, including those relating to King IV.

Risk Committee

The Committee oversees risk management, compliance, IT governance, fraud, ethics, whistleblowing, legal and regulatory matters, non-healthcare expenses, outsourcing and operations.

The purpose of the Risk Committee is to exercise ongoing oversight of risk management including:

- 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 which may impact on organisational objectives;
- Assessing the organisation's dependence on resources and relationships represented by the various forms of capital;
- Designing and implementing appropriate risk responses by continually assessing mitigation plans and their implementation by management, and recommending measures which may enhance the risk management process;
- Establishing and implementing business continuity arrangements that allow the organisation to operate under volatile conditions and to withstand and recover from acute shocks; and
- Integrating and embedding risk management in the business activities and culture of the organisation through continual risk monitoring and identification.

COMPLIANCE MANAGEMENT

The Trustees recognise their responsibility to internal and external stakeholders in terms of the regulatory requirements applicable to the Scheme.

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

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

RISK MANAGEMENT

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

The Trustees are satisfied that the risk management process is effective in continuously identifying and evaluating risks, and ensuring that these risks are managed in line with business strategy.

ACTIVITIES DURING 2019

- Participated in the annual risk assessment, which included representatives of the Committee, the Scheme Office, and the Administrator and Managed Care Provider.
- Regularly reviewed risk management reports and key risk indicators, and performed the annual review of the risk management framework and risk appetite that were recommended to the Trustees for approval.
- Regularly reviewed compliance reports and monitored exposure and actions taken to mitigate compliance risks, as well as the annual review of the Compliance Policy. The Committee considered the Policy and subsequently recommended it to the Trustees for approval.
- Received reports to assist in managing the Scheme's IT governance obligations and recommended the IT governance framework to the Board for approval. This included a focus on cybersecurity and business continuity.
- Considered specific risks related to data sharing across the industry to ensure that Scheme and member data are protected.
- Approved the Scheme's fraud risk management strategy.
- Reviewed and monitored reports on the service levels delivered by Discovery Health.
- Assessed the value added to the Scheme by Discovery Health.
- Reviewed the Scheme's non-healthcare expenses against budget.
- Reviewed the terms of reference which were amended to incorporate additional duties arising from the dissolution of the Scheme's Non-healthcare Expenses Committee.

The Committee is satisfied its activities recommendations and reporting to the Board during 2019 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, the Committee comprised two Independent 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.

Board Committees *continued*

Risk Committee attendance in 2019

		07 Mar	15 Aug	18 Sep	10 Oct
Independent Member/Chairperson	Mr Barry Stott#	✓	✓	–	–
Trustee/Chairperson	Mr David King (Trustee)▫	–	✓	✓	✓
Committee Members	Adv Joan Adams (Trustee)	✓	✓	✓	✓
	Mr Steven Green (Independent Member)◆	✓	✓	✓	✓
	Mr Johan Human (Trustee)∞	✓	✓	–	–
	Ms Susan Ludolph (Independent Member)∞	✓	✓	–	–
	Mr Eric Mackeown (Independent Member)◊	–	✓	✓	✓
	Ms Phlile Maphumulo (Independent Member)∞	✓	✓	–	–
	Ms Daisy Naidoo (Trustee)*	✓	✓	–	–
Scheme management	Dr Nozipho Sangweni (Principal Officer)&	✓	✓	x	x
	Charlotte Mbewu-Sanqela (CFO and Acting Principal Officer)@	✓	✓	✓	✓
	Selwyn Kahlberg (Chief Operations Officer)	✓	✓	✓	✓

 # Term ended on 31 August 2019.
▫ Appointed as Chairperson of the Risk Committee effective from 01 September 2019.
◆ Term ended on 31 December 2019.
∞ Term as a member of the Risk Committee ended effective 01 September 2019.
◊ Requested to attend the Risk Committee meeting held on 15 August 2019, and commenced his term as Chairperson of the Audit Committee and as an Independent Committee Member of the Investment and Risk Committees on 01 September 2019.
** Term ended on 22 June 2019.*
& The Principal Officer was on a sabbatical from 12 September 2019 to 04 November 2019.
@ Attended the meeting of 18 July as a Scheme Office invitee, and the last two as Acting Principal Officer during a sabbatical taken by the Principal Officer.
– 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 maintaining high-quality affordable benefits, developments in the regulatory landscape and cyber data 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 of the Scheme.

Ethics and society:

- Assist the Trustees to ensure that the Scheme has an ethical culture and is a good corporate citizen;
- 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 seen to be, a responsible corporate citizen;
- Oversee and monitor the development of adequate processes and procedures for the management of the Scheme's ethics and corporate citizenship; and
- Provide feedback to the Board regarding risks related to ethical and societal issues and provide mitigation 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 and monitor the development of adequate processes and procedures for engagement with the Scheme's material stakeholders;
- Oversee, monitor and evaluate the management of and engagement with the Scheme's material stakeholders; and
- Provide feedback and updates to the Board regarding stakeholder interactions, risks identified, or opportunities for new channels of engagement.

The Committee may rely on other Board Committees in its oversight responsibilities.

More about **our approach to social responsibility**

ACTIVITIES DURING 2019

- Reviewed reports relating to its social and ethics mandate, overall stakeholder engagement and risk, social media engagement, disputes and complaints, Treating Customers Fairly and high-risk cases.
- Reviewed stakeholder responses to year-end benefit changes, and plans for stakeholder engagement where required.
- Reviewed strategies for legal engagements affecting stakeholder relationships.
- As part of its mandate to assess the corporate citizenship of its value chain, reviewed the activity of Discovery Group's Fund, Foundation and staff volunteer programmes. The Discovery Fund actively supports the provision of primary healthcare to low-income communities, while the Foundation invests in the training and retention of medical specialists working in public healthcare and supports healthcare institutions.
- Reviewed plans for engagement with stakeholders regarding the Scheme's AGM and Trustee nominations and elections.
- Discussed impending regulatory changes which may affect the Scheme's members, other stakeholders, and the operations of the Scheme.

Board Committees *continued*

- Reviewed the outcomes of a comprehensive stakeholder assessment undertaken by the Scheme, including additional engagement plans.
- Considered and approved the recommendation that the operational Relationship Management (previously overseen by the Non-healthcare Expenses Committee) and Research Governance Committees be overseen by the Stakeholder Relations and Ethics Committee.
- The Research Governance Committee is a new operational Committee, established during the course of 2019, to oversee the governance of and requests from, among others, academic researchers to access Scheme data for the purposes of conducting research. It is essential that member privacy is safeguarded, and the Committee will ensure this while working to benefit society by supporting valuable research.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2019 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2019

At the end of 2019, the Committee comprised six Trustees, one of whom chaired the Committee, and the Principal Officer. The Committee requires that one of its members is a medical professional.

Committee meetings are attended by the Head: Special Projects and Stakeholder Relations. In addition, 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.

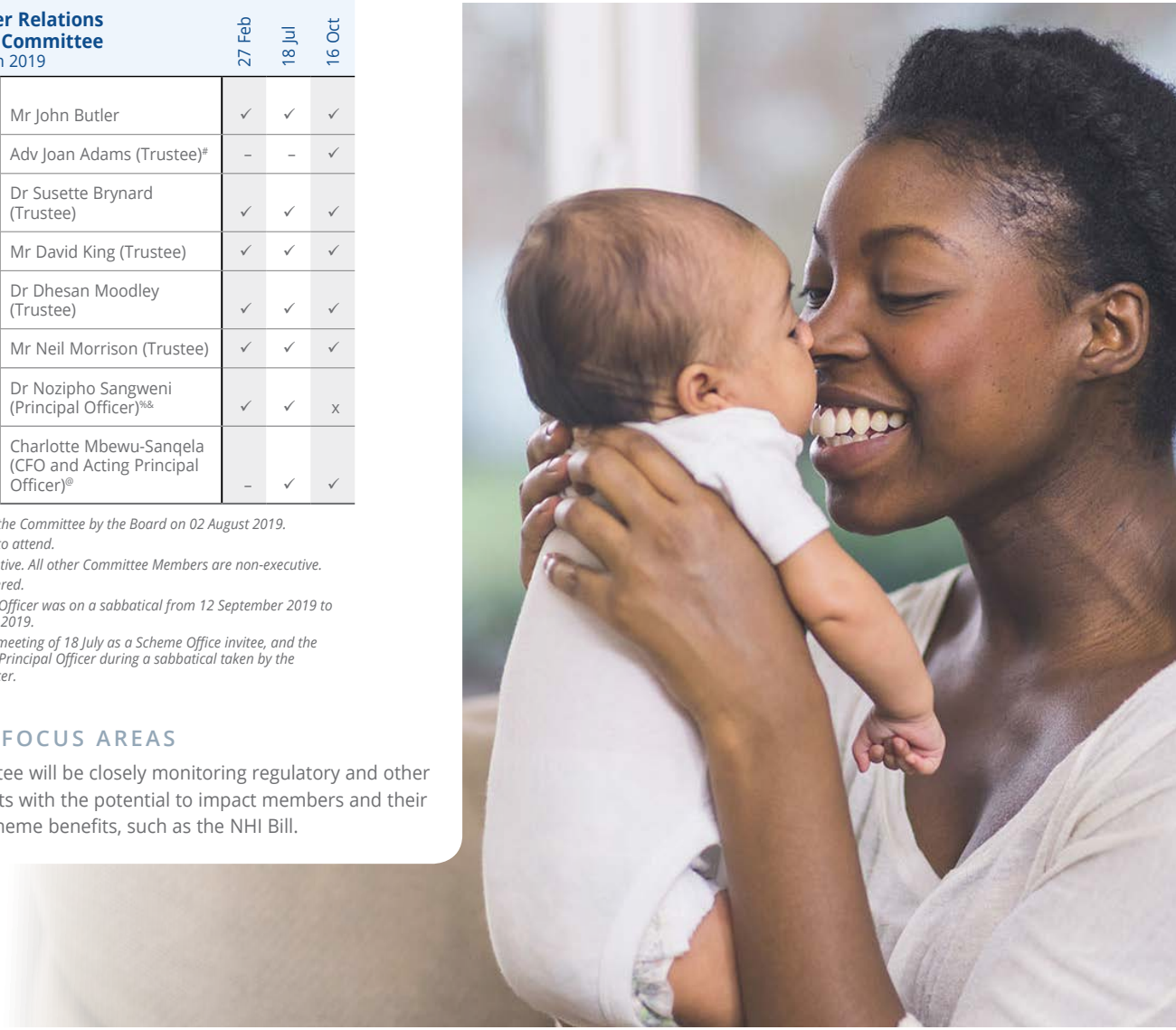
Stakeholder Relations and Ethics Committee attendance in 2019

		27 Feb	18 Jul	16 Oct
Trustee/ Chairperson	Mr John Butler	✓	✓	✓
Committee Members	Adv Joan Adams (Trustee)[#]	–	–	✓
	Dr Susette Brynard (Trustee)	✓	✓	✓
	Mr David King (Trustee)	✓	✓	✓
	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓
	Dr Nozipho Sangweni (Principal Officer)[%&]	✓	✓	x
	Charlotte Mbewu-Sanqela (CFO and Acting Principal Officer)[@]	–	✓	✓

[#] *Appointed to the Committee by the Board on 02 August 2019.*
– *Not required to attend.*
[%] *Scheme Executive. All other Committee Members are non-executive.*
x *Apology tendered.*
[&] *The Principal Officer was on a sabbatical from 12 September 2019 to 04 November 2019.*
[@] *Attended the meeting of 18 July as a Scheme Office invitee, and the last as Acting Principal Officer during a sabbatical taken by the Principal Officer.*

FUTURE FOCUS AREAS

The Committee will be closely monitoring regulatory and other developments with the potential to impact members and their access to Scheme benefits, such as the NHI Bill.



Our Remuneration Policy

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

The Board of Trustees has delegated oversight of Scheme remuneration to a Remuneration Committee (Remco). Remco is a Board Committee established in terms of the DHMS Board Charter, to assist the Board in fulfilling its remuneration governance and oversight obligations and responsibilities in terms of the Medical Schemes Act, No. 131 of 1998, Scheme Rules and best practice governance principles.

More about **our Remuneration Committee**

As and when required, Remco uses independent expert consultants and independent market benchmarking to assist the Committee to develop and implement best remuneration practices, as detailed in the approved Remuneration Policy. Trustee remuneration disclosure occurs in three forums:

- At the annual general meeting (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 Remco for Board approval and is tabled each year at the AGM for a non-binding vote by members.

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

- Number of meetings planned per year;
- Preparation time for each meeting;
- Duration of meetings;
- Estimated time between meetings required by the Chairpersons; and
- The number of actual meetings attended.

It is important to note that Trustees are also members of Board Committees and that each Board Committee differs with regard to 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 as per the annual meeting plan and is split into:

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

Full **Remuneration Policy** on the website

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 must be fit and proper to hold this office and may appoint any staff required for the proper execution of the business of the Scheme.

The Board delegates collective management responsibilities to the Principal Officer and determines the terms and conditions of service of any person employed by the Scheme. The Principal Officer is required to execute the decisions of the Board and bears ultimate responsibility for all management functions.

Guided by the Act, its Regulations, the Scheme Rules, the Board delegation of authority, along with applicable laws, codes and standards, 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 Administrator and Managed Care Provider, Discovery Health, to implement strategy.

The management team's expertise extends across a diverse array of capabilities related to medicine, actuarial science, risk management, accounting, business management, strategic development, financial management, investment, law, ethics, compliance and research.

Remuneration and human resources planning

The Trustees and the Remuneration Committee direct and oversee remuneration for employees of the Scheme Office. Remuneration is carefully structured and independently benchmarked according to the experience and skills required and is informed by best practice.

The Scheme must attract and retain high-calibre staff to manage and oversee its complex operations. In 2019, the Scheme Office consisted of thirteen staff members; this includes a team of six[1] executives who report to the Principal Officer and are supported by the Scheme Secretariat and administration departments. This very lean employee complement makes succession planning challenging and, as a result, the operational model applied by the Scheme Office requires significant overlap in executive team capabilities. In turn, this must be supported by a mature knowledge management and retention strategy to mitigate this risk, including a notice period sufficient to allow for transition and the recruitment of scarce skills.

Staff movements during 2019/20

The Principal Officer, Dr Nozipho Sangweni, resigned with effect from 30 November 2019, and the Chief Financial Officer, Ms Charlotte Mbewu-Sanqela, was appointed Acting Principal Officer with effect from 1 December 2019.

The Head: Legal and Ethics acted in the role of Head: Compliance and Governance for the period 1 February to 31 July 2019, prior to the appointment of Ms Lusani Nelufule-Mugivhi.

Scheme Secretariat

The Scheme has an appropriately qualified and experienced secretariat function within its operational structure that provides the Trustees with support regarding their duties, responsibilities and powers. In addition, the secretariat function ensures that accurate minutes of all Board and Committee meetings are appropriately prepared, distributed and stored.

Delegation of authority

The Board has implemented a formal delegation of authority that provides a framework for achieving our strategic priorities within compliance requirements, while also balancing the interests of our stakeholders, minimising and avoiding conflicts of interest, and practicing good corporate behaviour. The delegation of authority contributes to the effective exercise of authority and responsibility required for the optimal operation of the Scheme, promoting independent judgement and ensuring a balance of power. The delegation of authority is reviewed and updated whenever necessary to ensure relevance to operating requirements and alignment with the accountabilities and authorities of Scheme employees.

1 *The Head: Compliance and Governance role, which had been vacant from 31 January 2019, was filled from 1 August 2019. The Head: Legal and Ethics acted during this vacancy.*

Executive team

Principal Officer

Dr Nozipho Sangweni[1]
MBChB; MBA; PGDip Occupational Health; PGDip Civil Aviation Management

Accounting Officer of the Scheme, Council member of iFHP[2], and a board member of the HFA[3].

1 Head: Legal and Ethics (HLE)

Mr Howard Snoyman
LLB; MSc. Med (Bioethics and Health Law); Certified Deal Architect[4]; Dip Sports Management; Adv Dip Sports Management; Certified Ethics Officer (in progress); Certified Fraud Examiner (in progress)

Board member of the Marketing Code Authority, Member of the Independent Regulatory Board for Auditor's (IRBA) Committee for Auditor Ethics.

The HLE advises on, formulates and oversees strategic and operational legal and ethics frameworks and activities, including escalated member disputes and complaints, and ensures the incorporation of all relevant requirements into the legislative universe of the Scheme.

2 Head: Compliance and Governance (HCG)

Mrs Lusani Nelufule-Mugivhi[5]
LLB; Postgraduate Diploma in Compliance Management

President and board member of the Corporate Counsel Association of South Africa.

The HCG provides a central source of guidance to the Scheme on governance matters and ensures the management, co-ordination and responsibility for the Scheme Secretariat function, as well as compliance with the Scheme's legislative and regulatory obligations.

3 Chief Financial Officer (CFO)

Acting Principal Officer (from 1 December 2019)

Ms Charlotte Mbewu-Sanqela
BCom (Hons) Accounting; CA (SA)

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.

4 Chief Medical Officer (CMO)

Dr Unati Mahlati
MBChB; FCPHM[6]; MMed

Board member of HQA[7].

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

5 Chief Operations Officer (COO)

Mr Selwyn Kahlberg
BSc (Hons) Actuarial; CFA; FASSA; FIA

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

6 Head: Special Projects and Stakeholder Relations (HSPSR)

Ms Michelle Culverwell
BA (Hons); MBA in Executive Management

Member of the HFA[8] Technical Advisory Committee.

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

1 *Resigned with effect from 30 November 2019.*
2 *iFHP: International Federation of Health Plans. Resigned with effect from 01 December 2019.*
3 *HFA: Health Funders Association. Resigned from the board of HFA with effect from 30 November 2019.*
4 *The Vested® Certified Deal Architect (CDA) programme, offered by the University of Tennessee, certifies individuals as an expert in the field of collaborative contracting and negotiations.*
5 *Joined the Scheme on 1 August 2019.*
6 *Fellow of the College of Public Health Medicine of South Africa.*
7 *HQA: Health Quality Assessment.*
8 *HFA: Health Funders Association.*

Regulatory and industry matters dealt with in 2019

Low-Cost Benefit Options and Demarcation Exemption Framework

In December 2019, CMS Circulars 80 and 82 announced that no further Low-Cost Benefit Options (LCBO) exemptions would be granted by the CMS, and that all existing products exempted from the requirements of the Medical Schemes Act (the Act) in terms of the Demarcation Exemption Framework must wind up their products before March 2021.

A Section 50 appeal regarding the Circular was submitted to the CMS in January 2020 by the Health Funders Association (HFA), to which DHMS was a party, joining other medical schemes and administrators. The CMS has subsequently held a number of stakeholder engagements in accordance with Circular 5 of 2020 and has indicated through Circular 12 of 2020 that it will be establishing two advisory committees. The advisory committees, which will incorporate stakeholders from both the insurance and medical scheme industries, will develop a roadmap for the products and assist the CMS to establish the best way forward, while protecting the many lives currently covered by these products. DHMS will engage with this process through the HFA wherever appropriate and supports the development of an LCBO framework that will expand access for low-income households, ensuring access to quality care while expanding and improving the risk pools of medical schemes.

CMS matters

Certain provisions of **Rule 11 of the Scheme Rules** remain unregistered with the CMS. This Rule deals with preventing members from re-joining the Scheme immediately after committing fraud or deliberate non-disclosure against it. To protect the Scheme's greater membership, the Scheme believes that such members should be prohibited from re-joining for a certain time period. During 2016, the Scheme lodged two appeals both of which were unsuccessful. Following legal advice, on 17 May 2017 the Trustees lodged a High Court Application for Review in terms of the Promotion of Administrative Justice Act. The High Court Review has yet to be set down.

A Scheme Rule, once registered, remains registered until either the Scheme's Board of Trustees amends or rescinds the Rule and the amended Rule is then registered by the CMS, or a Court rescinds the Rule in question upon application by the Registrar of CMS.

Scheme Rule 14.7 dealing with the rejection of claims from providers where they have placed the Scheme at risk, was submitted to the CMS in 2012 and was registered by the CMS. Subsequent iterations of the Rule were the subject of debate with the CMS and were not re-registered. The matter was taken on appeal in terms of Section 49 of the Act and was set down for hearing on 13 July 2018. Just prior to the appeal hearing, the CMS conceded that the Rule was in effect still registered and, by agreement, the hearing was no longer necessary. The effect of this concession is that the Rule, as it stood when last registered in 2012, remains legally registered and enforceable. At the time of writing, iterations of the Rule from 2014, up to and including 2020, remain unstamped by the CMS, however this does not affect the validity of the 2012 registration (also stamped in 2013).

The explanatory notes to Annexure A of the Regulations to the Medical Schemes Act 181 of 1998, acknowledges that, due to constantly changing medical practice and health technology, the PMBs must be reviewed every two years taking cognisance of the impact, effectiveness and appropriateness of the PMB package. Despite concerns expressed by stakeholders, a full PMB review has not been completed since promulgation of the Regulations; a first attempt was made in 2008/9 and was rejected in 2010 by the then Minister of Health on the basis that primary healthcare was not sufficiently incorporated. A second review was initiated through CMS Circulars 83 of 2016 and 1 of 2017, with the establishment of Advisory and Costing Committees that will report and make recommendations to the PMB Review Steering Committee.

Following the adoption of a priority setting framework, the Advisory Committee drafted a **PMB Primary Healthcare (PHC) package.** The CMS appointed working committees including contributors from relevant academic healthcare settings. The draft PHC package was published through CMS Circular 79 of 2019 on 27 November 2019. Prior to the publication of the Circular, the HFA, in its capacity as a representative member of the PMB Review Advisory Committee, submitted comments on the same draft PHC package document before the document was published for broader stakeholder comments.

While confirming support for the PMB review in principle, the HFA noted concerns relating to a lack of clarity on how the draft PHC package and broader PMB review could be impacted by policy and regulatory changes such as National Health Insurance (NHI), and the LCBO framework. The HFA also proposed that the Review did not adequately address challenges with the current PMB package, and may be additive to the already-costly PMB package, which drives utilisation, and thereby contributes to healthcare inflation.

The Scheme strongly supports funding primary care and will continue to engage actively and constructively in the multi-stakeholder group convened by the CMS to review the PMBs.

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

The CMS website

Competition Commission's Health Market Inquiry (HMI) into the private healthcare sector

The final report of the inquiry by the Competition Commission into the private health sector to determine whether there are aspects of the market which distort, restrict or prevent competition was published on 30 September 2019. In its report, the HMI identified the need for improved competition across all sectors of the private healthcare market and has made wide-ranging recommendations encompassing a variety of factors and stakeholders.

The report was presented to the Minister of Trade and Industry and the Deputy Minister of Health. Minister Patel committed to closely scrutinising its contents and to engaging with his counterparts at the Department of Health. In addition, Commissioner Bonakele announced the establishment of a special unit within the Competition Commission that will advocate for the implementation of the HMI recommendations and contribute to the debates on NHI and proposed health system reforms.

The Scheme congratulates the Competition Commission on the substantial work done and many positive recommendations towards industry improvements. The Scheme looks forward to supporting the implementation of the HMI's recommendations wherever they contribute to improved functioning within the healthcare industry, to the benefit of all South Africans.

The HMI's final report is available on the Competition Commission's website

Discovery Health accreditation

All administrators and managed care providers in the industry must renew their accreditation by the CMS every two years. In December 2019, the CMS informed the Scheme that accreditation was granted to Discovery Health to perform administration services for a further two-year period, extending this to 31 December 2021. The accreditation is subject to conditions which Discovery Health is required to fulfil and which the Trustees and Principal Officer monitor closely, in line with their governance accountabilities and fiduciary duties.

Fraud, waste and abuse

In recognition of the severe impact of fraud, waste and abuse (FWA) on medical schemes and their members, the CMS held its inaugural annual FWA Summit in early 2019. DHMS attended and, together with other industry stakeholders, signed an industry charter pledging to combat FWA.

During 2019, the CMS convened an inquiry into the scope, use and potential abuse of Section 59 of the Act which confers on medical schemes forensic powers to recover funds unduly paid to either members or practitioners. Various healthcare professionals, facilities, medical schemes and medical scheme administrators testified at the inquiry, as did Discovery Health and DHMS. The Scheme and its Administrator were able to explain in detail the processes and principles of its activities to combat FWA, and to demonstrate that these are legal and ethical. The Scheme supports the stated objectives of the inquiry and its process, while also underscoring the importance of the provisions of Section 59 of the Act which allows DHMS to protect members' funds against fraudulent and wasteful activity.

The Scheme looks forward to the second FWA Summit which, together with the release of the draft Section 59 investigation report, has been postponed in light of the COVID-19 outbreak.

More about **the impact of FWA**

National Health Insurance and the draft Medical Schemes Amendment Bill

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

The NHI policy was approved by Cabinet in June 2017, and two draft NHI Bills have been released for public consultation, in June 2018 and July 2019. The Scheme and Discovery Health made joint submissions on both Bills and engaged in other consultative forums including the HFA and Business Unity South Africa, which also made submissions. These submissions support the provision of universal healthcare to all South Africans within a social solidarity framework, but protect the rights of individual citizens to purchase and access cover, beyond mandatory contributions to the NHI Fund.

The next version of the Medical Schemes Amendment Bill is expected to be published in 2021.

DHMS looks forward to continuing our active engagement with all stakeholders on health policy and regulatory changes.

05

OUR PERFORMANCE

Our Principal Officer's review of the year

Discovery Health Medical Scheme (DHMS) exists to provide our members with access to quality, affordable and appropriate healthcare, supported by excellent member service.

In our efforts to deliver on this mandate, we are acutely aware of the impact on the Scheme and our stakeholders of dynamics in the external environment. Economically, 2019 proved to be particularly challenging, with low growth, volatile investment markets, rising unemployment and wage increases below inflation.

The demographic profile of our membership base continues to worsen, albeit gradually – a key indicator of an increasing burden of disease. Added to this are above-inflation increases in healthcare costs, attributable to supply- and demand-side factors, and health policy uncertainty. It is in this environment that the Scheme continues to work hard to meet the objectives associated with our strategic themes.

Our **strategic themes**

Our Principal Officer's review of the year *continued*

In the period under review, the Scheme experienced marginal membership growth of 0.06% and better than expected utilisation of healthcare services, although the severity of in-hospital cases increased. The combined effect of these factors, fortunately, had a positive impact on the Scheme's claims experience. This resulted in a moderately positive net healthcare result of R136 million for the year ended 31 December 2019, which together with investment income of R1 698 million, contributed to the net surplus for the year of R1 563 million. This leaves the Scheme in a healthy financial position, with members' funds of R19.2 billion and a solvency level of 27.5%, against the legislative requirement of 25%. In light of the 2020, COVID-19 outbreak, we have assessed the potential impact of the outbreak on claims experience, investments and ultimately the financial soundness of the Scheme. Because of the assumptions that must be made, these assessments do come with risk; however, having taken a pragmatic approach, we believe that the Scheme remains in a strong position to continue to meet the needs of its members and pay claims as they fall due.

Globally, the healthcare industry has seen the rapid development of new diagnostic and treatment technologies and modalities, including medicines and surgical technologies. These are often far more costly relative to the prevailing standard of care. The challenge faced by funders worldwide in the face of these advancements is to balance the care and access needs of members, protection of members – particularly in instances where information asymmetry exists – while also ensuring the financial sustainability of the funder to enable it to meet the future care needs of members. Our Scheme is not immune to this challenge. The Trustees review the potential use of these new technologies and medicines, and continuously assess the framework developed by Discovery Health in this regard – to ensure we achieve this balance.

Analysis conducted on the Scheme's claims data, utilising Discovery Health's analytical and informatics capabilities, indicates that 5.1% more of our members had a chronic condition in November 2019 versus November 2018, and that the overall prevalence of cancer has increased 58% since 2011 (as of end 2019). In an effort to respond to members needs in this regard:

- Discovery Health, on the Scheme's behalf, has negotiated reduced tariffs with the pharmaceutical companies who manufacture medicines used in treating some of these conditions. A significant price reduction was negotiated for the drug Trastuzamab, used in the treatment of metastatic breast cancer, benefiting the whole industry.
- Extending the funding of curative treatment for Hepatitis C infection in support of the national goal to eliminate viral hepatitis.
- Introduction of a mental healthcare programme through the Premier Plus GP Network.

To ensure best quality care, the Scheme has continued to focus on developing value-based models to align the remuneration of healthcare providers with defined health outcomes. The evolution of value-based contracts remains a challenge in the South African healthcare environment, with most providers reporting a preference for the traditional fee-for-service model[1] . Nonetheless, we continue to lead this important market shift through collaboration with healthcare providers, professionals and their respective societies. Building on the Scheme's other successful value-based contracting initiatives, in 2019, given the burden of disease and cost associated with managing chronic back pain, work started on a collaborative effort with the SA Spine Society to achieve the best possible clinical outcomes for patients, while unlocking additional funding for spinal surgeons. We look forward to the implementation of this initiative in 2020.

The Scheme also introduced a day surgery network, in line with trends in global best-practice[2] for clinically appropriate procedures supported by our HomeCare benefit. After some initial challenges and in-depth engagement with healthcare providers and societies to establish the best parameters for day treatments; this has been supported by facilities, doctors and their patients. The Scheme continues to monitor this initiative, particularly with regard to the clinical outcomes.

Fraud, waste and abuse

In managing costs and protecting members' funds, the prevalence of fraud, waste and abuse (FWA) in healthcare continues to be a challenge. The Global Health Care Anti-Fraud Network estimates USD260 billion (approximately six percent of global healthcare spending) being lost to fraud each year[3]. We estimate that our efforts to combat FWA activity have resulted in our members' contributions being 14% lower[4] today than they otherwise would be. In our Integrated Report we provide some case studies to illustrate to our members the types of FWA activity we have uncovered.

Examples of **fraud, waste and abuse**

In 2019, we recovered R463.86 million for the benefit of our members. Wherever identifiable, recoveries are returned directly to the member concerned. More broadly, the fraud management frameworks of schemes and administrators have been subject to scrutiny over the past year, resulting in the Council for Medical Schemes (CMS) launching an inquiry into allegations made by healthcare providers. The Scheme and Discovery Health made submissions and representations to the Inquiry Panel. The release of the draft Section 59 investigation report was due to be released in April 2020, but has been postponed in light of the COVID-19 outbreak.

1 *Source: Bain & Company, "Healthcare's Evolving Payment Landscape". 16 January 2020. https://www.bain.com/insights/healthcare-payments-infographic/.*
2 *Guidelines in the UK target 75% of elective surgery to be performed as day cases, but minimally invasive surgery is now well established, allowing more procedures to be performed as day surgery and even greater rates should be possible, helping to achieve good outcomes, manage costs and reduce levels of hospital acquired infections. (Source: Guidelines for day-case surgery 2019 https://onlinelibrary.wiley.com/doi/10.1111/anae.14639).*
3 *Source: Global Health Care Anti-Fraud Network, http://www.ghcan.org/global-anti-fraud-resources/the-health-care-fraud-challenge/.*
4 *Taking into account the last seven years.*

Policy and regulatory activity

Policy and regulatory review and reform in South Africa aims to improve the healthcare system in South Africa, in both the public and private spheres. The Health Market Inquiry (HMI) Report identified various factors in the private sector that exacerbate inflationary trends, fragmentation of care and supply-induced demand with overutilisation of services, among others. We are pleased that the HMI also identified remedies, which the Scheme is already working on, such as quality outcomes measurement and the move to value-based care. The HMI also identified specific interventions, such as introducing a risk adjustment mechanism for the funder industry, and advocated for the review of Prescribed Minimum Benefits (PMBs), which is in progress, led by the CMS. The Scheme supports the implementation of such interventions, as they have the potential to benefit our members greatly.

The National Health Insurance (NHI) Bill has been the focus of much robust debate in recent times, with the Portfolio Committee for Health conducting country-wide roadshows to engage citizens. The NHI Fund is intended to be the supporting mechanism for South Africa's move towards universal healthcare. Universal healthcare is a social good and human right, as per the United Nations' Universal Declaration of Human Rights and the South African Constitution, which we fully support as a function of our social responsibility mandate. The Scheme and Discovery Health have published our views and answers to frequently asked questions to assist members in understanding NHI and its potential impact.

More about the **National Health Insurance Bill**

Our **NHI FAQ**

The CMS is driving industry reform aimed at protecting low-income earners while ensuring their access to care. In this regard, the CMS announced the termination in 2021 of the demarcation exemption afforded to long-term insurers, currently enabling these entities to provide primary healthcare products, as well as the non-renewal of exempted Low-Cost Benefit Options (LCBOs) within the medical scheme industry.

Both these measures have the unintended consequences of excluding some 500 000 covered individuals from the private healthcare sector. We welcome the CMS's initiative to engage the medical scheme and insurer industries on these matters. Through the mechanisms the CMS has established, we hope to find a lasting solution for the inclusion of low-income earners, ensuring that they have access to appropriate care in an affordable and sustainable manner.

Notable changes for 2020

In the coming year, the Scheme will continue working towards making higher quality and value-based care available to its members, to improve health outcomes and contain healthcare inflation, which relates directly to increases in member contributions.

In the first quarter of 2020, the Scheme responded to the rapid spread of COVID-19 by implementing the WHO Global Outbreak Benefit across all our benefit plans. This will assist members who become infected by funding screening, diagnosis and management of the coronavirus.

COVID-19 information

We have also made virtual consultations more accessible to our members through extensive partnerships with pharmacies, and our doctor networks via DrConnect.

> We implemented the WHO Global Outbreak Benefit across all our benefit plans, to assist members affected by the virus. This will assist infected members by funding screening, diagnosis and management of the coronavirus.

This makes care more accessible and streamlines the healthcare journey for patients, with referrals to face-to-face consultations as needed. This virtual facility may prove invaluable in mitigating the risk of highly infectious disease spread from close contact, for both patients and healthcare providers.

Our full **performance report**

Our team

In late 2019, our Principal Officer, Dr Nozipho Sangweni, resigned to focus on her other interests. We thank Dr Sangweni for her vision and deep dedication to the Scheme and all of its stakeholders. In her time as Principal Officer, Dr Sangweni had a great impact on our culture and forged strong relationships on behalf of the Scheme, enabling us to work effectively towards our vision and objectives.

We welcomed a new Scheme executive, Ms Lusani Nelufule-Mugivhi, who joined us in August 2019 to head our Compliance and Governance function. Ms Nelufule-Mugivhi is an admitted attorney of the High Court of South Africa and has extensive regulatory and compliance experience.

My gratitude to the Trustees, Independent Committee Members and to the Scheme Office team for their thought leadership and hard work in protecting and growing the Scheme, despite operational constraints and financial pressures.

In closing, our 2 808 106 beneficiaries[1] can continue to rest assured that their Scheme is sustainable, secure and constantly seeking ways to optimise their access to high-quality, value-based and equitable care, as well as working on their behalf towards a better healthcare system for all South Africans.

C Mbewu-Sangela

Ms Charlotte Mbewu-Sanqela
Acting Principal Officer

1 *At 31 December 2019.*

Scheme performance for the 2019 financial year

Overview

For the year ended 31 December 2019, DHMS delivered a positive net healthcare result[1] of R136 million (2018: negative healthcare result of R352 million). This year-on-year improvement in results is primarily attributable to the continued rollout of in-hospital risk management initiatives. The positive effect of these initiatives was, however, offset by increased utilisation of out-of- and in-hospital benefits which continue to impact the Scheme's results.

Despite volatile investment markets, the Scheme generated healthy investment income of R1 698 million (2018: R1 512 million), contributing to the net surplus of R1 563 million (2018: R816 million) for the year.

This solid financial performance increased members' funds to R19.2 billion (2018: R17.6 billion) with a solvency level of 27.5% (2018: 27.3%), exceeding the regulatory requirement of 25%. Receiving a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co (GCR), the Scheme has achieved the highest possible rating for a medical scheme in South Africa for the 19th consecutive year, confirming the Scheme's financial strength and ability to pay claims. In the Trustees' view, DHMS ended 2019 in a strong financial position despite challenging market conditions and is well-positioned to continue to meet members' needs going forward.

INVESTMENT INCOME

R1 698 million

(2018: R1 512 million).

NET SURPLUS

R1 563 million

(2018: R816 million)

MEMBERS' FUNDS

R19.2 billion

(2018: R17.6 billion)

SOLVENCY LEVEL

27.5%

(2018: 27.3%)

CREDIT RATING

AAA

The highest possible rating for a medical scheme in South Africa for the

19TH CONSECUTIVE YEAR

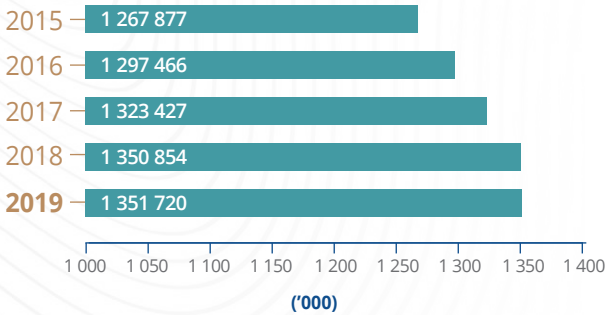
1 *At 31 December 2019.*

Key performance information

Historical performance indicators

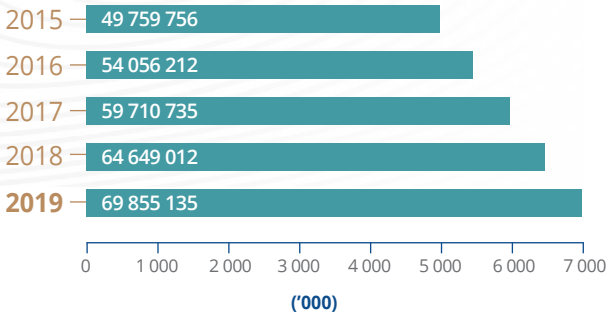
Consistent with the stagnant South African economy, the medical scheme industry is experiencing only marginal growth. Despite this environment, the Scheme's number of principal members and total lives under management remain stable, and members' funds are sufficient to assure members that the Scheme is able to take care of them.

SCHEME PRINCIPAL MEMBERS



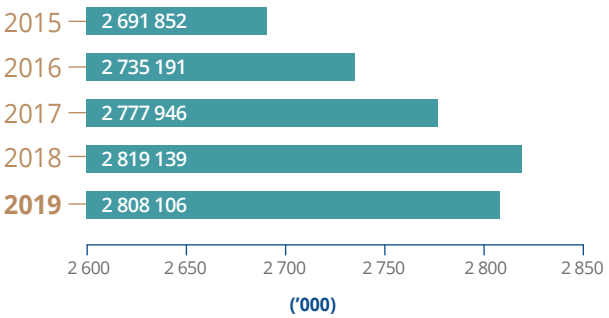
INCREASE
0.06%[1]

GROSS CONTRIBUTIONS (R'000)



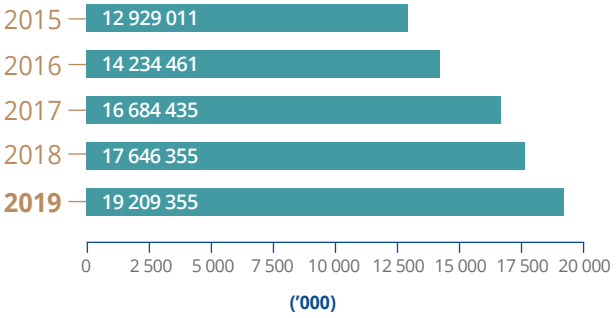
INCREASE
8.05%[1]

SCHEME LIVES



DECREASE
0.39%[1]

MEMBERS' FUNDS (R'000)



INCREASE
8.86%[1]

1 Year-on-year change (2018 – 2019).

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 below, together with an explanation of why we consider them important to monitor:

GROWTH AND SUSTAINABILITY

MEMBERSHIP GROWTH

Growth of young and healthy lives improves risk pooling through cross-subsidisation principles, which reflects the attractiveness and competitiveness of the Scheme.

AVERAGE NET MEMBERSHIP GROWTH[1]
0.06%
(2018: 2.07%)

AVERAGE BENEFICIARY DECLINE[1]
0.39%
(growth 2018: 1.48%)

AVERAGE AGE AT YEAR END[2]
35.33
(2018: 34.91)

10.35%
PENSIONER RATIO
(2018: 9.83%)

5.41%
ANNUALISED LAPSE RATE
(2018: 5.36%)

MEMBERSHIP SIZE

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

1 351 720
PRINCIPAL MEMBERS
as at 31 December 2019
(2018: 1 350 854)

2 808 106
BENEFICIARIES
as at 31 December 2019
(2018: 2 819 139)

56.7%[3]
SHARE OF OPEN SCHEME MARKET
(2017: 56.6%)

PLAN MOVEMENTS

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

94.27%
PLANS DID NOT CHANGE FOR 2020
(2019: 94.076%)

2.81%
PLANS WERE UPGRADED
(2019: 3.02%)

2.91%
PLANS WERE DOWNGRADED
(2019: 2.91%)

RELATIVE CONTRIBUTION LEVELS

Reflects value for money for members, effective risk management and value added by the Administrator.

AVERAGE CONTRIBUTIONS FOR 2020
16.7%
Lower than the next
EIGHT LARGEST OPEN SCHEMES[4]
(2019: 16.5%)

1 *Membership growth across medical schemes is currently constrained by affordability and a challenging economic climate, including stagnant job growth.*
2 *An increase of less than one year per annum is favourable as it indicates that young people are joining the Scheme.*
3 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 June 2019 (www.medicalschemes.com/Publications.aspx).*
4 *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a single member and for a family unit comprising one principal member, one adult dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight 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.*
This methodology has since been updated to make use of an average of the increases for a principal member and a family of three, as being more representative of DHMS plan holders. Using this updated methodology, the difference for 2019 would have been 16.7% vs the 16.5% reported last year.

Ensuring the Scheme's sustainability *continued*

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

27.5%
(2018: 27.3%)
exceeding the statutory solvency requirement of 25%

AAA INDEPENDENT CREDIT RATING

for claims paying ability[1] (2018: AAA)

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims.

NET SURPLUS FOR THE YEAR OF

R1 563 million
(2018: R816 million)

PRUDENT INVESTMENT MANAGEMENT

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

7.09%
GROSS RETURN ON INVESTMENTS
(2018: 5.85%)

Value-added Administration and Managed Care

FOR EVERY R1.00 SPENT BY DHMS ON ADMINISTRATION AND MANAGED CARE FEES IN 2018[2], MEMBERS OF DHMS RECEIVED

R2.12
(2017: R2.02)
in value from the activities of Discovery Health. This is equivalent to nominal added value of R7.34 billion in 2018
(2017: R6.24 billion)

ADMINISTRATION FEES

7.38%
of gross contributions
(2018: 7.54%)

MANAGED CARE FEES

2.53%
of gross contributions

1 *How many times the Scheme is able to cover its monthly claims expense with its liquid investments.*

2 *As the assessment uses industry information, results are only available for the preceding year. Discovery Health's value-adding initiatives for the Scheme constantly evolve, and from time to time new initiatives that have proven their value-add are included in the calculation, which was the case for the 2018 calculation. Applying this updated methodology for 2017, the figure would have been R2.09 value received by the Scheme for every R1.00 spent.*

DHMS plans and beneficiary distribution

Priority series
7.1%
- Classic Priority
- Essential Priority

Executive series
0.7%
- Executive

Smart series
4.0%
- Classic Smart
- Essential Smart

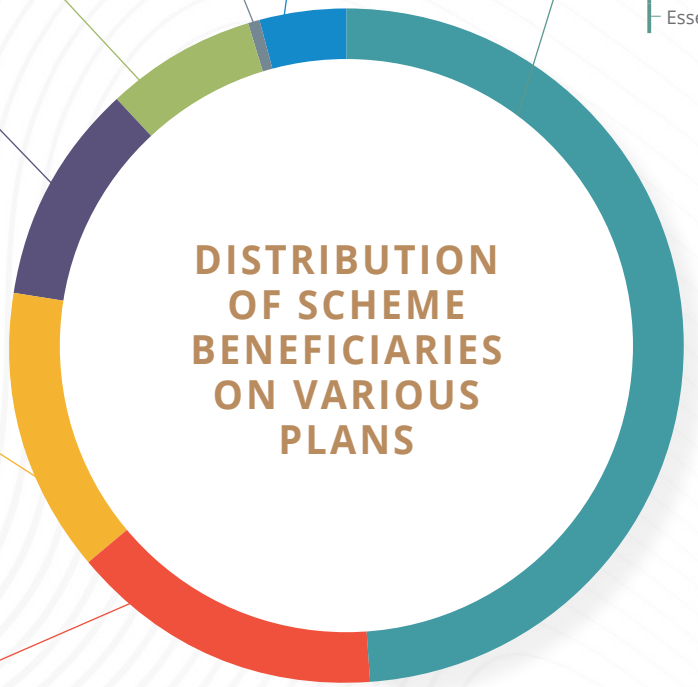
Saver series
49.0%
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta* Saver
- Essential Delta* Saver

Comprehensive series
10.6%
- Classic Comprehensive
- Classic Comprehensive Zero MSA[1]
- Essential Comprehensive
- Classic Delta* Comprehensive
- Essential Delta* Comprehensive

1 *For 2020, the Classic Comprehensive Zero MSA plan was changed to Classic Smart Comprehensive.*

Core series
13.6%
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

Keycare series
15.0%
- KeyCare Plus
- KeyCare Core
- KeyCare Access



17 **BENEFIT OPTIONS**
(2017: 17)

6 *** NETWORK EFFICIENCY DISCOUNT OPTIONS**
(2017: 6)

GROSS CONTRIBUTION INCOME

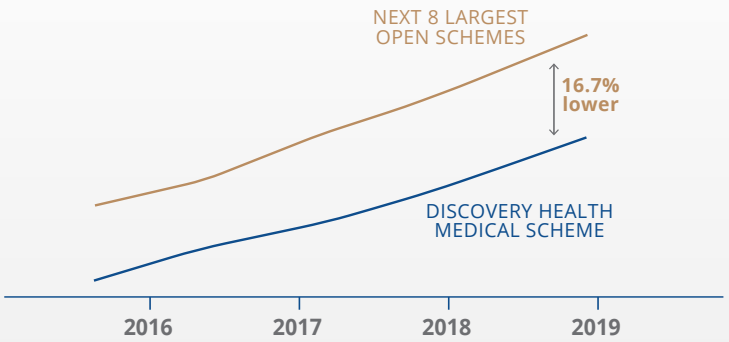
Maintaining the balance between competitive contributions, providing affordable quality healthcare to our members while also retaining regulatory reserve requirements remains a challenge.

The Scheme remained highly competitive with average contributions for 2020 being 16.7% lower[1] on a plan-for-plan basis (for 2019: 16.5%) than the next eight largest open schemes; this is predominantly due to our ability to contain the impact of medical inflation. The Scheme's members experienced contribution increases slightly lower than the weighted average across the next eight largest open schemes (9.5% vs 9.8%).

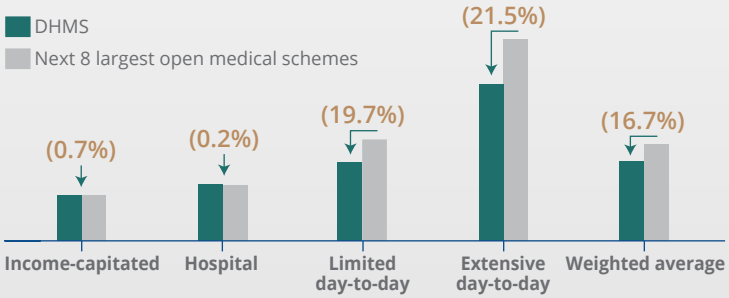
The Scheme's high levels of efficiency resulted in 87.3% of contributions being used for members' direct benefit by funding claims and reserves. The remainder of the funds are used to support and benefit members in areas such as innovation, managed care, administration, financial advisers and the daily operations of the Scheme.

Driven by contribution increases required to match healthcare inflation, gross contribution income rose 8.05% to R69.9 billion (2018: R64.6 billion). The most significant net membership growth was recorded in the mid- to low-tier options, where the Saver and Smart series recorded net membership growth of 11 923 and 17 028 respectively. At 11 628, the Comprehensive series of plans experienced the largest decline in principal membership.

DHMS contributions are 16.7% lower than the next eight largest open schemes in 2020



DHMS is more affordable across all plan categories in 2020



Healthcare inflation and **claims incurred**

Full statistics for our **benefit plans**

1 *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a single member and for a family unit comprising one principal member, one adult dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight 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.*

NET CLAIMS INCURRED

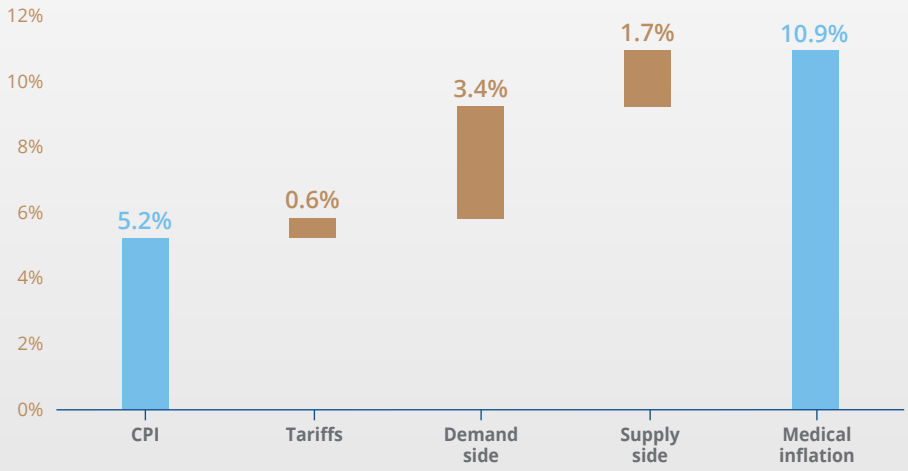
Net claims incurred rose by 7.9% to R48.5 billion (2018: R45.1 billion), a lower rate of increase than in the previous year.

Escalating healthcare costs remain a concern for medical schemes, with healthcare inflation consistently above consumer price index (CPI) inflation.

The primary driver of healthcare inflation is higher utilisation of healthcare services due to demand- and supply-side effects, and the contribution from tariff increases remains limited. 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 the deterioration in the demographic profile of beneficiaries; specifically, by higher ratios of older and chronically ill members requiring more healthcare services, often at a higher price. A summary of the composition of medical inflation (annualised over the period 2010 to 2019) is illustrated in the diagram alongside.

Despite these cost pressures, the Scheme was able to contain the gross claims ratio[1] to 87.73% (2018: 88.46%) due to robust risk management interventions implemented by the Scheme's Administrator and Managed Care Provider, Discovery Health.

Average annualised healthcare inflation (2010 – 2019)



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).*

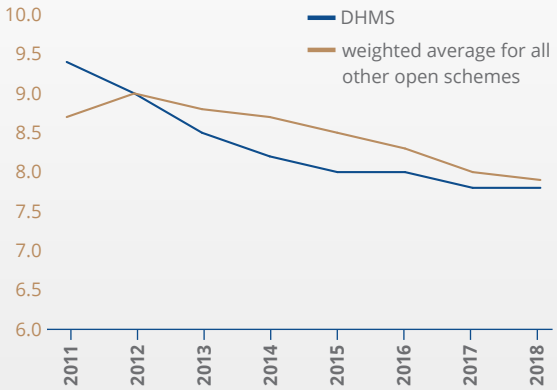
GROSS ADMINISTRATION EXPENDITURE

Gross administration expenditure consists of administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's Administrator, Discovery Health. The gross increase in administration fees of 5.77% to R5.2 billion (2018: R4.9 billion) was driven by an increase in the administration fee per member of 5.16% from R304.33 to R320.05, which reflects the impact of an annual CPI increase. The balance of the increase is due to an increase in the number of members over the year.

The graph alongside depicts the continued decrease in gross administration expenses as a percentage of gross contribution income, compared to the weighted average of other open medical schemes.

The Scheme's analysis of the CMS Annual Report 2018-2019 shows that, at 7.8% for 2018, DHMS continued to rank below the weighted average gross administration expenditure for open schemes when considered as a proportion of gross contribution income, which was 7.9% excluding the Scheme. This means that the Scheme's gross administration expenditure is the seventh lowest out of 21 open medical schemes in the market.

Members benefit through continuously reducing administration expenditure that is among the lowest in the industry



Administration expenditure as % of gross contribution income (2011 – 2018)
Source: CMS Annual Report 2018-19

ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 6.76% to R1.77 billion (2018: R1.65 billion) is predominantly attributable to the increase of 6.15% in accredited managed care costs per member per month, with the balance of the increase due to the increase in the number of members over the year.

Managed care costs per average member per month increased by 6.15%, from R103.24 to R109.59, reflecting the impact of an annual CPI increase as well as an expansion in services provided by Discovery Health during the year, including the Member Care Programme, Advanced Illness Benefit and various Case Management initiatives. Managed care costs as a percentage of gross contribution income continued to decline with the 2019 ratio at 2.53% (2018: 2.56%).

An analysis of the CMS Annual Report 2018–2019 demonstrates that the Scheme's managed care cost as a proportion of gross contribution income was 2.56%, compared to the weighted average of 2.31% excluding the Scheme. Our managed care costs are slightly higher than those of other open schemes; this difference reflects 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 Administrator and Managed Care Provider.

More about **how we operate**

In 2018, claims cost savings of R199.73 (2017: R171.51) per average beneficiary per month were realised through claims review processes, implemented protocols, price negotiations and drug utilisation reviews[1]. This equates to a saving of R3.05 (2017: R2.68) for every Rand paid in managed care costs – an exceptional return on investment of 305%.

1 *Source: The Value Added Assessment report presented to the Board of 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 these fall due. Given the short-term nature of Scheme liabilities, a significant portion of our assets are invested in money market and cash investments, with smaller allocations to bonds (local and foreign) and equities.

The Scheme earned a gross investment return of 7.02% for 2019 (2018: 5.85%). The Scheme's diversified investment strategy resulted in outperformance of its strategic benchmark.

MEMBER DISPUTES AND CMS COMPLAINTS

We thoroughly investigate and review all formal disputes lodged by Scheme members, aiming to resolve as many as possible internally to prevent members having to resort to laying complaints with the CMS.

The number of CMS complaints made by DHMS members reduced by 1% to 604 in 2019 (2018: 609), a fraction of the 51 206 844 claims made by all Scheme members in 2019. The ratio of internal disputes to CMS complaints has continued to improve from 39% in 2015, to 51.7% in 2016, 97% in 2017, 119% in 2018 and ultimately to 130% in 2019.

The internal disputes mechanism continues to be effective for amicably resolving the majority of cases, with a high rate of withdrawals and settlements achieved without the member requiring a hearing. In 2019, 786 disputes were lodged in terms of Rule 27[1], with 628 or 93% of disputes being settled or withdrawn prior to a hearing. Only 47 cases proceeded to a hearing before the Disputes Committee.

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.*

SOLVENCY

The Medical Schemes Act 131 of 1998, as amended (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 2019, the Scheme's solvency level of 27.5% (2018: 27.3%) of gross annual contributions was R1.8 billion (2018: R1.5 billion) more than the statutory solvency requirement.

R'000	**2019**	2018
Total members' funds	**19 209 355**	17 646 355
Less: cumulative unrealised net gain on re-measurement of investments	**–**	–
Total net assets (Regulation 29)	**19 209 355**	17 646 355
Gross annual contributions	**69 855 135**	64 649 012
Solvency ratio	**27.50%**	27.30%
Average accumulated funds per member at year-end	**14 211**	13 063

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 11.11 for 2019 (11.40 in 2018). As at year-end, only a very small proportion of contributions had not yet been collected.

Year ended	**2019**	2018
Gross contributions	**69 855 135**	64 649 012
Total outstanding – excluding December contributions	**23 653**	32 602
% Outstanding	**0.03**	0.05

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2019

Circular 11 of 2006 (the Circular) 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 external auditor considers them to be material or not.

During 2019, the Scheme did not comply with the following Sections and Regulations of the Act:

- **Sustainability of benefit plans**
- **Investments in employer groups and medical scheme administrators**
- **Investments in other assets in territories outside the Republic of South Africa**
- **Contributions received after due date**
- **Broker fees paid**
- **Direct or indirect borrowing of money**
- **Amounts debited to Scheme bank account**
- **Prescribed Minimum Benefits**
- **Claims paid in excess of 30 days**
- **Suspension of member's membership**
- **Disclosure of personal information**

RESERVE ACCOUNTS

Statement of Changes in **Funds and Reserves**

OUTSTANDING CLAIMS

Note 6 in the **Financial Statements**

PERSONAL MEDICAL SAVINGS ACCOUNTS

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

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

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

The Scheme's liability to members in respect of PMSAs is reflected as a current liability in the Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act.

Note 8 in the **Financial Statements**

GOING CONCERN

Subsequent to the reporting date, and prior to the date the Financial Statements were authorised for issue, the President of South Africa declared a national state of disaster as a result of the global COVID-19 pandemic on 15 March 2020. Even though South Africa is in the early stage of the outbreak, and there exist uncertainties about the potential impact of COVID-19 on the Scheme and its members, various possible scenarios, including stress test scenarios, have been considered to assess the potential impact of COVID-19 on the Scheme. Based on the most likely scenario, the Trustees believe there will be no impact on the Scheme's ability to pay claims as they arise.

AUDITOR INDEPENDENCE

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

OPERATIONAL STATISTICS PER BENEFIT PLAN

for the year ended 31 December 2019

2019	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Comp Zero MSA[1]	Classic Smart	Essential Smart	Total
Number of members at the end of the accounting period	9 208	124 221	49 266	309 501	84 204	14 133	137 403	44 796	5 741	180 347	78 975	221 607	14 819	6 620	935	39 160	30 784	**1 351 720**
Number of beneficiaries at the end of the accounting period	19 475	270 914	106 212	679 976	188 130	26 159	290 458	97 184	11 788	405 809	177 397	388 027	24 183	8 659	1 972	76 059	35 704	**2 808 106**
Average number of members for the accounting period	9 466	127 688	49 132	310 504	85 653	14 448	133 406	42 986	5 836	181 471	78 826	218 098	14 042	6 403	970	36 868	26 962	**1 342 758**
Average number of beneficiaries for the accounting period	20 131	279 510	106 116	680 656	191 645	26 834	281 736	93 224	11 956	408 459	177 269	381 637	22 735	8 488	2 061	71 594	31 056	**2 795 107**
Average risk contributions per member per month (R')	8 473.04	6 770.47	3 865.58	3 654.46	4 617.93	5 791.61	2 996.50	3 073.05	4 166.48	3 284.21	3 231.67	1 981.96	1 656.47	1 235.29	6 692.64	2 787.30	1 497.35	**3 551.29**
Average risk contributions per beneficiary per month (R')	3 984.17	3 092.93	1 789.77	1 667.10	2 063.90	3 118.36	1 418.89	1 417.01	2 033.55	1 459.11	1 437.03	1 132.65	1 023.11	931.88	3 149.88	1 435.37	1 299.95	**1 706.02**
Average net claims incurred per member per month (R')	10 706.07	6 966.25	2 982.63	2 846.13	3 910.46	5 177.17	1 955.29	2 176.74	2 673.64	2 772.68	2 714.29	1 878.11	1 099.19	501.39	6 837.40	1 928.57	704.26	**3 010.95**
Average net claims incurred per beneficiary per month (R')	5 034.18	3 182.36	1 380.96	1 298.36	1 747.71	2 787.53	925.86	1 003.71	1 304.93	1 231.85	1 206.96	1 073.30	678.91	378.24	3 218.00	993.15	611.42	**1 446.45**
Average administration costs per member per month (R')	349.40	349.38	349.40	349.40	349.40	349.40	349.40	349.40	349.40	349.40	349.40	189.34	101.62	189.34	349.40	349.40	349.40	**320.05**
Average administration costs per beneficiary per month (R')	164.29	159.60	161.77	159.39	156.16	188.13	165.45	161.11	170.53	155.23	155.37	108.20	62.76	142.84	164.44	179.93	303.34	**153.75**
Average managed care: Management services per member per month (R')	110.32	110.27	109.53	109.53	109.59	110.09	109.50	109.51	109.53	109.51	109.50	109.44	109.45	109.45	109.82	109.46	109.62	**109.59**
Average managed care: Management services per beneficiary per month (R')	51.87	50.37	50.71	49.97	48.98	59.28	51.85	50.50	53.46	48.65	48.69	62.54	67.60	82.57	51.69	56.37	95.17	**52.65**
Average family size	2.12	2.18	2.16	2.20	2.23	1.85	2.11	2.17	2.05	2.25	2.25	1.75	1.63	1.31	2.11	1.94	1.16	**2.08**
Loss ratio (%)	127.54%	104.38%	79.99%	80.87%	87.05%	91.15%	68.90%	74.39%	66.79%	87.75%	87.37%	99.34%	72.97%	48.90%	103.65%	71.61%	55.26%	**87.73%**
Total non-healthcare expenses as a percentage of risk contributions (%)	5.54%	6.98%	11.80%	12.84%	10.24%	8.19%	15.26%	14.63%	11.26%	14.15%	14.04%	13.55%	10.32%	20.03%	7.01%	16.01%	27.72%	**12.04%**
Average non-healthcare expenses per member per month	469.71	472.33	455.99	469.08	472.68	474.22	457.26	449.54	469.26	464.85	453.59	268.48	170.90	247.40	469.05	446.34	415.00	**427.45**
Average non-healthcare expenses per beneficiary per month	220.86	215.77	211.12	213.98	211.25	255.33	216.52	207.29	229.04	206.52	201.70	153.43	105.56	186.63	220.76	229.85	360.29	**205.35**
Average age of beneficiaries (years)	45.79	43.01	40.80	34.29	39.50	49.41	31.84	37.85	38.43	35.33	39.35	29.98	35.70	34.43	41.68	31.15	34.19	**35.33**
Pensioner ratio (beneficiaries over 65 years)	25.11%	20.00%	16.99%	8.56%	14.49%	32.36%	6.38%	12.75%	13.81%	9.07%	14.19%	7.04%	12.86%	8.20%	16.65%	4.36%	4.05%	**10.35%**
Average relevant health care expenses per member per month	10 806.46	7 067.29	3 092.15	2 955.45	4 019.69	5 279.20	2 064.60	2 286.11	2 782.96	2 881.96	2 823.61	1 968.89	1 208.64	604.06	6 936.93	1 996.06	827.49	**3 115.42**
Average relevant health care expenses per beneficiary per month	5 081.39	3 228.52	1 431.67	1 348.23	1 796.53	2 842.47	977.62	1 054.14	1 358.29	1 280.40	1 255.57	1 125.18	746.51	455.69	3 264.85	1 027.91	718.40	**1 496.64**
Net surplus/(deficit) per benefit plan	(309 257)	(1 055 160)	248 429	1 155 784	211 704	20 574	887 873	227 538	69 653	38 527	55 241	(396 536)	64 135	37 469	(7 091)	198 392	115 724	**1 563 000**

1 *For 2020, the Classic Comprehensive Zero MSA plan was changed to Classic Smart Comprehensive.*

Key performance information
continued

2018	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Core	Essential Saver	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Access	Classic Comp Zero MSA[1]	Classic Smart	Essential Smart	Total
Number of members at the end of the accounting period	9 813	134 349	50 279	302 177	89 861	15 653	42 305	128 611	6 384	184 540	81 100	232 791	14 561	4 599	915	30 607	22 309	**1 350 854**
Number of beneficiaries at the end of the accounting period	21 082	297 212	108 239	663 032	203 166	29 249	91 012	270 854	13 017	417 639	181 951	406 661	23 309	6 573	1 990	58 281	25 872	**2 819 139**
Average number of members for the accounting period	10 086	137 597	49 812	301 250	91 394	15 995	40 343	124 268	6 426	184 229	80 846	227 771	13 644	4 507	929	27 947	18 049	**1 335 093**
Average number of beneficiaries for the accounting period	21 734	305 549	107 439	659 519	206 262	30 020	86 838	261 327	13 121	417 251	181 288	397 742	21 800	6 403	2 015	53 406	20 870	**2 792 583**
Average risk contributions per member per month (R')	7 745	6 212	3 546	3 354	4 257	5 309	2 818	2 760	3 808	2 994	2 931	1 807	1 529	1 195	6 158	2 524	1 374	**3 297**
Average risk contributions per beneficiary per month (R')	3 594	2 798	1 644	1 532	1 886	2 829	1 309	1 313	1 865	1 322	1 307	1 035	957	841	2 841	1 321	1 188	**1 576**
Average net claims incurred per member per month (R')	10 042	6 390	2 686	2 597	3 589	4 744	1 954	1 783	2 224	2 509	2 493	1 760	1 075	535	5 400	1 607	649	**2 815**
Average net claims incurred per beneficiary per month (R')	4 660	2 878	1 245	1 186	1 590	2 527	908	848	1 089	1 108	1 112	1 008	673	376	2 491	841	561	**1 346**
Average administration costs per member per month (R')	334	333	334	334	334	333	334	334	334	334	334	181	97	116	334	333	334	**304**
Average administration costs per beneficiary per month (R')	155	150	155	152	148	178	155	159	163	147	149	104	61	82	154	174	289	**146**
Average managed care: Management services per member per month (R')	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	**103**
Average managed care: Management services per beneficiary per month (R')	48	46	48	47	46	55	48	49	51	46	46	59	65	73	48	54	89	**49**
Average family size at 31 December	2.15	2.21	2.15	2.19	2.26	1.87	2.15	2.11	2.04	2.26	2.24	1.75	1.60	1.43	2.17	1.90	1.16	**2.09**
Loss ratio (%)	131%	105%	79%	81%	87%	91%	73%	68%	61%	87%	89%	102%	77%	53%	90%	67%	56%	**88%**
Total non-healthcare expenses as a percentage of risk contributions (%)	6%	7%	12%	13%	11%	9%	15%	16%	12%	15%	15%	14%	11%	14%	7%	17%	29%	**12%**
Average non-healthcare expenses per member per month	447	448	432	444	448	449	426	433	443	439	429	252	160	171	447	420	392	**403**
Average non-healthcare expenses per beneficiary per month	207	202	200	203	199	239	198	206	217	194	191	144	100	120	206	220	339	**193**
Average age of beneficiaries (years)	44.91	41.56	39.18	32.54	38.47	43.57	35.96	30.37	37.76	34.65	38.68	29.64	35.53	33.10	40.05	30.80	33.81	**34.91**
Pensioner ratio (beneficiaries over 65 years)	24%	18%	14%	7%	13%	22%	10%	5%	13%	8%	13%	7%	12%	7%	13%	4%	4%	**10%**
Average relevant healthcare expenses per member per month	10 151	6 503	2 789	2 700	3 692	4 856	2 057	1 886	2 327	2 612	2 596	1 845	1 178	635	5 520	1 689	767	**2 916**
Average relevant healthcare expenses per beneficiary per month	4 711	2 928	1 293	1 233	1 636	2 587	956	897	1 140	1 153	1 158	1 057	738	447	2 546	884	663	**1 394**
Net surplus/(deficit) per benefit plan	(337 379)	(1 110 523)	246 407	998 019	199 678	13 262	204 151	756 292	85 085	17 494	(6 029)	(558 058)	45 394	25 719	3 104	168 028	65 139	**815 783**

1 *For 2020, the Classic Comprehensive Zero MSA plan was changed to Classic Smart Comprehensive.*

How Discovery Health supports the Scheme's value creation

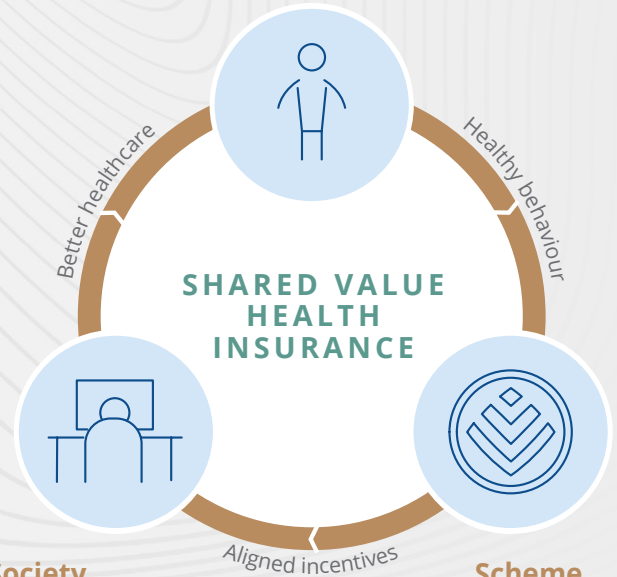
Discovery Health's business model: shared value health insurance

Discovery Health shares the Scheme's commitment to deliver an integrated value-driven healthcare system, centred on meeting the needs of members and delivering 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, thereby reducing claims cost. It also incentivises healthcare professionals through value-based contracting with an emphasis on quality of care. This model supports the growth and sustainability of the Scheme and, ultimately, shared value healthcare leads to a better healthcare system.

More about the **shared value model** on the website

Members

- Better health
- Lower contributions



Society

- Healthier and more productive workforce
- Increased revenues for healthcare providers engaged in high-quality care

Scheme

- Increased growth and sustainability

Discovery Health's initiatives for our members

Discovery Health's innovative and integrated approach has resulted in state-of-the art medical scheme risk management and service delivery, extending their services to DHMS well beyond traditional administration and managed care services. Their ongoing investments in market-leading digital capabilities, along with their strategic focus on improving value in healthcare through efficiency and quality care, help to ensure better health outcomes. This is supported by their focus on extensive care, support and the latest medical technologies.

By creating healthcare journeys that are both intuitive and accessible, Discovery Health aims to fundamentally change the way the members of DHMS experience the healthcare system. Their holistic approach to health management is underpinned by a robust and flexible systems infrastructure and a suite of digital tools, which are continually enhanced to ensure that service offerings maximise value and efficiency.

Co-ordinated care and disease management

HOMECARE
Read more

NEW DIABETES PROGRAMME
Read more

CADCARE
Read more

KIDNEYCARE
Read more

DAY SURGERY NETWORK
Read more

ONSITE HOSPITAL BENEFIT SPECIALISTS
Read more

SPINAL CARE
Read more

Digital initiatives

DISCOVERY HEALTHID
Read more

MEMBER APP
Read more

TELEMEDICINE CONSULTATIONS
Read more

DR CONNECT
Read more

1 *Provided by Vitality, which members may elect to join. Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.*

Discovery Health's client journeys demonstrate its capabilities in 2019*

New business

A new membership activated every **22 seconds**

A Discovery Baby is born every **5 minutes**

SERVICE CLAIMS

R7.5 billion billed in contributions per month

R38 million paid in claims per hour

286 000 claims received per day

36 630 calls per day

DIGITAL SUPPORT

420 000 Website users

423 000 Mobile users

27% of calls Interactive Voice Response assisted

3 417 Current HealthID users

431 000 social media followers

1 967 355 digital membership cards downloaded

MEMBERSHIP PROFILES

Average member accesses website **4** TIMES PER MONTH

Average member makes **20** CLAIMS PER YEAR

21% Members with a cronic condition

Family memberships **44%** SINGLE | **56%** FAMILY

Oldest life **108**

Average pricipal member age **45**

BENEFIT MANAGMENT

3 000 hospital admissions approved per day

2 000 chronic illness benefit applications received per day

74 438 HIV programme members

68 044 Oncology programme members

Wellness management

R3.5 million lives covered

33 400 Vitality checks per month

17 000 wellness screenings per month

29 100 personal health reviews completed per month

* *For members of all schemes administered by Discovery Health. As at 31 December 2019, Discovery Health administered 3.55 million beneficiaries, including 2.8 million for DHMS.*

Discovery Health combats fraud, waste and abuse to protect our members

On behalf of the schemes to which it provides administration and managed care services, Discovery Health investigates approximately 3 500 potential fraud cases, and confirms that fraud or claims abuse take place in approximately 2 900 cases each year. Wherever possible, funds are recovered from the fraudulent party and all recovered funds are returned to medical schemes.

While the vast majority of healthcare providers are honest, hardworking and ethical, and deliver good quality care to their patients, forensic investigations reveal that a small minority of healthcare professionals commit material fraud and claims abuse against medical schemes, resulting in significant costs to schemes and their members. This behaviour is not limited to healthcare providers; members also defraud their schemes.

Most investigations are triggered by tip-offs received by members, healthcare providers and other stakeholders. In other instances, Discovery Health identifies providers whose claiming patterns are significantly different to their peers, and requests further information from them to substantiate discrepancies. In many cases, providers are able to demonstrate that their actions have been warranted.

The following examples show the serious, costly and complex nature of fraud perpetrated against medical schemes and their members:

Pharmacy fraud of R4 million – all linked to a single member

A member complained that a pharmacist had submitted claims for high-cost medicines that were never dispensed. Investigations revealed that the pharmacy had submitted false claims in excess of R4 million, all linked to one member, over four years. Following the investigation, the pharmacist acknowledged the fraud, and agreed to repay the amounts fraudulently claimed. The matter was reported to the authorities for further investigation.

Ambulance services falsify claims and offer a 'free ride'

Certain emergency medical service providers have committed fraud by giving scheme members cash or vouchers in exchange for their personal information. This information is used to submit false claims, frequently multiple claims per membership, stating the member was transported to hospital, with claim values of up to R7 500 each.

A cardiologist's excessive and inappropriate claims

A tip-off exposed a cardiologist whose costs were 43% higher with double the number of claims for angiograms with stents, compared to the national average. The inflated costs for this cardiologist were a result of numerous fraudulent practices including:

- Claiming that his patients were in a costlier intensive care unit when they were actually in a high care facility;
- Submitting claims with false condition codes to ensure increased payments and to artificially extend the length of patients' hospital stays; and
- Manipulating the claim dates of outpatient consultations, submitting them only once his patients were admitted to hospital to increase the amounts billed per consultation.

This cardiologist acknowledged these fraudulent claiming activities and agreed to refund R9 million. Related costs were also recovered from the hospital in which the cardiologist practices.

Waste and abuse of members' optometry benefits

An optometric practice was identified as being an outlier with regards to the cost per claim. Further investigation revealed that the practice was purchasing frames for between R80 – R250 per frame, but submitting claims for the same frames for an average of R2 300 – R3 000 per frame. Although this is not considered fraudulent behaviour, it constitutes gross waste and abuse of members' benefits and calls into question the quality of the frames provided to members.

A member submits multiple fraudulent claims for financial gain

A healthcare provider reported potentially fraudulent transactions on the practice's claims statement, alleging that transactions appeared on a 2019 statement for a dependant of a DHMS member last treated in August 2018. On the same policy, claims also appeared for a second dependant who was never treated by the practice.

The investigation established that the member submitted several false paper claims, with a total value of R47 775.00 of which R39 615.00 was paid directly to the member in question. Further investigation, during which several other service providers were contacted to verify claims submitted for payment by the member, established that additional false claims were made to the value of R292 121.00, of which R182 328.00 was paid. These claims were submitted using the details of three additional service providers who had previously treated one or more dependants on the policy.

When confronted, the member admitted to committing the fraud due to financial strain. The full amount was refunded to DHMS, the policy was terminated, and the matter was reported to the South African Police Service (SAPS).

A GP using unqualified doctors

A GP started several practices, employing unqualified doctors to consult with patients on his behalf. He then submitted fraudulent claims to various medical aids. Numerous other GP practices are currently being investigated by the Health Professions Council of South Africa and the SAPS for similar conduct.

Falsified claims by dentist

A tip-off was received regarding numerous claims submitted by a dentist on a specific membership.

The investigation found that the dentist had submitted these claims over a two-year period for basic dentistry such as fillings and root canal therapy. In certain instances, claims were submitted for multiple repeat root canals on the same tooth. Further investigation and review of the dental notes and charts confirmed the dentist was performing specialised dentistry (crowns, implants etc.) but submitting numerous false claims for basic dentistry not performed, to obtain payment for benefits that the member's plan did not allow for, thereby bypassing the scheme benefit rules and limits.

The claims that could not be validated during the investigation amounted to R600 000, which was recovered from the provider. The matter was reported to the authorities.

Dietician working up to 35 hours in one day

A dietician practice was reported for billing for services that were not rendered. The practice was identified as the highest claimer nationally, compared to peers, and an analysis showed that the solo practice was billing for around 35 hours per day.

The investigation revealed that in most instances the patients were not referred by their treating medical professional, and that claims had been submitted for:

- In-hospital services not rendered;
- Multiple lengthy nutritional assessments per day;
- Pre-operative nutritional assessments that were not clinically justified; and
- More expensive services when less expensive services had been performed.

This investigation led to R420 000 being recovered from the practitioner.

A year later, the practice was again identified as an outlier, with similar claiming behaviour as previously identified, with the addition of lactation education to members in the maternity ward, a service included in the hospital fee. The dietician agreed that he owed R920 000 as a result of the added fraud, and Discovery Health stopped paying the provider directly (members are reimbursed instead).

Subsequent to these findings, the dietician attempted to submit further claims under a group practice number rather than his own.

06 FINANCIALS

The Financial Statements comprise the Statement of Financial Position as at 31 December 2019, 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 and the Medical Schemes Act, No 131 of 1998, as amended, (the Act) and include amounts based on judgements and reasonable estimates.

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2019

THE BOARD OF 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 (THE SCHEME).

More about the Scheme's reserves and how we ensure the protection of your funds and the **sustainability of DHMS**

The Trustees consider that in preparing the Financial Statements they have used the most appropriate accounting policies, consistently applied, and that all applicable International Financial Reporting Standards have been followed. The Trustees are satisfied that the information contained in the annual Financial Statements fairly presents the results of operations for the year and the financial position of the Scheme at year-end. The Trustees have also reviewed the other information included in the Integrated Report and are responsible for both its accuracy and its consistency with the Financial Statements.

The Trustees are responsible for the Scheme's systems of internal control and incorporate risk management and internal control procedures, which are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being controlled. Reliance is placed on Discovery Health (Pty) Ltd's system of internal controls.

Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention and the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and, in particular, the presentation of 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 2020. Subsequent to the reporting date and prior to the date the financial statements were authorised for issue, the President of South Africa declared a national state of disaster as a result of the global COVID-19 pandemic on 15 March 2020. Even though South Africa is in the early stage of the outbreak, and there exist uncertainties about the potential impact of COVID-19 on the Scheme and its members, various possible scenarios, including stress test scenarios, have been considered to assess the potential impact of COVID-19 on the Scheme.

The Scheme's strong financial position and Reserve levels allows the Scheme to absorb the potential negative impact of COVID-19, with a potential negligible impact on the Scheme's 2020 Solvency level, based on the most likely scenario, and it is not envisaged that it will have an impact on the Scheme's ability to pay claims as they arise. The Trustees also concluded that there was no need to adjust the 2019 Financial Statements.

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 support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Financial Statements and their unqualified report is presented on pages 87 – 89. The Financial Statements, which are presented on pages 90 – 160, were approved by the Board of Trustees on 8 April 2020 and are signed on its behalf by:

N Morrison
Chairperson

J Human
Trustee

C Mbewu-Sanqela
Acting Principal Officer

REPORT OF THE AUDIT COMMITTEE

for the year ended 31 December 2019

We are pleased to present our report for the financial year ended 31 December 2019. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit Committee terms of reference and assessment

The Committee's role and responsibilities include statutory duties as per the Act and further responsibilities assigned to it by the Board. The Committee has adopted formal terms of reference that have been approved by the Board of 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 at least every two years either by external independent parties, or through self-appraisals. The last Committee evaluation was conducted by the IoDSA in 2018 with highly satisfactory results reporting in the 2018 Integrated Report. The next evaluation will be conducted in 2020.

Audit Committee members, meeting attendance and assessment

The membership and attendance of the members of the Committee has been set out on pages 45 – 46.

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 as the statutory auditor of the Scheme for the financial period 1 January 2019 to 31 December 2019 in accordance with section 36(2) of the Act on 18 September 2019.

The Committee has satisfied itself that the External Auditor is independent of the Scheme as set out in Section 36(3) of the Act. Requisite assurance was sought and provided by the Auditor that internal governance processes within the audit firm 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 2019. The Committee approved the actual audit fees for the year ended 31 December 2018.

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 are reflected in Note 16 to the annual Financial Statements.

During the year, the Committee met with the External Auditors without management being present. The Committee Chairperson 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 Committee Chairperson also met separately with IA.

Financial statements and accounting practices

The Committee reviewed the accounting policies and the Scheme's Financial Statements and is satisfied that they are appropriate and comply with International Financial Reporting Standards, the Act and circulars issued by the Council for Medical Schemes.

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.

Report of the Audit Committee *continued*

This included a formal documented review by the Internal Audit 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 Reasonable Assurance* can be placed on the internal controls and risk management and that High Assurance** 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 33 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

As there were no cases of COVID-19 identified in South Africa by the reporting date, and the decline in the fair value of investments occurred after the reporting date, these events are non-adjusting events occurring after the reporting date and require no adjustment to the amounts recognised in the Financial Statements at 31 December 2019. In light of these events, 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 as at 31 December 2019, as well as the budget for the year ending 31 December 2020 and the impact of the global COVID-19 pandemic, which is not expected to have a material impact on the Scheme's financial position. The Committee has considered the potential impact of results of stress testing performed and investment market volatility on the Scheme post year-end. Note 28 to the Financial Statements sets out the considerations that have been taken into account in assessing the impact of COVID-19. The Committee therefore believes that it is appropriate to continue to apply the going concern basis of accounting. Total members' funds exceeded R19.2 billion with a solvency level of 27.5% as at 31 December 2019. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) as at 31 December 2019 to cover monthly claims expenditure 4.99 times.

On the basis of this review and taking note of the current net surplus of R1.6 billion, the Committee considers that:

1. The Scheme's assets currently exceed 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

8 April 2020

INDEPENDENT AUDITOR'S REPORT

To the members of Discovery Health Medical Scheme

Report on the financial statements

OPINION

We have audited the financial statements of Discovery Health Medical Scheme (the Scheme), set out on pages 90 to 160, which comprise the Statement of Financial Position as at 31 December 2019, and the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and the Statement of Cash Flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2019, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

BASIS FOR OPINION

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

INDEPENDENCE

We are independent of the Scheme in accordance with the sections 290 and 291 of the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (Revised January 2018), parts 1 and 3 of the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (Revised November 2018) (together the IRBA Codes) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities, as applicable, in accordance with the IRBA Codes and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Codes are consistent with the corresponding sections of the International Ethics Standards Board for Accountants' Code of Ethics for Professional Accountants and the International Ethics Standards Board for Accountants' International Code of Ethics for Professional Accountants (including International Independence Standards) respectively.

KEY AUDIT MATTERS

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The outstanding claims provision of R1,526 billion at year-end as described in Note 6 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end. The outstanding claims provision is calculated by the Scheme's actuaries which is reviewed by management and the Audit Committee and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to project the year-end provision. This model applies a combination of the Basic Chain Ladder ("BCL") and Cost Per Event ("CPE") methods. The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern can cause a material change to the amount of the provision.	We obtained an understanding from the Scheme's actuaries regarding the process to calculate the outstanding claims provision. The actuarial methods applied by the Scheme are generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the year ended 31 December 2019. For a sample of actual claims received by the Scheme in the 31 December 2019 financial year, we tested the accuracy of the service and process dates. No material inconsistencies were noted. We substantively tested a sample of claims against the relevant Scheme rules and assessed completeness of the claims data. The claims data that was included in the Scheme's actuarial model was agreed to the above actual claims data with no material inconsistencies noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. Based on our assessment, the estimation process was considered reasonable. Our internal actuarial experts independently calculated the Scheme's outstanding claims provision, taking into account the claims data tested above. We compared our results with that of the Scheme and found the amounts to approximate each other.

Independent Auditor's report *continued*

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 2019 Integrated Report" The other information does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

RESPONSIBILITIES OF THE SCHEME'S TRUSTEES FOR THE FINANCIAL STATEMENTS

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Scheme's trustees are responsible for assessing the Scheme's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless the Scheme's trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

AUDITOR'S RESPONSIBILITIES FOR THE AUDIT OF THE FINANCIAL STATEMENTS

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Scheme's trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Independent Auditor's report *continued*

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:

- **Section 33(2)(b) of the Medical Schemes Act of South Africa:** Certain benefit options were not self-supporting in terms of financial performance.
- **Section 29(1)(o) and Regulation 8 of the Medical Schemes Act of South Africa:** During the financial year, there were instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits.
- **Regulation 28(2), 28(5) and 28(8) of the Medical Schemes Act of South Africa:** There were instances where 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.

These material non-compliance findings are disclosed in Note 33 of the financial statements.

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 19 years.

The engagement partner, Linda Pieterse, has been responsible for Discovery Health Medical Scheme's audit for 1 year.

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.
Director: L. Pieterse
Registered Auditor
Waterfall

28 April 2020

Statement of responsibility by the Board of Trustees | Report of the Audit Committee | Statement of Financial Position | Statement of Comprehensive Income
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STATEMENT OF FINANCIAL POSITION

As at 31 December 2019

R'000	Notes	2019	2018
ASSETS			
Non-current assets		**18 426**	22 377
Property and equipment	1	**12 630**	14 116
Long term employee benefit plan asset		**5 796**	8 261
Current assets		**27 818 342**	28 796 006
Financial assets at fair value through profit or loss	3	**23 191 456**	20 519 767
Derivative financial instruments	7	**75 179**	142 856
Trade and other receivables	4	**2 560 425**	2 357 902
Cash and cash equivalents	5	**1 991 282**	5 775 481
Total assets		**27 836 768**	28 818 383
FUNDS AND LIABILITIES			
Members' funds		**19 209 355**	17 646 355
Accumulated funds		**19 209 355**	17 646 355
LIABILITIES			
Non-current liabilities		**9 933**	10 316
Leases	2	**9 933**	10 316
Current liabilities		**8 617 480**	11 161 712
Leases	2	**1 713**	1 600
Derivative financial instruments	7	**14 689**	–
Outstanding claims provision	6	**1 526 497**	1 499 227
Personal Medical Savings Account liabilities	8	**5 522 613**	5 040 832
Trade and other payables	9	**1 551 968**	4 620 053
Total funds and liabilities		**27 836 768**	28 818 383

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STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2019

R'000	Notes	2019	2018
Risk contribution income	10	**57 222 228**	52 828 931
Relevant healthcare expenditure		**(50 199 101)**	(46 718 953)
Net claims incurred	11	**(48 515 757)**	(45 099 436)
Claims incurred	11	**(48 672 460)**	(45 186 030)
Third party claim recoveries	11	**156 703**	86 594
Accredited managed healthcare services (no risk transfer)	12	**(1 765 827)**	(1 653 972)
Net profit on risk transfer arrangements	13	**82 483**	34 455
Risk transfer arrangement fees		**(299 464)**	(382 719)
Recoveries from risk transfer arrangements		**381 947**	417 174
Gross healthcare result		**7 023 127**	6 109 978
Broker service fees	14	**(1 444 563)**	(1 313 741)
Expenses for administration	25	**(5 156 926)**	(4 875 746)
Other operating expenses	15	**(286 051)**	(272 952)
Net healthcare result		**135 587**	(352 461)
Other income		**1 757 601**	1 468 467
Investment income	21	**1 697 827**	1 512 368
Net gains/(losses) on financial assets	22	**44 250**	(116 578)
Sundry income	23	**15 524**	72 677
Other expenditure		**(330 188)**	(300 202)
Expenses for asset management services rendered		**(76 610)**	(71 366)
Other expenses	23	**(5 938)**	(10 746)
Finance costs	24	**(247 640)**	(218 090)
Net surplus for the year		**1 563 000**	815 804
Other comprehensive income		**–**	–
Total comprehensive income for the year		**1 563 000**	815 804

STATEMENT OF CHANGES IN FUNDS AND RESERVES

for the year ended 31 December 2019

R'000	Notes	2019 Accumulated funds	2018 Accumulated funds
Balance at beginning of the year		**17 646 355**	16 684 435
Total comprehensive income for the year		**1 563 000**	815 804
Transfer of reserves from other medical schemes	29	**–**	146 116
Total member funds end of the year		**19 209 355**	17 646 355

STATEMENT OF CASH FLOWS

for the year ended 31 December 2019

R'000	Notes	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows generated/(utilised) from operations before working capital changes	27	**181 892**	(254 606)
Working capital changes:			
Increase in trade and other receivables	27	**(308 631)**	(1 313 257)
Increase in outstanding claims provision		**27 270**	259 164
Increase in Personal Medical Savings Account liabilities		**481 781**	384 199
(Decrease)/Increase in trade and other payables	27	**(3 068 085)**	1 554 535
Cash generated by operations		**(2 685 773)**	630 035
Payments for financial assets	3	**(4 783 355)**	(9 665 768)
Proceeds from sale of financial assets	27	**2 238 283**	2 891 623
Increase in long term employee plan asset		**(3 271)**	(7 371)
Cash transferred from other medical schemes		**–**	146 116
Interest received	21	**1 513 838**	1 350 237
Dividend income	21	**183 989**	162 131
Interest paid	24	**(246 309)**	(217 415)
Net cash outflow from operating activities		**3 782 598**	(4 710 412)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for property and equipment	27	**–**	(2 844)
Net cash outflow from investing activities		**–**	(2 844)
CASH FLOWS FROM FINANCING ACTIVITIES			
Payment of lease liabilities	2	**(1 601)**	(774)
Net cash outflow from financing activities		**(1 601)**	(774)
NET DECREASE IN CASH AND CASH EQUIVALENTS		**(3 784 199)**	(4 714 030)
Cash and cash equivalents at beginning of the year		**5 775 481**	10 489 511
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**1 991 282**	5 775 481

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ACCOUNTING POLICIES

for the year ended 31 December 2019

General information

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

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

These Financial Statements were authorised for issue by the Board of Trustees on 8 April 2020.

1 Basis of preparation

The Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS), which are set by the International Accounting Standards Board (IASB). The Financial Statements are also prepared in accordance with the Act, which requires additional disclosures for registered medical schemes.

The detailed accounting policies have been set out in the respective Note to the Financial Statements, with the general accounting policies applied in the preparation of these Financial Statements set out below. These policies have been consistently applied to all years presented, except for changes required by the mandatory adoption of new and revised IFRS.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the Financial Statements, are disclosed in Note 32.

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

- Financial instruments at fair value through profit or loss; and
- Derivative financial instruments carried at fair value through profit or loss.

All monetary information and figures presented in these financial statements are stated in thousands of rand (R'000), unless otherwise indicated.

Accounting Policies *continued*
for the year ended 31 December 2019

2 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 may result in additional disclosure in the financial statements.

Standard	Scope	Effective date
IFRS 17: *Insurance contracts*	The Standard was issued in May 2017 and supersedes IFRS 4 *Insurance Contracts.* The Standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The Standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and takes into account any uncertainty relating to insurance contracts. The Standard provides for a simplified approach ("premium allocation approach") for the measurement of a group of insurance contracts only if, at the inception of the group, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the general measurement model and if the coverage period is one year or less. Potential impact: The Scheme has assessed the requirements of the standard and agreed a project plan to implement the standard. The coverage period for the Scheme's contracts is one year or less allowing for the premium allocation approach to be applied, resulting in similar treatment to the current accounting. The most notable exceptions relate to the accounting for Personal Medical Savings Accounts, the treatment of onerous contracts and changes to disclosures in the financial statements.	During the IASB board meeting held on 17 March 2020, the IASB decided to defer the effective date to 1 January 2023.
IAS 1: *Presentation of Financial Statements*	Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS Standards.	1 January 2020
IAS 8: *Accounting Policies, Changes in Accounting Estimates and Errors*	Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS Standards.	1 January 2020

3 Foreign currency translation

Functional and presentation currency

Items included in the Financial Statements are measured using the currency of the primary economic environment in which the entity operates (functional currency). The functional and presentation currency of the Scheme is the South African Rand (R).

Transactions and balances

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions, and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies are recognised in the Statement of Comprehensive Income.

Accounting Policies *continued*

4 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.

5 Members' funds

The funds represent the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act.

6 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.

7 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.

8 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.

9 Member insurance contracts

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts.

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 30.

Accounting policies *continued*

10 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services (no risk transfer) and net income or expense from risk transfer arrangements.

11 Liability adequacy test

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities as at the reporting date. In performing these tests, current estimates of future cash flows under the Scheme's insurance contracts are used. Any deficiency is immediately recognised in the Scheme's surplus or deficit for the year.

12 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.

13 Allocation of income and expenditure to benefit plans

The following items are directly allocated to benefit plans:

- Contribution income.
- Claims incurred.
- Risk transfer arrangement fees.
- Accredited managed healthcare service fees.
- Expenses for administration.
- Broker service fees.
- Interest paid on Personal Medical Savings Accounts.

The remaining items are allocated as detailed below:

- For contributions that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net contribution income per plan.
- For claims that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net claims incurred per plan.
- The following items are apportioned based on the number of members per benefit plan:
  - Other operating expenditure;
  - Investment income;
  - Net fair value gains/(losses) on financial assets at fair value through profit or loss;
  - Other income;
  - Expenses for asset management services rendered; and
  - Interest paid, excluding Personal Medical Savings Accounts.

14 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 31 to the Financial Statements. 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 fair value gains/(losses) on financial assets at fair value through profit or loss'.

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NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2019

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 has been determined as 10 years when assessing the term under IFRS 16 (Note 2).

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:

R'000 **Non-current**	**Right-of-use asset land and buildings**	**Leasehold improvements**	**Total**
Balance as at 1 January 2018	**–**	**–**	**–**
Additions	**12 015**	**2 844**	**14 859**
Depreciation charge	**(601)**	**(142)**	**(743)**
Balance as at 31 December 2018	**11 414**	**2 702**	**14 116**
Depreciation charge	**(1 202)**	**(284)**	**(1 486)**
Balance as at 31 December 2019	**10 212**	**2 418**	**12 630**

Leased assets

The Right-of-use asset arises from the lease agreement for the Scheme's offices. (Refer to Note 2 for further details.)

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 purposes 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.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

2 Leases *continued*

Right-of-use asset

The right-of-use asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for any lease payments made at or before the commencement date, plus any initial direct costs incurred. An estimate of the costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located are also included in the cost. The total cost is reduced by any lease incentives received.

The right-of-use asset is subsequently depreciated using the straight line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term. The estimated useful lives of right-of-use assets are determined on the same basis as those of property and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain remeasurements of the lease liability.

Lease liability

The lease liability is initially measured at the present value of the lease payments that are not paid at the commencement date, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, the Scheme's incremental borrowing rate. Generally, the Scheme uses its incremental borrowing rate as the discount rate.

Lease payments included in the measurement of the lease liability comprise fixed payments, increasing annually at a rate set out in the lease agreement.

The lease liability is measured at amortised cost using the effective interest method. The lease liability is remeasured by discounting the revised lease payments using a revised discount rate if there is a change in the lease term, or if the Scheme changes its assessment of whether it will exercise an extension option.

When the lease liability is remeasured in this way, a corresponding adjustment is made to the carrying amount of the right-of-use asset, or is recorded in the surplus or deficit if the carrying amount of the right-of-use asset has been reduced to zero.

Leases of low-value assets

The Scheme has elected not to recognise right-of-use assets and lease liabilities for leases of low-value assets, with a value of less than one hundred thousand rand.

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 and leases of low-value assets as an expense on a straight line basis over the lease term.

Effective date

IFRS 16: Leases is effective for year ends commencing on 1 January 2019, early adoption is permitted. The Scheme early adopted this Standard with effect from 1 January 2018.

Note:

NATURE OF LEASING ACTIVITIES

The Scheme leases land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of five years and includes an option to renew the lease for an additional period of the same duration, after the end of the initial term. It is reasonably certain that the renewal option will be exercised and the term of this lease has been determined as 10 years when assessing the term under IFRS 16. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred. Detail of this lease is presented below.

The Scheme leases IT equipment and certain office equipment with contract terms of one to two years. These leases are leases of low-value items.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

R'000	Land and Buildings	Total
2 Leases *continued*		
RIGHT-OF-USE ASSET		
Balance as at 1 January 2018	–	–
Additions	12 015	12 015
Depreciation charge for the year	(601)	(601)
Balance as at 31 December 2018	**11 414**	**11 414**
Depreciation charge for the year	**(1 202)**	**(1 202)**
Balance as at 31 December 2019	**10 212**	**10 212**
LEASE LIABILITY		
Balance as at 1 January 2018	–	–
Additions	12 015	12 015
Interest expense	675	675
Lease payments	(774)	(774)
Balance as at 31 December 2018	**11 916**	**11 916**
Interest expense	**1 331**	**1 331**
Lease payments	**(1 601)**	**(1 601)**
Balance as at 31 December 2019	**11 646**	**11 645**

R'000	2019	2018
MATURITY ANALYSIS – CONTRACTUAL UNDISCOUNTED CASH FLOWS		
Less than one year	**1 713**	1 600
One to five years	**10 538**	7 604
More than five years	**6 741**	11 388
Total undiscounted lease liabilities at 31 December	**18 992**	20 592
LEASE LIABILITIES INCLUDED IN THE STATEMENT OF FINANCIAL POSITION AT 31 DECEMBER		
Non-current	**9 933**	10 316
Current	**1 713**	1 600
	11 646	11 916
AMOUNTS RECOGNISED IN THE STATEMENT OF COMPREHENSIVE INCOME		
Depreciation	**1 201**	601
Interest on lease liabilities	**1 331**	675
Expenses relating to leases of low-value assets	**71**	52
AMOUNTS RECOGNISED IN THE STATEMENT OF CASH FLOWS		
Total cash outflow for leases	**1 601**	774

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

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 portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolios 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 or loss.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the surplus or deficit section of the Statement of Comprehensive Income.

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments 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.

Note:

R'000	**2019**	2018
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
Current assets	**23 191 456**	20 519 767
– Offshore bonds	**876 156**	847 314
– Equities	**4 182 545**	4 038 399
– Yield-enhanced bonds	**6 620 669**	5 631 601
– Inflation-linked bonds	**1 125 768**	1 104 552
– Money market instruments	**9 799 918**	8 324 805
– Listed property	**586 400**	573 096
	23 191 456	20 519 767
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	**20 519 767**	14 005 644
Acquisitions	**4 783 355**	9 665 768
Disposals	**(2 215 835)**	(2 863 320)
Net gains/(losses) on revaluation of financial assets at fair value through profit or loss (Note 22)	**104 169**	(288 325)
At the end of the year	**23 191 456**	20 519 767

A register of investments is available for inspection at the registered office of the Scheme.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

4 Trade and other receivables

Accounting policy:

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Receivables are initially recognised at fair value, plus transaction costs. The Scheme holds its insurance receivables and other receivables with the objective to collect the contractual cash flows and measures them subsequently at amortised cost using the effective interest method, less provision for impairment.

Trade and other receivables comprise insurance receivables, arising from the Scheme's insurance contracts with its members and other receivables.

Impairment of insurance receivables

The Scheme assesses at each reporting date whether there is objective evidence that an insurance receivable is impaired. An insurance receivable, or group of insurance receivables is impaired, and impairment losses are incurred if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the insurance receivable (a "loss event") and that loss event (or events) has an adverse impact on the estimated future cash flows of the insurance receivable that can be reliably estimated.

Objective evidence that an insurance receivable or group of insurance receivables is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service provider or member debtors.
- Breach of contract, such as non-payment of member contributions when due, and if these remain unpaid for extended periods.
- Default or delinquency in payments due by service providers and other debtors.
- Adverse changes in the payment status of members of the Scheme.
- National or local economic conditions that correlate with non-payment of debtor contributions.

The Scheme first assesses whether objective evidence of impairment exists, individually for insurance receivables that are individually significant, such as service provider debtors. In the case of insurance receivables which are not individually significant, such as contribution debtors, receivables are grouped on the basis of similar credit characteristics, such as type of receivable and past due status. These characteristics are used in the estimation of future recoverable cash flows.

If there is objective evidence that an impairment loss on an insurance receivable has been incurred, the amount of the loss is measured as the difference between the carrying amount and the present value of estimated future cash flows. The carrying amount of the receivable is reduced and the amount of the loss is recognised in the Statement of Comprehensive Income.

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary collection procedures have been completed and the amount of the loss has been determined. Where a provision for impairment has not been raised, the receivable is written off directly to the Statement of Comprehensive Income. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed by adjusting the allowance account. The amount of the reversal is recognised in the Statement of Comprehensive Income.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

4 Trade and other receivables *continued*

Impairment of 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, other receivables are grouped based on shared credit risk characteristics and days past due. Note 31sets out information about impairment of other receivables.

Note:

R'000	**2019**	2018
Insurance receivables		
Contribution receivables	**2 108 912**	2 005 164
Contributions outstanding	**2 126 734**	2 019 897
Less: Provision for impairment	**(17 822)**	(14 733)
Member and service provider claims receivables	**102 455**	98 899
Amount due	**443 355**	403 991
Less: Provision for impairment	**(340 900)**	(305 092)
Other risk transfer arrangements	**4 253**	5 498
Recoveries due from other risk transfer arrangements	**2 647**	4 076
Share of outstanding claims provision (Note 6)	**1 606**	1 422
Broker fee receivables	**885**	214
Amounts due from brokers	**2 220**	1 478
Less: Provision for impairment	**(1 335)**	(1 264)
Other insurance receivables	**96 129**	39 097
Balance due by related party	**16 383**	14 387
Discovery Third Party Recovery Services (Pty) Ltd (Note 25)	**16 383**	14 387
Forensic receivables	**214 212**	186 328
Amount due	**227 931**	197 638
Less: Provision for impairment	**(13 719)**	(11 310)
Total receivables arising from insurance contracts	**2 543 229**	2 349 587
Other receivables		
Sundry accounts receivable	**15 158**	5 294
Interest receivable	**2 038**	3 021
Total receivables arising from other receivables	**17 196**	8 315
	2 560 425	2 357 902

At 31 December 2019, 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.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

5 Cash and cash equivalents

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.

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Coins and bank notes.
- Money on call and short notice.
- Balances with banks.

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	**2019**	2018
Current accounts	**827 030**	3 863 605
Money market instruments	**1 164 252**	1 911 876
	1 991 282	5 775 481

At 31 December 2019 cash and cash equivalents are carried at amortised cost, which approximates fair value.

6 Outstanding claims provision

Accounting policy:

Claims outstanding comprise provisions for the Scheme's best estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. Claims outstanding are determined as accurately as possible based on a number of factors. These include previous experience in claims patterns, claims settlement patterns, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

Claims handling expenses are not separately accounted for as this service is provided by the Administrator and a fixed fee is paid for the full administration service, including claims handling. No provision for claims handling expenses is required as the Scheme has no further liability to the Administrator at year-end.

Estimated co-payments and payments from members' Personal Medical Savings Accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims since the effect of the time value of money is not considered material.

Note:

R'000	**2019**	2018
Outstanding claims provision – not covered by risk transfer arrangements	**1 524 891**	1 497 805
Outstanding claims provision – covered by risk transfer arrangements (Note 4)	**1 606**	1 422
	1 526 497	1 499 227
Analysis of movement in outstanding claims		
Balance at beginning of the year	**1 499 227**	1 240 063
Payments in respect of prior year	**(1 508 343)**	(1 252 366)
Under provision in prior year (Note 11)	**(9 116)**	(12 303)
Outstanding claims provision raised in current year	**1 535 613**	1 511 530
Not covered by risk transfer arrangements	**1 534 007**	1 510 108
Covered by risk transfer arrangements (Note 4)	**1 606**	1 422
Balance at end of the year	**1 526 497**	1 499 227
Analysis of outstanding claims provision		
Estimated gross claims	**1 623 483**	1 587 327
Less:		
Estimated recoveries from savings plan accounts (Note 8)	**(96 986)**	(88 100)
Balance at end of the year	**1 523 497**	1 499 227

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

R'000	2019	2018
7 Derivative financial instruments		
Note:		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	**75 179**	142 856
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**(14 689)**	–
Derivative financial asset at the end of the year	**60 490**	142 856
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset/(liability) at the beginning of the year	**142 856**	(588)
Net realised gain on derivative financial instruments (Note 27)	**(22 447)**	(28 303)
Realised gains on derivative financial instruments	**(27 448)**	(28 303)
– Zero-cost currency collars	**–**	(2 101)
– Zero-cost equity fences	**(27 448)**	(26 202)
Realised losses on derivative financial instruments	**5 001**	–
– Zero-cost equity fences	**5 001**	–
Net fair value (loss)/gain on derivative financial instruments (Note 22)	**(59 919)**	171 747
Gains on revaluation of derivative financial instruments to fair value	**52 598**	252 649
– Zero-cost equity fences	**27 810**	192 732
– Zero-cost currency collars	**24 788**	59 917
Losses on revaluation of derivative financial instruments to fair value	**(112 517)**	(80 902)
– Zero-cost equity fences	**(112 517)**	–
– Zero-cost currency collars	**–**	(80 902)
Derivative financial asset at the end of the year	**60 490**	142 856

The Trustees approved a strategy to protect the value of the Scheme's investments by entering into zero-cost equity fences which protects the Scheme's equity portfolios against a fall in equity markets and zero-cost currency collars to protect the Scheme's offshore US Dollar denominated bond portfolios against rand appreciation.

Some of the Scheme's equity managers entered into futures contracts to generate an equity-related return on cash held in the equity portfolios. Some of the Scheme's bond managers entered into bond futures to hedge the bond portfolios and provide protection against market risk.

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 31).

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

8 Personal Medical Savings Account liabilities

Accounting policy:

The Scheme Rules for Personal Medical Savings Accounts (PMSAs) were amended, effective from 1 January 2018. The effect of the amendment is that a trust relationship is no longer established. Prior to the 2018 reporting period PMSAs were disclosed as trust liabilities. From 1 January 2018 the Scheme rules have been amended to no longer establish a trust relationship, therefore no longer requiring the disclosure as a trust liability.

Members' PMSAs represent savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered Rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and the Scheme's accounting policies do not otherwise require recognition of all obligations and rights arising from the deposit component.

The savings accounts contain a demand feature and are initially measured at fair value plus transaction costs, which is the amount payable to a member on demand, discounted from the first date that the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest rate method.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Act, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's funds and the risk of impairment is carried by the Scheme.

Interest payable on members' PMSAs is expensed when incurred.

Note:

R'000	**2019**	2018
Balance on Personal Medical Savings Accounts at the beginning of the year	**5 040 832**	4 656 633
Add:		
Personal Medical Savings Accounts contributions received or receivable	**12 632 907**	11 820 081
For the current year (Note 10)	**12 632 907**	11 820 081
Interest on Personal Medical Savings Accounts (Note 24)	**246 267**	220 294
Transfers received from other medical schemes	**22 456**	24 393
Less:		
Claims paid to or on behalf of members (Note 11)	**(12 004 885)**	(11 279 740)
Refunds on death or resignation	**(414 964)**	(400 829)
Balance due to members on Personal Medical Savings Accounts at the end of the year	**5 522 613**	5 040 832

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2019 but not reported will amount to approximately R96 986 357 (2018: R88 100 000) (Note 6).

As at 31 December 2019 the carrying amount of the members' PMSAs were deemed to be equal to their fair values, which is the amount payable on demand. Interest is determined from time to time by the Scheme at its discretion and added to the funds allocated to the member's PMSA in terms of the Scheme Rules. The Scheme does not charge interest on negative (overdrawn) PMSA balances.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

9 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, that is funds older than three years, are written back and included under Sundry income on the face of 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	**2019**	2018
Insurance payables		
Contributions received in advance	**164 395**	153 229
Contribution refunds due to employers	**689**	1 867
Reported claims not yet paid	**634 337**	628 147
Balance at the beginning of the year	**628 147**	562 086
Net movement for the year	**6 190**	66 061
Broker fee creditors	**93 250**	88 483
Accredited brokers	**93 250**	88 483
Total liabilities arising from insurance contracts	**892 671**	871 726
Financial liabilities		
Balances due to related parties (Note 25)	**609 002**	592 543
Discovery Health (Pty) Ltd	**598 846**	585 452
Discovery Life Limited	**120**	51
Discovery Vitality (Pty) Ltd	**9 898**	3 768
Discovery Central Services (Pty) Ltd	**138**	3 272
Unallocated funds	**10 382**	3 130 793
Total accruals	**39 913**	24 991
General accruals	**39 757**	24 861
Leave pay provision	**156**	130
Total arising from financial liabilities	**659 297**	3 748 327
	1 551 968	4 620 053

At 31 December 2019 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

10 Risk contribution income

Accounting policy:

Gross contributions comprise risk contributions and Personal Medical Savings Account contributions. Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

Risk contributions are shown before the deduction of broker service fees.

Note:

R'000	**2019**	2018
Gross contributions per registered Scheme Rules	**69 855 135**	64 649 012
Less:		
Personal Medical Savings Account contributions (Note 8)	**(12 632 907)**	(11 820 081)
	57 222 228	52 828 931

11 Net claims incurred

Accounting policy:

Claims incurred

Gross claims incurred comprises of the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether or not reported by the end of the year.

Risk claims incurred comprise:

- Claims submitted and accrued for services rendered during the year.
- Payments under provider contracts for services rendered to members.
- Over or under provisions relating to prior year claims estimates.
- Claims incurred but not yet reported.
- Claims settled in terms of risk transfer arrangements.

Net of:

- Claims from members' Personal Medical Savings Accounts.
- Recoveries from members for co-payments.
- Recoveries from third parties.
- Discount received from service providers.

Anticipated recoveries under risk transfer arrangements are disclosed separately as assets, and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

11 Net claims incurred *continued*

Reimbursements from the Road Accident Fund

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made against the Road Accident Fund, administered in terms of the Road Accident Fund Act No 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged, contractually, to 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.

Note:

R'000	**2019**	2018
Current year claims per registered Scheme rules	**60 650 075**	56 206 607
Claims not covered by risk transfer arrangements	**60 268 128**	55 789 433
Claims covered by risk transfer arrangements (Note 13)	**381 947**	417 174
Movement in outstanding claims provision	**27 270**	259 163
Under provision in prior year (Note 6)	**9 116**	12 303
Adjustment for current year	**18 154**	246 860
	60 677 345	56 465 770
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 8)	**(12 004 885)**	(11 279 740)
Claims incurred	**48 672 460**	45 186 030
Third party claim recoveries	**(156 703)**	(86 594)
	48 515 757	45 099 436

Risk transfer arrangements

- **Risk transfer arrangement providing optometry services to members on the KeyCare Plus and KeyCare Start plans.**

  An analysis as to the expected costs of optometry benefits using the experience from other Scheme plans was conducted. These claim amounts are adjusted to include a provision for outstanding claims and converted to a Per Life Per Month (PLPM) rate. Generally the claims experience on KeyCare Plus and KeyCare Start is different to that of other Scheme plans as KeyCare Plus and KeyCare Start is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Start claims experience to the other plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Start.

- **Risk transfer arrangement providing dentistry services to members on the KeyCare Plus and KeyCare Start plans.**

  The cost of the group of dental procedure codes was isolated. Using claims data linked to this group, the overall PLPM cost of dental services on all plans excluding KeyCare Plus and KeyCare Start was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally, the claims experience on KeyCare Plus and KeyCare Start is different to that of other Scheme plans as KeyCare Plus and KeyCare Start is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Start claims experience to the other benefit plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Start.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

11 Net claims incurred *continued*

- **Risk transfer arrangement covering treatment for Executive and Comprehensive Plan members diagnosed with diabetes (type I and II).**

  For their diabetes-related treatment, members have a choice of using the managed care organisation under this risk transfer arrangement or not. As the risk profile of the two groups of members are similar, the claims experience of the Executive and Comprehensive Plan members who have not elected to use this provider was used to estimate the members' fee-for-service cost for those who have elected to use this provider.

  As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

  PLPM estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive Plan members who have not elected this provider.

  The expected fee-for-service cost was calculated by multiplying the calculated PLPM costs by the number of members exposed for the period on this programme.

- **Risk transfer arrangement providing acute medication dispensing services to members on the Smart plan.**

  The Scheme contracted with two providers to provide acute medication dispensing services for Smart plan members and remunerates at the contracted monthly capitation fee.

  The estimated claims incurred under this arrangement is determined using the acute medicine claims experience for members not on the Smart plan and calculating a PLPM rate. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for Smart plan members.

12 Accredited managed healthcare services (no risk transfer)

Accounting policy:

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred.

Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Note:

R'000	**2019**	2018
The accredited managed healthcare services (no risk transfer) have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Active Disease Risk Management Services and Disease Risk Management Support Services	**561 058**	532 673
Hospital Benefit Management Services	**520 453**	494 141
Managed Care Network Management Services and Risk Management Services	**507 555**	459 294
Pharmacy Benefit Management Services	**176 761**	167 864
	1 765 827	1 653 972

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

13 Net profit on risk transfer arrangements

Accounting policy:

Risk transfer arrangements are contractual arrangements entered into by the Scheme and third parties who undertake to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees (including Managed care: healthcare services) are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions, and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for insurance receivables. The impairment loss is also calculated following the same method used for these receivables. These processes are described in Note 4.

Note:

R'000	**2019**	2018
The Scheme operated the following risk transfer arrangements during the year:		
Risk transfer arrangement fees	**(299 464)**	(382 719)
Recoveries under risk transfer arrangements (Note 11)	**381 947**	417 174
	82 483	34 455

14 Broker service fees

Accounting policy:

Broker service fees are fees paid as acquisition costs for the introduction and provision of ongoing services to members and are expensed as incurred.

Note:

R'000	**2019**	2018
Brokers' fees	**1 444 563**	1 313 741
	1 444 563	1 313 741

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

15 Other operating expenses

Accounting policy:

Fees paid to the Scheme Administrator are included in Expenses for administration and are expensed as incurred. Other operating expenses include expenses, other than administration fees, and are expensed as incurred.

Note:

R'000	2019	2018
Association fees	1 423	1 900
Audit fees	10 497	6 023
Audit services for the year ended 2019	1 709	–
Audit services for the year ended 2018	3 713	1 881
Audit services for the year ended 2017	–	3 270
Other services	5 075	872
Audit Committee and Risk Committee fees (Note 16)	1 817	1 983
Audit Committee	1 270	1 419
Risk Committee	547	564
Bank charges	9 938	9 591
Clinical Governance Committee fees (Note 16)	644	629
Council for Medical Schemes	52 255	51 699
Debt collecting fees	3 104	3 818
Depreciation	1 486	743
Dispute Committee fees	1 587	1 467
Fidelity Guarantee Insurance	252	249
General meeting costs	6 374	4 271
Investment Committee fees (Note 16)	418	749
Investment reporting fees	3 865	4 142
Legal fees	509	812
Net impairment losses (Note 17)	106 108	103 020
Nomination Committee fees (Note 18)	515	131
Office operating costs	3 788	1 795
Other expenses	27 940	28 387
Principal Officer fees – Remuneration	4 849	5 963
Principal Officer fees – Unvested long term employee benefit	4 039	1 676
Printing, postage and stationery	122	214
Professional fees	8 154	8 584
Remuneration Committee fees (Note 16)	95	88
Scheme office costs	2 968	4 385
Staff costs (Note 19)	23 578	20 823
Sundry amounts written off	6	54
Trustees' remuneration and consideration expenses (Note 20)	9 720	9 756
	286 051	272 952

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

16 Board committee fees and considerations

Note:

31 December 2019 R'000	**Audit**	**Risk**	**Clinical Governance**	**Investment**	**Remuneration**	**Total**
S Green	**200**	**149**				**349**
S Ludolph	**194**	**85**				**279**
N Luthuli					**95**	**95**
P Maphumulo	**147**	**85**		**199**		**431**
N Mlaba			**256**			**256**
S Smith			**227**			**227**
E Mackeown	**228**	**100**		**61**		**389**
B Stott	**501**	**128**		**158**		**787**
Z Van Der Spuy – fees			**126**			**126**
Z Van Der Spuy – travel			**35**			**35**
Total	**1 270**	**547**	**644**	**418**	**95**	**2 974**

31 December 2018 R'000	Audit	Risk	Clinical Governance	Investment	Remuneration	Total
I Ahmed				291		291
S Green	218	131				349
S Ludolph	260	119				379
N Luthuli					88	88
P Maphumulo	214	131		206		551
N Mlaba			84			84
M Sathekge			54			54
S Smith			198			198
B Stott	727	183		252		1 162
Z Van Der Spuy – fees			237			237
Z Van Der Spuy – travel			56			56
Total	1 419	564	629	749	88	3 449

For detail of the Chairperson of the respective committee refer to pages 40 to 41 and 45 to 46.

Statement of responsibility by the Board of Trustees | Report of the Audit Committee | Statement of Financial Position | Statement of Comprehensive Income
Statement of Changes in Funds and Reserves | Statement of Cash Flows | Accounting Policies | Notes to the Financial Statements

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

17 Net impairment losses

Note:

R'000	2019	2018
Insurance receivables		
Contributions that are not collectable	**3 089**	3 240
Movement in provision	**3 089**	3 240
Members' and service providers' portions that are not recoverable	**100 014**	98 973
Movement in provision	**100 014**	98 973
Amounts due by brokers that are not recoverable	**71**	317
Movement in provision	**71**	317
Forensic debtors that are not recoverable	**2 409**	–
Movement in provision	**2 409**	–
Payables/receivables written off directly to the Statement of Comprehensive Income	**525**	490
	106 108	103 020

18 Other committee fees

Note:

R'000	2019	2018
Nomination Committee fees		
P Goss – Independent Member (Chairperson)	**223**	44
T Wixley – Independent Member	**146**	44
R Shough – Independent Member	**146**	43
	515	131

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

19 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	**2019**	2018
Salaries and bonuses	**19 822**	17 055
Pension costs – defined contribution plans	**1 165**	1 123
Medical and other benefits	**843**	755
Long term employee benefit service cost	**1 697**	1 852
Increase in leave pay accrual	**51**	38
	23 578	20 823
Number of employees at 31 December	**12**	12

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

20 Trustees' remuneration and considerations

Note:

The following table records the remuneration and consideration paid to Trustees during the year:

31 December 2019 R'000	Services as Trustee	Committee fees								Travel	Training	Total
		Audit	Risk	Investment	Clinical Governance	Product	Non-Healthcare Expenses	Re-muneration	Stakeholder Relations and Ethics			
N Morrison (Chairperson)	1 002			228			77	98	147		2	1 554
D Moodley	601			278	311	147			147	28	2	1 514
D King	644		80				66	117	128	109	2	1 146
D Naidoo	272	83	66	114		66	77				10	688
J Adams SC	583	136	171		261				49		6	1 206
J Butler SC	534	90					77	110	184	116	2	1 113
J Human	661	196	98	182		184				194	2	1 517
S Brynard	477					128		96	128	131	22	982
Total	**4 774**	**505**	**415**	**802**	**572**	**525**	**297**	**421**	**783**	**578**	**48**	**9 720**

The following table records the remuneration and consideration paid to Trustees during the prior year:

31 December 2018 R'000	Services as Trustee	Committee fees								Travel	Total
		Audit	Risk	Investment	Clinical Governance	Product	Non-Healthcare Expenses	Re-muneration	Stakeholder Relations and Ethics		
N Morrison (Chairperson)	850	–	–	261	–	–	128	145	140	–	1 524
D Moodley	466	–	–	288	274	130	3	–	143	33	1 337
D King	441	–	–	–	–	–	114	151	132	84	922
D Naidoo	506	224	150	268	–	125	165	31	–	–	1 469
J Adams SC	506	224	150	–	246	8	4	–	–	–	1 138
J Butler SC	479	–	–	–	–	–	118	141	188	91	1 017
J Human	484	211	150	266	–	173	4	–	–	154	1 442
S Brynard	441	–	–	–	–	108	3	103	132	120	907
Total	4 173	659	450	1 083	520	544	539	571	735	482	9 756

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

21 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 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	**2019**	2018
Financial assets at fair value through profit or loss:	**1 473 813**	1 229 231
Dividend income	**183 989**	162 131
Interest income	**1 289 824**	1 067 100
Cash and cash equivalents interest income	**224 014**	283 137
Investment income per Statement of Comprehensive Income	**1 697 827**	1 512 368
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	**224 014**	283 137
Financial assets at fair value through profit or loss:		
Interest income	**1 289 824**	1 067 100
Total interest income	**1 513 838**	1 350 237

22 Net gains/(losses) on financial assets

Note:

R'000	**2019**	2018
Net fair value gains/(losses) on financial assets at fair value through profit or loss (Note 3):	**104 169**	(288 325)
Fair value gains on financial assets at fair value through profit or loss:	**219 791**	277 606
– Equities	**69 580**	–
– Money market instruments	**57 636**	55 204
– Offshore bonds	**29 167**	142 889
– Listed property	**–**	–
– Yield-enhanced bonds	**63 408**	79 513
Fair value losses on financial assets at fair value through profit or loss:	**(115 622)**	(565 931)
– Equities	**(67 092)**	(399 790)
– Offshore bonds	**–**	–
– Inflation-linked bonds	**(26 242)**	(41 826)
– Listed property	**(22 288)**	(124 315)
– Yield-enhanced bonds	**–**	–
Net fair value (losses)/gains on derivative financial instruments (Note 7):	**(59 919)**	171 747
Fair value gains on derivative financial instruments:	**52 598**	252 649
Fair value losses on derivative financial instruments:	**(112 517)**	(80 902)
	44 250	(116 578)

Statement of responsibility by the Board of Trustees | Report of the Audit Committee | Statement of Financial Position | Statement of Comprehensive Income
Statement of Changes in Funds and Reserves | Statement of Cash Flows | Accounting Policies | Notes to the Financial Statements

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

R'000	2019	2018
23 Sundry income		
Note:		
Prescribed amounts written back	**15 524**	72 677
Reversal of stale cheques written back	**(5 938)**	(10 746)
	9 586	61 931
24 Finance costs		
Note:		
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings accounts (Note 8)	**246 267**	220 294
Interest paid – other	**42**	–
Interest paid to Administrator (Note 25)	**–**	(2 879)*
Interest paid	**246 309**	217 415
Interest on lease liability (Note 2)	**1 331**	675
	247 640	218 090

* *During 2018 an amount of R2,8 million was refunded to the Scheme by Discovery Health (Pty) Ltd related to interest charged in prior periods on balances owed to the Administrator.*

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 (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and wellness programmes. As Discovery Health (Pty) Ltd is a related party, its subsidiaries and fellow subsidiaries within the Discovery Ltd group are related parties to the Scheme. Discovery Ltd's Annual Report provides detail of its group structure.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

25 Related party transactions *continued*

Parties with significant influence over the Scheme *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	2019	2018
Statement of Comprehensive Income transactions		
Compensation		
Short term employee benefits	**(31 819)**	(30 379)
Unvested long term employee benefit	**(5 736)**	(3 527)
Contributions and claims		
Gross contributions received	**1 161**	991
Claims paid from the Scheme	**(299)**	(308)
Claims paid from the Personal Medical Savings Account	**258**	(222)
Interest paid on Personal Medical Savings Accounts	**(3)**	(1)
Statement of Financial Position transactions		
Long term employee benefit plan asset	**5 796**	8 261
Plan asset	**19 198**	15 167
Plan liability	**(13 402)**	(6 906)
Contribution debtors	**93**	72
Personal Medical Savings Account balances	**(68)**	(32)

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 as 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.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

25 Related party transactions *continued*

R'000	2019	2018
Transactions with entities that have significant influence over the Scheme		
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(5 156 926)**	(4 875 746)
Interest refund received on monthly balances (Note 24)	**–**	2 879
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 9)*	**(429 839)**	(446 372)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 12)	**(1 763 579)**	(1 653 972)
Diabetes management services (Note 12)	**(2 248)**	–
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year-end (Note 9)*	**(169 007)**	(139 080)
Discovery Health (Pty) Ltd – Lifestyle and health assessments		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(6 630)**	(15 821)
Statement of Financial Position transactions		
Claims due to provider	**–**	(589)
Transactions between Discovery Health (Pty) Ltd's subisidiaries and the Scheme are provided below		
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	**(23 255)**	(24 275)
Statement of Financial Position transactions		
Balance due to the Scheme at year-end (Note 4)	**16 383**	14 387
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(286 951)**	(242 068)
Statement of Financial Position transactions		
Claims due to provider	**(304)**	(2 389)
Grove Nursing Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(13 565)**	(11 851)
Statement of Financial Position transactions		
Claims due to provider	**–**	(101)

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R599 million (2018: R585 million), disclosed in Note 9.*

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

25 RELATED PARTY TRANSACTIONS *continued*

R'000	2019	2018
Discovery Life Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Life Limited at year-end (Note 9)	**(120)**	(51)
Discovery Vitality (Pty) Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Vitality (Pty) Ltd at year-end (Note 9)	**(9 898)**	(3 768)
Discovery Connect Distribution Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Broker fees paid	**(72 279)**	(58 830)
Statement of Financial Position transactions		
Balance due to Discovery Connect Distribution Services (Pty) Ltd at year-end	**(6 573)**	(12 780)
Discovery Central Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Contractual lease and non lease payments	**(5 388)**	(2 568)
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note 9)	**(138)**	(3 272)

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 Board of Trustees. The agreement is for a five year period effective from 1 January 2018. The Scheme and the Administrator shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The administration fees are an all-inclusive fee, calculated on a Per Member Per Month basis. The total expense for administration cost changes in line with membership growth and inflation.

The main categories of service provided can be broken down as follows:

- Member and provider servicing;
- Marketing and advertising;
- Financial and actuarial services; and
- Governance, risk, compliance and internal audit.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

25 Related party transactions *continued*

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 Board of Trustees. The agreement is for a five year period and effective from 1 January 2018. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

Third party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2019 to 31 December 2019 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R16 million (2018: R14 million).

Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd to provide specialist pharmaceutical services to members of the Scheme.

Lifestyle and health assessments

Discovery Health (Pty) Ltd provides wellness experiences through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

Home-based nursing services

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare services, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based care to members of the Scheme in the comfort of their home.

Broker service fees

The Scheme contracted with Discovery Connect Distribution Services (Pty) 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.

Contractual lease payments

The Scheme has contracted with Discovery Central Services (Pty) Ltd, a wholly owned subsidiary of Discovery Ltd, to lease land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of five years. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

26 Surplus/(deficit) from operations per benefit plan

2019 R'000	Executive	Classic Comp	Classic Comp Zero MSA	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**962 444**	**10 374 065**	**77 909**	**2 279 078**	**13 616 672**	**4 746 448**	**1 004 132**	**4 797 023**	**1 585 191**
Net claims incurred	(1 216 092)	(10 674 040)	(79 594)	(1 758 507)	(10 604 808)	(4 019 294)	(897 602)	(3 130 178)	(1 122 838)
Claims incurred	(1 219 713)	(10 706 488)	(79 846)	(1 764 172)	(10 639 377)	(4 031 902)	(900 449)	(3 140 400)	(1 126 476)
Third party claim recoveries	3 621	32 448	252	5 665	34 569	12 608	2 847	10 222	3 638
Accredited managed healthcare services (no risk transfer)	(12 531)	(168 954)	(1 278)	(64 574)	(408 112)	(112 636)	(19 088)	(175 290)	(56 491)
Net income/ (expense) on risk transfer arrangements	1 127	14 131	120	6	785	372	1 398	295	70
Risk transfer arrangement fees	(4 000)	(52 675)	(356)	(501)	(3 884)	(1 678)	(5 035)	(951)	(417)
Recoveries from risk transfer arrangements	5 127	66 806	476	507	4 669	2 050	6 433	1 246	487
Relevant healthcare expenditure	**(1 227 496)**	**(10 828 863)**	**(80 752)**	**(1 823 075)**	**(11 012 135)**	**(4 131 558)**	**(915 292)**	**(3 305 173)**	**(1 179 259)**
Gross healthcare result	**(265 052)**	**(454 798)**	**(2 843)**	**456 003**	**2 604 537**	**614 890**	**88 840**	**1 491 850**	**405 932**
Broker service fees	(11 648)	(161 176)	(1 186)	(52 376)	(379 750)	(108 453)	(18 562)	(144 251)	(42 509)
Expenses for administration	(39 688)	(535 334)	(4 067)	(206 000)	(1 301 881)	(359 124)	(60 578)	(559 346)	(180 233)
Other operating expenses	(2 017)	(27 214)	(207)	(10 466)	(66 168)	(18 254)	(3 079)	(28 420)	(9 149)
Net healthcare result	**(318 405)**	**(1 178 521)**	**(8 303)**	**187 161**	**856 738**	**129 059**	**6 621**	**759 833**	**174 040**
Investment income	11 968	161 433	1 226	62 123	392 604	108 294	18 267	168 698	54 360
Net gains/(losses) on financial instruments	341	4 564	35	1 646	10 268	2 969	512	4 035	1 348
Other income	110	1 480	11	568	3 595	993	167	1 540	495
Other income	12 419	167 477	1 272	64 337	406 467	112 256	18 946	174 273	56 203
Expenses for asset management services rendered	(536)	(7 225)	(55)	(2 801)	(17 676)	(4 860)	(819)	(7 653)	(2 473)
Other expenses	(42)	(571)	(4)	(218)	(1 377)	(382)	(65)	(584)	(188)
Interest paid	(2 692)	(36 320)	(1)	(50)	(88 368)	(24 368)	(4 110)	(37 994)	(44)
Other expenditure	**(3 270)**	**(44 116)**	**(60)**	**(3 069)**	**(107 421)**	**(29 610)**	**(4 994)**	**(46 231)**	**(2 705)**
Net surplus/(deficit) for the period	**(309 256)**	**(1 055 160)**	**(7 091)**	**248 429**	**1 155 784**	**211 705**	**20 573**	**887 875**	**227 538**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

26 Surplus/(deficit) from operations per benefit plan *continued*

2019 R'000	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Smart	Essential Smart	Total
Risk contribution income	**291 762**	**7 151 844**	**3 056 879**	**5 187 124**	**279 123**	**94 912**	**1 233 159**	**484 463**	**57 222 228**
Net claims incurred	(187 224)	(6 037 913)	(2 567 481)	(4 915 340)	(185 220)	(38 524)	(853 241)	(227 861)	(48 515 757)
Claims incurred	(187 819)	(6 057 432)	(2 575 728)	(4 931 311)	(185 822)	(38 670)	(855 949)	(228 646)	(48 670 200)
Third party claim recoveries	595	19 519	8 247	15 971	602	146	2 708	785	154 443
Accredited managed healthcare services (no risk transfer)	(7 670)	(238 468)	(103 575)	(286 413)	(18 443)	(8 409)	(48 428)	(35 467)	(1 765 827)
Net income/ (expense) on risk transfer arrangements	14	482	169	48 827	–	521	18 569	(4 403)	82 483
Risk transfer arrangement fees	(77)	(2 014)	(631)	(194 700)	–	(4 267)	(22 266)	(6 012)	(299 464)
Recoveries from risk transfer arrangements	91	2 496	800	243 527	–	4 788	40 835	1 609	381 947
Relevant healthcare expenditure	**(194 880)**	**(6 275 899)**	**(2 670 887)**	**(5 152 926)**	**(203 663)**	**(46 412)**	**(883 100)**	**(267 731)**	**(50 199 101)**
Gross healthcare result	**96 882**	**875 945**	**385 992**	**34 198**	**75 460**	**48 500**	**350 059**	**216 732**	**7 023 127**
Broker service fees	(7 150)	(212 739)	(81 760)	(160 686)	(8 687)	(3 098)	(35 043)	(15 489)	(1 444 563)
Expenses for administration	(24 467)	(760 870)	(330 502)	(495 536)	(17 123)	(14 548)	(154 582)	(113 047)	(5 156 926)
Other operating expenses	(1 243)	(38 668)	(16 791)	(46 441)	(2 987)	(1 363)	(7 847)	(5 737)	(286 051)
Net healthcare result	**64 022**	**(136 332)**	**(43 061)**	**(668 465)**	**46 663**	**29 491**	**152 587**	**82 459**	**135 587**
Investment income	7 378	229 450	99 670	275 773	17 757	8 095	46 626	34 105	1 697 827
Net gains/(losses) on financial instruments	203	6 078	2 642	7 295	439	211	1 084	580	44 250
Other income	68	2 101	912	2 517	161	74	424	308	15 524
Other income	**7 649**	**237 629**	**103 224**	**285 585**	**18 357**	**8 380**	**48 134**	**34 993**	**1 757 601**
Expenses for asset management services rendered	(331)	(10 323)	(4 492)	(12 470)	(810)	(368)	(2 131)	(1 587)	(76 610)
Other expenses	(26)	(806)	(349)	(963)	(61)	(28)	(160)	(114)	(5 938)
Interest paid	(1 660)	(51 642)	(81)	(223)	(14)	(7)	(38)	(28)	(247 640)
Other expenditure	**(2 017)**	**(62 771)**	**(4 922)**	**(13 656)**	**(885)**	**(403)**	**(2 329)**	**(1 729)**	**(330 188)**
Net surplus/(deficit) for the period	**69 654**	**38 526**	**55 241**	**(396 536)**	**64 135**	**37 468**	**198 392**	**115 723**	**1 563 000**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

26 Surplus/(deficit) from operations per benefit plan *continued*

2018 R'000	Executive	Classic Comp	Classic Comp Zero MSA	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**937 324**	**10 257 684**	**68 673**	**2 119 838**	**12 124 262**	**4 668 227**	**1 018 948**	**4 116 330**	**1 364 223**
Net claims incurred	(1 215 340)	(10 551 200)	(60 221)	(1 605 487)	(9 386 512)	(3 935 812)	(910 483)	(2 658 364)	(945 775)
Claims incurred	(1 215 969)	(10 559 812)	(60 280)	(1 608 710)	(9 405 883)	(3 941 572)	(911 486)	(2 666 608)	(948 487)
Third party claim recoveries	629	8 612	59	3 223	19 371	5 760	1 003	8 244	2 712
Accredited managed healthcare services (no risk transfer)	(12 494)	(170 451)	(1 151)	(61 709)	(373 197)	(113 217)	(19 814)	(153 955)	(49 982)
Net income/(expense) on risk transfer arrangements	(783)	(15 047)	(183)	–	–	–	(1 789)	–	–
Risk transfer arrangement fees	(10 720)	(145 231)	(1 317)	–	–	–	(14 875)	–	–
Recoveries from risk transfer arrangements	9 937	130 184	1 134	–	–	–	13 086	–	–
Relevant healthcare expenditure	**(1 228 617)**	**(10 736 698)**	**(61 555)**	**(1 667 196)**	**(9 759 709)**	**(4 049 029)**	**(932 086)**	**(2 812 319)**	**(995 757)**
Gross healthcare result	**(291 293)**	**(479 014)**	**7 118**	**452 642**	**2 364 553**	**619 198**	**86 862**	**1 304 011**	**368 466**
Broker service fees	(11 571)	(160 984)	(1 069)	(48 530)	(336 003)	(106 886)	(18 957)	(122 714)	(36 574)
Expenses for administration	(40 377)	(550 532)	(3 720)	(199 325)	(1 205 874)	(365 781)	(63 942)	(497 534)	(161 525)
Other operating expenses	(2 103)	(28 649)	(192)	(10 204)	(61 867)	(18 974)	(3 330)	(25 111)	(8 101)
Net healthcare result	**(345 344)**	**(1 219 178)**	**2 137**	**194 583**	**760 809**	**127 557**	**633**	**658 652**	**162 266**
Investment income	11 425	155 868	1 053	56 427	341 247	103 527	18 119	140 766	45 701
Net gains/(losses) on financial instruments	(867)	(11 826)	(81)	(4 340)	(26 289)	(7 887)	(1 378)	(10 927)	(3 559)
Other income	559	7 625	51	2 718	16 445	5 041	885	6 691	2 164
Other income	**11 117**	**151 666**	**1 023**	**54 805**	**331 403**	**100 681**	**17 626**	**136 530**	**44 306**
Expenses for asset management services rendered	(537)	(7 322)	(49)	(2 662)	(16 087)	(4 869)	(852)	(6 661)	(2 166)
Other expenses	(83)	(1 128)	(7)	(402)	(2 432)	(745)	(131)	(989)	(320)
Interest paid	(2 532)	(34 540)	2	83	(75 676)	(22 946)	(4 015)	(31 240)	64
Other expenditure	**(3 152)**	**(42 990)**	**(54)**	**(2 981)**	**(94 195)**	**(28 560)**	**(4 998)**	**(38 890)**	**(2 422)**
Net surplus/(deficit) for the period	**(337 379)**	**(1 110 502)**	**3 106**	**246 407**	**998 017**	**199 678**	**13 261**	**756 292**	**204 150**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

26 Surplus/(deficit) from operations per benefit plan *continued*

2018 R'000	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Smart	Essential Smart	Total
Risk contribution income	**293 648**	**6 618 810**	**2 843 896**	**4 937 863**	**250 388**	**64 637**	**846 532**	**297 648**	**52 828 931**
Net claims incurred	(171 517)	(5 546 618)	(2 418 126)	(4 809 473)	(176 025)	(28 928)	(539 023)	(140 532)	(45 099 436)
Claims incurred	(171 926)	(5 558 448)	(2 423 325)	(4 824 396)	(176 958)	(29 223)	(540 985)	(141 962)	(45 186 030)
Third party claim recoveries	409	11 830	5 199	14 923	933	295	1 962	1 430	86 594
Accredited managed healthcare services (no risk transfer)	(7 961)	(228 227)	(100 153)	(282 177)	(16 904)	(5 584)	(34 627)	(22 369)	(1 653 972)
Net income/(expense) on risk transfer arrangements	–	–	–	48 170	–	152	7 131	(3 196)	34 455
Risk transfer arrangement fees	–	–	–	(188 082)	–	(3 033)	(15 651)	(3 810)	(382 719)
Recoveries from risk transfer arrangements	–	–	–	236 252	–	3 185	22 782	614	417 174
Relevant healthcare expenditure	**(179 478)**	**(5 774 845)**	**(2 518 279)**	**(5 043 480)**	**(192 929)**	**(34 360)**	**(566 519)**	**(166 097)**	**(46 718 953)**
Gross healthcare result	**114 170**	**843 965**	**325 617**	**(105 617)**	**57 459**	**30 277**	**280 013**	**131 551**	**6 109 978**
Broker service fees	(7 095)	(196 271)	(75 597)	(148 772)	(7 602)	(2 018)	(23 730)	(9 368)	(1 313 741)
Expenses for administration	(25 726)	(737 465)	(323 576)	(494 182)	(15 888)	(6 297)	(111 712)	(72 291)	(4 875 746)
Other operating expenses	(1 329)	(37 875)	(16 614)	(46 251)	(2 712)	(914)	(5 470)	(3 256)	(272 952)
Net healthcare result	**80 020**	**(127 646)**	**(90 170)**	**(794 822)**	**31 257**	**21 048**	**139 101**	**46 636**	**(352 461)**
Investment income	7 280	208 685	91 581	258 024	15 459	5 104	31 658	20 445	1 512 368
Net gains/(losses) on financial instruments	(559)	(16 013)	(7 025)	(19 965)	(1 227)	(403)	(2 511)	(1 721)	(116 578)
Other income	352	10 071	4 420	12 347	725	241	1 464	878	72 677
Other income	**7 073**	**202 743**	**88 976**	**250 406**	**14 957**	**4 942**	**30 611**	**19 602**	**1 468 467**
Expenses for asset management services rendered	(343)	(9 836)	(4 317)	(12 189)	(734)	(242)	(1 509)	(991)	(71 366)
Other expenses	(52)	(1 489)	(653)	(1 826)	(107)	(36)	(216)	(130)	(10 746)
Interest paid	(1 614)	(46 276)	135	372	21	7	42	23	(218 090)
Other expenditure	**(2 009)**	**(57 601)**	**(4 835)**	**(13 643)**	**(820)**	**(271)**	**(1 683)**	**(1 098)**	**(300 202)**
Net surplus/(deficit) for the period	**85 084**	**17 496**	**(6 029)**	**(558 059)**	**45 394**	**25 719**	**168 029**	**65 140**	**815 804**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

27 Cash flows generated/(utilised) from operations before working capital changes

R'000	2019	2018
Net surplus for the year	**1 563 000**	815 804
Adjustments for:		
Impairment losses (Note 17)	**106 108**	103 020
Depreciation (Note 1)	**1 486**	743
Interest received (Note 21)	**(1 513 838)**	(1 350 237)
Dividend income (Note 1, 21)	**(183 989)**	(162 131)
Interest paid (Note 24)	**247 640**	218 090
Unvested long term employee benefit	**5 735**	3 527
Net (gains)/losses on financial assets (Note 22)	**(44 250)**	116 578
	181 892	(254 606)
Reconciliation of movements in the cash flow statement		
Increase in trade and other receivables	**(308 631)**	(1 313 257)
Opening balance	**2 357 902**	1 147 665
Closing balance (Note 4)	**(2 560 425)**	(2 357 902)
Impairment losses	**(106 108)**	(103 020)
(Decrease)/increase in trade and other payables	**(3 068 085)**	1 554 535
Opening balance	**(4 620 053)**	(3 065 518)
Closing balance (Note 9)	**1 551 968**	4 620 053
Proceeds from sale of financial assets	**2 238 283**	2 891 623
Financial assets at fair value through profit or loss (Note 3)	**2 215 835**	2 863 320
Derivative financial instruments (Note 7)	**22 448**	28 303
Payments for property and equipment	**–**	2 844
Additions to leasehold improvements (Note 1)	**–**	2 844

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

28 Events after the reporting period

At the reporting date, there were no cases of COVID-19 identified in South Africa, and the decline in the fair value of investments occurred after the reporting date. These events are non-adjusting events after the reporting date and no adjustments were made to the amounts recognised in the financial statements as at 31 December 2019.

Subsequent to the reporting date and prior to the date the financial statements were authorised for issue, the President of South Africa declared a national state of disaster as a result of the global COVID-19 pandemic on 15 March 2020. Even though South Africa is in the early stage of the outbreak, and there exist uncertainties about the potential impact of COVID-19 on the Scheme and its members, the Scheme has considered various possible scenarios, including stress test scenarios, to assess the potential impact of COVID-19. The results of the scenarios indicate that the Scheme's net surplus for 2020 could decrease by between approximately 140% to 430%.

The Board of Trustees are of the view that the Scheme's strong financial position and Reserve levels will allow the Scheme to absorb the potential direct and indirect negative impact of COVID-19 with a reduction of less than 3 percentage points in the 2020 Solvency level, based on the most likely scenario and it is not envisaged that it will have an impact on the Scheme's ability to pay claims as they arise.

COVID-19 has also had a dramatic impact on the South African and global investment markets resulting in a decline in the fair value of investments between the reporting date and the date when the financial statements were authorised for issue of around 5%.

The market conditions post year-end, including the decrease in the Repo rate announced by the South African Reserve Bank, has not resulted in a significant change in the fair value of the Scheme's money market and yield-enhanced bond portfolios, consequently no further disclosure has been provided. The potential impact on the fair value of the Scheme's offshore, listed equities and property investments has been provided below, with the percentage decrease reflecting the changes compared to levels at 31 December 2019.

The following sensitivity analysis expands on the year-end sensitivity analysis included in Note 31.

Currency risk sensitivity analysis

R'000	**25% price decrease**	35% price decrease
Gain arising from price decrease *before zero cost currency collars*	**219 039**	306 655
Gain arising from price decrease *after zero cost currency collars*	**112 553**	200 168

Listed equity price risk sensitivity analysis

Index	**25% decrease**	35% decrease
DTOP	**2 690**	3 765
DCAP	**4 060**	5 684

R'000	**25% decrease**	35% decrease
Loss arising from price decrease *before zero cost equity fences*	**(1 070 646)**	(1 498 904)
Loss arising from price decrease *after zero cost equity fences*	**(537 870)**	(966 129)

Listed property price risk sensitivity analysis

R'000	**25% price decrease**	35% price decrease
Loss arising from price decrease	**(158 482)**	(221 874)

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

29 Amalgamations

Accounting policy:

Scheme amalgamations are accounted for by applying the acquisition method.

The cost of an amalgamation is measured as the fair value of the assets transferred and liabilities incurred or assumed at the date of exchange.

When an entity is amalgamated into the Scheme, all identifiable assets, liabilities and members' funds are accounted for at their fair values at the acquisition date. No consideration is paid for these transactions and they are recognised as from the transaction date.

The Scheme recognises the net assets from amalgamated schemes as a direct addition to reserves in its Statement of Financial Position.

Section 63(14) of the Act, prescribes that relevant assets and liabilities of the party effecting the transfer shall vest in and become binding upon the party to which transfer is effected.

No goodwill is recognised on the amalgamation of schemes.

Note:

University of the Witwatersrand Staff Medical Aid Fund

An amalgamation between the Scheme and University of the Witwatersrand Staff Medical Aid Fund ("WitsMed") was confirmed and effective from 1 January 2018. The disclosures provided below have been provided to enable users to evaluate the nature and financial effect of the amalgamation.

WitsMed was a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme was open to all current and retired employees of the University of the Witwatersrand, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, were able to continue their membership if they so elected.

In terms of the Act, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and WitsMed voted that the amalgamation of WitsMed with the Scheme would be in the best interest of the WitsMed members.

The Scheme obtained control of WitsMed by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 2 604 principal members and 4 920 beneficiaries joined the Scheme.

No goodwill was recognised as a result of this transaction.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

29 Amalgamations *continued*

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:

R'000	2019	2018
University of the Witwatersrand Staff Medical Aid Fund		
Reserves effectively transferred:		
(Acquisition date fair value of WitsMed members' interest)	–	149 191
Net recognised values of WitsMed identifiable assets and liabilities:	–	149 191
Current assets	–	156 989
Available for sale investments	–	1 762
Cash and cash equivalents	–	151 584
Member and service provider claims receivables	–	1 370
Provision for impairment	–	(1 158)
Interest receivable	–	767
Other accounts receivable	–	2 664
Current liabilities	–	(7 798)
Outstanding claims provision	–	(4 400)
Reported claims not yet paid	–	(2 188)
Contribution in advance	–	(159)
Unallocated funds	–	(40)
Discovery Health (Pty) Ltd	–	(468)
General accruals	–	(543)
Movement subsequent to amalgamation	–	(3 075)
Closing balance	–	146 116
Movements subsequent to the amalgamation date generally relate to contributions, claims and operating expenses adjustments.		
As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below.		
Fair value of receivables acquired:	–	3 463
Insurance receivables	–	2 876
Member claim debtors	–	211
Service provider claim debtors	–	1 159
Other accounts receivable	–	2 664
Provision for impairment	–	(1 158)
Other receivables	–	767
Interest receivable	–	767
Gross contractual amounts receivable:	–	4 801
Insurance receivables	–	4 034
Member claim debtors	–	211
Service provider claim debtors	–	1 159
Other accounts receivable	–	2 664
Other receivables	–	767
Interest receivable	–	767

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

29 Amalgamations *continued*

R'000	2019	2018
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	–	(1 158)
Member claim debtors	–	(178)
Service provider claim debtors	–	(980)
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.		
Non-current assets	–	–
Available for sale investments	–	–
Current assets	–	156 989
Available for sale investments	–	1 762
Cash and cash equivalents	–	151 584
Member claim debtors	–	33
Service provider claim debtors	–	179
Interest receivable	–	767
Other accounts receivable	–	2 664
Current liabilities	–	(7 798)
Outstanding claims provision	–	(4 400)
Reported claims not yet paid	–	(2 188)
Contribution in advance	–	(159)
Unallocated funds	–	(40)
Discovery Health (Pty) Ltd	–	(468)
General accruals	–	(543)
	–	149 191

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

30 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

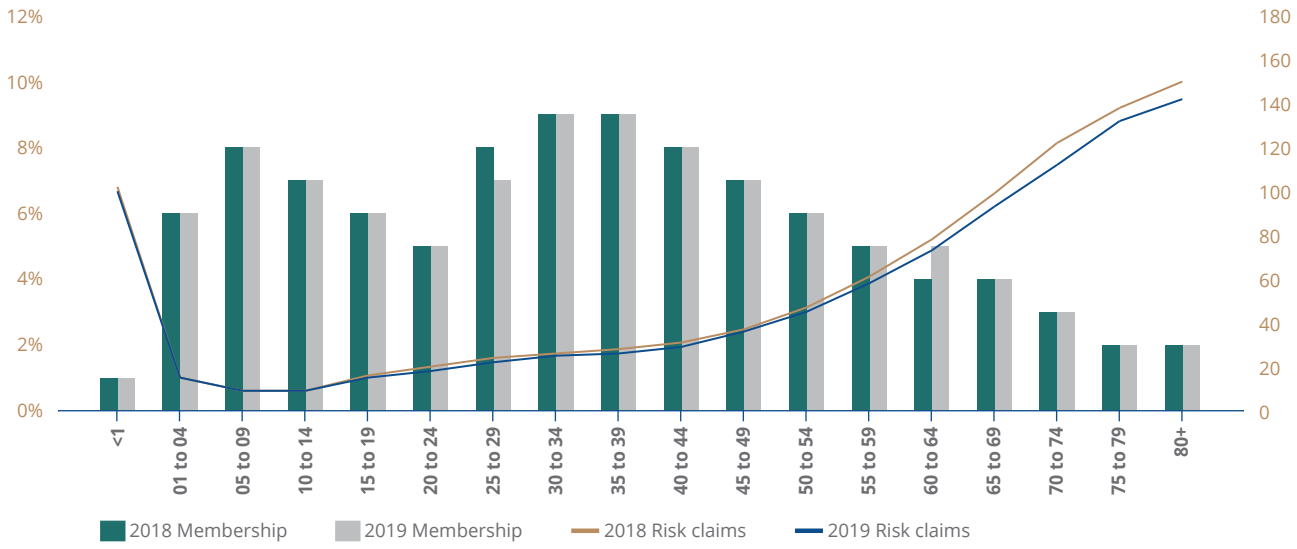
The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The 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 graph indicates the distribution of beneficiaries by age band for 2018 and 2019, as well as the risk claims paid. The risk claims are indexed to a value of 100 for the "<1" age band in 2018. There has been an increase in the proportion of beneficiaries older than 45 over the past year.

MEMBERSHIP DISTRIBUTION AND RISK CLAIMS (claims indexed to age band "<1" 2018 = 100)



Notes to the Financial Statements *continued*
for the year ended 31 December 2019

30 Insurance risk management report *continued*

Insurance risk *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 Personal Medical Savings Account (PMSA) and an insurance risk element. This includes the Day-to-day Extender Benefit and the 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 51 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

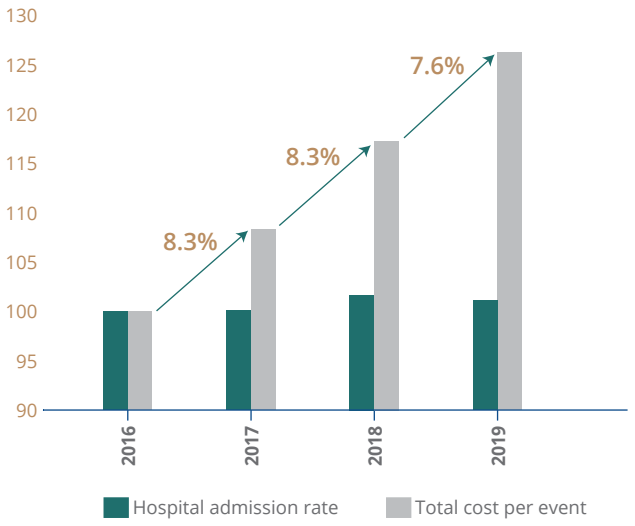
HOSPITAL BENEFIT RISK

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result 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 2016.

HOSPITAL CLAIMS EXPERIENCE (indexed to 2016 = 100)



Notes to the Financial Statements *continued*
for the year ended 31 December 2019

30 Insurance risk management report *continued*

Insurance risk *continued*

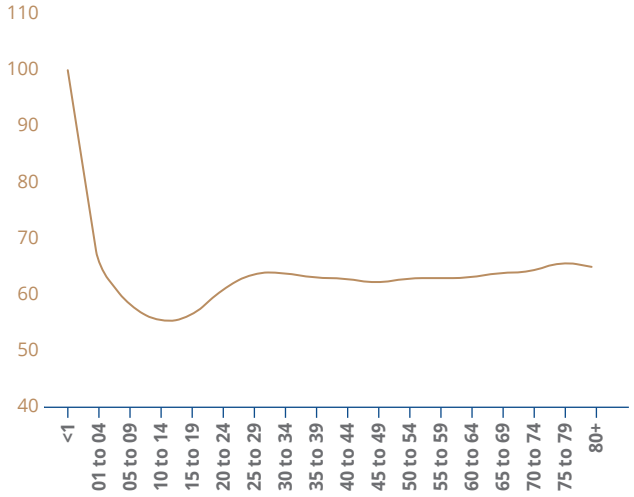
DAY-TO-DAY BENEFITS RISK

The frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options as well as an increase in the number of claims categorised as Prescribed Minimum Benefit (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.

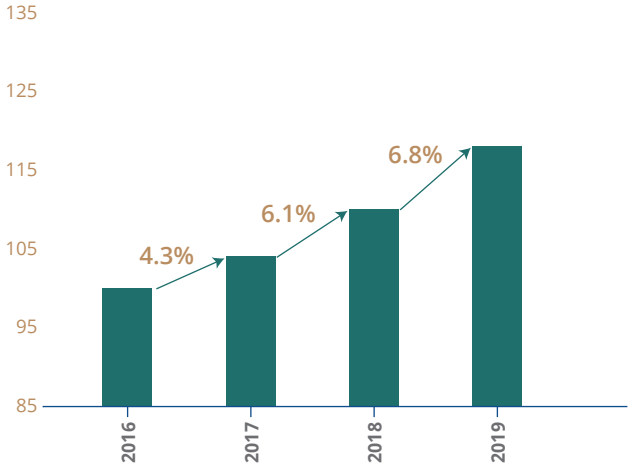
The first graph below shows that the frequency of out of hospital claims are materially higher for babies under one year of age, and then drops off sharply until age 19 after which a stable but increasing trend is apparent.

The second graph below indicates the change in the claims cost per out of hospital claimant over the past four years. This graph is indexed to a value of 100 as at 2016.

2019 CLAIMANTS PER 1 000 BENEFICIARIES FROM OH RISK BENEFITS (indexed to age band "<1" 2019 = 100)



COST PER OUT OF HOSPITAL CLAIMANT (indexed to January 2016 = 100)



Notes to the Financial Statements *continued*
for the year ended 31 December 2019

30 Insurance risk management report *continued*

Insurance risk *continued*

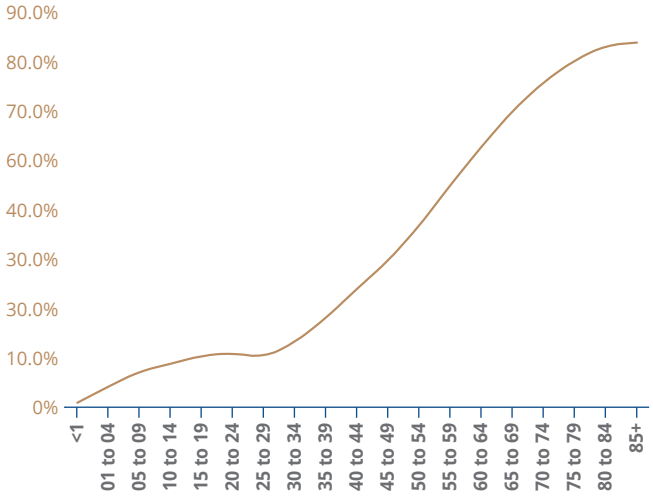
CHRONIC BENEFITS RISK

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

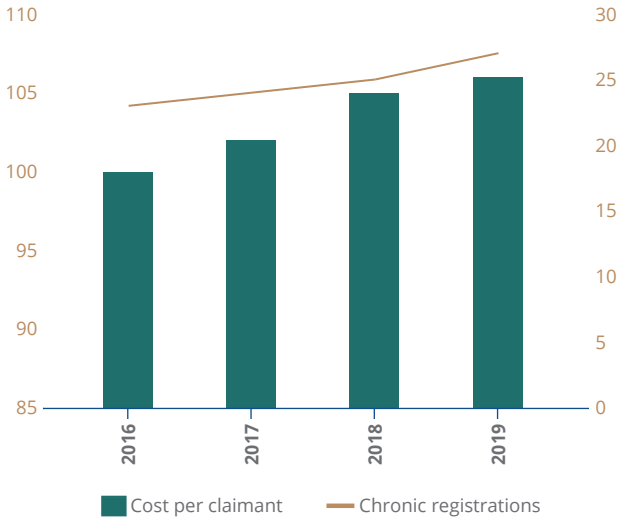
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and the presence of multiple chronic conditions per person will have an impact on the severity of the claims.

The following graphs indicate the percentage of chronic registrations by age band for 2019, as well as the change in the cost per claimant over the past four years. The cost per claimant graph is indexed to a value of 100 as at 2016.

PROPORTION OF CHRONIC REGISTRATIONS BY AGE BAND



COST PER CHRONIC CLAIMANT (indexed to 2016 = 100)



Risk management

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include:

- Members have to be referred by a doctor prior to an elective admission.
- All hospital admissions have to be pre-authorised.
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times.
- The work of the Centre for Clinical Excellence, which 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.
- A dedicated unit to focus on reducing surgical consumable spend.
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.
- A Co-ordinated 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.
- An Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients who are terminally ill.
- A disease management unit dedicated to managing high-risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Centre for Clinical Excellence is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

30 Insurance risk management report *continued*

Concentration of insurance risk

As the largest open medical scheme by membership in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme also offers a wide range of benefit plans which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

An annual actuarial valuation is performed, which specifies the contributions to be charged in return for the benefits to be provided given the expected demographic profile of each benefit option.

RISK TRANSFER ARRANGEMENTS

The Scheme has risk transfer agreements in which suppliers are paid to provide certain minimum benefits to Scheme members, as and when it is required by the members. These arrangements are also known as capitation arrangements and fix the cost to the Scheme of providing these benefits.

Arrangements are in place that provide optometry, dentistry and diabetes management services to members on certain plans. There is also an arrange that covers Smart plan members for acute medication prescribed by their network doctors.

RISK IN TERMS OF RISK TRANSFER ARRANGEMENTS

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the cost 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.

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, with the majority of cases being resolved within three months. At year-end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chainladder method and another method using the estimated cost per event and pre-authorised admissions is also followed.

The estimation of the December 2019 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this guidance note, the following factors are considered to determine whether they would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

Based on the processing patterns and claims development up to the end of December 2019 in respect of treatment dates during 2019, the recommended provision for outstanding claims as at December 2019 is R1,526 million (2018: R1 499 million).

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

30 Insurance risk management report *continued*

Concentration of insurance risk *continued*

CLAIMS DEVELOPMENT *continued*

The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:

R'000	**2019**	2018
Total estimate of incurred claims		
In-hospital claims incurred	**35 844 867**	33 386 416
Chronic claims incurred	**2 868 279**	2 703 488
Out-of-hospital risk claims incurred	**9 583 273**	8 925 462

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.

R'000	**Change in variable %**	**Impact on outstanding claims provision 2019**	Impact on outstanding claims provision 2018
In-hospital claims incurred	1% slower claims processing	**396 064**	370 810
Chronic claims incurred	1% slower claims processing	**12 270**	11 475
Out-of-hospital risk claims incurred	1% slower claims processing	**92 272**	85 277

Liquidity risk

The main component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time, approximately 97% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Liquidity risk can also arise when the Scheme's investment mix does not match the nature of the liabilities. However, investments are managed by professional asset managers and finance professionals who ensure that investments, including cash and cash equivalents, are always suffiently 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 are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 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 Board of Trustees has 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 Board of Trustees for approval. The Investment Committee meets at least quarterly and reports back to the Board of Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- Independent valuation of the Scheme's investments is performed by a third party.

Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

R'000	Total	Currency risk	Price risk	Interest rate risk
31 December 2019				
Investments	**23 191 456**			
Offshore bonds	**876 156**	✓		✓
Equities	**4 182 545**		✓	
Yield-enhanced bonds	**6 620 669**			✓
Inflation-linked bonds	**1 125 768**			✓
Money market instruments	**9 799 918**			✓
Listed property	**586 400**		✓	
31 December 2018				
Investments	20 519 767			
Offshore bonds	847 314	✓		✓
Equities	4 038 399		✓	
Yield-enhanced bonds	5 631 602			✓
Inflation-linked bonds	1 104 552			✓
Money market instruments	8 324 805			✓
Listed property	573 096		✓	

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently, changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report

Currency risk

The majority of the Scheme's benefits are rand-denominated and therefore the Scheme does not have significant net currency risk relating to benefits.

For the purpose of seeking investment diversification, the Scheme continued to invest in offshore bond portfolios (reference currency is the US Dollar). Derivative financial instruments are utilised by the independent bond managers within these portfolios for risk mitigation and efficient portfolio construction. At 31 December 2019, R876 million (2018: R847 million) (Note 3) was invested in these portfolios.

- CURRENCY DERIVATIVES FINANCIAL INSTRUMENT (ZERO-COST CURRENCY COLLARS)

The Scheme enters into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in the rand/US Dollar exchange rate with respect to its offshore bond portfolios. The following table provides detail of the open contracts at year-end.

			2019		
Contract	Expiry date	Nominal USD value $'000	**USD put ("floor")**	**USD call ("cap")**	**% above floor**
1	15/06/2020	$30 000	**R14.52**	**R15.79**	**8.72%**
2	15/09/2020	$30 000	**R14.52**	**R16.26**	**12.00%**

The zero-cost currency collars are categorised as at fair value through profit or loss.

At the time of expiry of the zero-cost currency collars 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 have been included in financial assets. Gains and losses on these arrangements are included in the Net surplus (Note 7).

- CURRENCY RISK SENSITIVITY ANALYSIS

The sensitivity of the rand appreciating and depreciating against the US Dollar is presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity are based on the assumption that the rand has strengthened or weakened against the US Dollar by 5% (*increase or decrease of R0.70*) or 15% (*increase or decrease of R2.10*) from a spot level of R14.00 to the US Dollar, with all other variables held constant. The analysis is presented including and excluding the impact of the zero-cost currency collars, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost currency collars would be based on the exchange rate at the date of expiry of the respective contracts.

R'000	**15% price decrease**	**5% price decrease**	**5% price increase**	**15% price increase**
(Loss)/gain arising from price decrease/increase *before zero-cost currency collars*	**(131 423)**	**(43 808)**	**43 808**	**131 423**
(Loss)/gain arising from price decrease/increase *after zero-cost currency collars*	**4 158**	**16 430**	**42 933**	**78 558**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

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 listed equity and property investments amounted to R4.8 billion (2018: R4.6 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.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market. The derivative strategy considers the impact of the decision to limit the maximum exposure to 15% of any constituent of the benchmark.

- EQUITY DERIVATIVE FINANCIAL INSTRUMENT (ZERO-COST EQUITY FENCE)

  The Scheme entered into zero-cost equity fence arrangements to hedge approximately 100% of the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 15% after a reduction in equity prices of 5% (ie. the Scheme is at risk for the first 5% drop in equity prices but protected for the next 15%). To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the pre-determined level (the cap). The cap for these contracts range between 12% and 15% above the pre-determined level. These contracts expire during 2020.

	2019					
Contract	Nominal value R'000	Index level	Index level at trade date	Short put level ("lower floor")	Long put level ("upper floor")	Call level ("cap")
1	160 000	DTOP[1]	11 152	80.00%	95.00%	114.77%
2	640 000	DCAP[2]	17 001	80.00%	95.00%	112.42%
3	250 000	DTOP	10 926	83.90%	95.00%	114.80%
4	750 000	DCAP	16 629	83.70%	95.00%	112.40%
5	250 000	DTOP	10 901	80.00%	95.00%	114.65%
6	750 000	DCAP	16 531	80.00%	95.00%	112.45%
7	140 000	DTOP	10 552	81.50%	95.00%	115.25%
8	560 000	DCAP	15 681	81.50%	95.00%	112.42%
9	335 000	DTOP	10 201	80.00%	95.00%	114.77%
10	335 000	DCAP	15 569	80.00%	95.00%	113.23%

1 DTOP – FTSE/JSE TOP 40 Index
2 DCAP – FTSE/JSE CAPPED SWIX TOP 40 Index

The zero-cost equity fences are categorised as at fair value through profit or loss.

At the time of expiry, the following transactions could occur depending on the level at which the equity index trades:

- If the index level is higher than the cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the upper floor, no action would take place.
- If the index level is trading between the upper floor and the lower floor, the counterparty would be required to pay the difference between the index level and the lower floor to the Scheme.
- If the index level is trading lower than lower floor, the Scheme would be required to pay the difference between the lower floor and the index level minus 15% to the counterparty.

The fair value of these contracts have been included in financial assets and financial liabilities. Gains and losses on these arrangements are included in the Net surplus (Note 7).

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Price risk *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 Net Surplus. The potential outcomes of the sensitivity are based on the assumption that equity prices had increased or decreased by 5% or 15%, spot reference levels of 10,758 (DTOP) and 16,240 (DCAP) respectively, with all other variables held constant. The analysis is presented including and excluding the impact of the zero-cost equity fences, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost equity fences would be based on the reference level at the date of expiry of the respective contracts.

The following table indicates the 5% or 15% change in the respective index.

Index	5% increase or decrease	15% increase or decrease
DTOP	**538**	**1 614**
DCAP	**812**	**2 436**

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase *before zero-cost equity fences*	**(642 388)**	**(214 129)**	**214 129**	**642 388**
(Loss)/gain arising from price decrease/increase *after zero-cost equity fences*	**(451 444)**	**(139 284)**	**172 347**	**456 739**

The analysis reflecting the impact of increases or decreases in prices of the listed property portfolio has been presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity are based on the assumption that prices had increased or decreased by 5% or 15%, with all other variables held constant. The Scheme has not hedged this portfolio.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase	**(95 089)**	**(31 696)**	**31 696**	**95 089**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 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.

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.

As at 31 December 2019 R'000	**0 – 3 Months**	**3 – 12 Months**	**>12 Months**	**Total**
Cash and cash equivalents	**1 991 282**	**–**	**–**	**1 991 283**
Money market instruments carried at fair value through profit or loss	**–**	**9 799 918**	**–**	**9 799 863**
Yield-enhanced bonds carried at fair value through profit or loss	**–**	**6 620 669**	**–**	**6 620 669**
Inflation-linked bonds carried at fair value through profit or loss	**–**	**1 125 768**	**–**	**1 125 823**
Offshore bonds carried at fair value through profit or loss	**–**	**876 156**	**–**	**876 156**

As at 31 December 2018 R'000	0 – 3 Months	3 – 12 Months	>12 Months	Total
Cash and cash equivalents	5 775 481	–	–	5 775 481
Money market instruments carried at fair value through profit or loss	–	8 324 805	–	8 324 805
Yield-enhanced bonds carried at fair value through profit or loss	–	5 631 601	–	5 631 601
Inflation-linked bonds carried at fair value through profit or loss	–	1 104 552	–	1 104 552
Offshore bonds carried at fair value through profit or loss	–	847 314	–	847 314

INTEREST RATE RISK SENSITIVITY ANALYSIS

A sensitivity analysis indicating results of increases/decreases in interest rates has been presented below. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that local or foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

Gains/(losses) arising from change in: R'000	**2% interest rate decrease**	**1% interest rate decrease**	**1% interest rate increase**	**2% interest rate increase**
Local portfolios	**75 044**	**26 189**	**(27 862)**	**(65 289)**
Foreign portfolios	**81 213**	**40 607**	**(40 607)**	**(81 213)**

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. 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.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 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. At 31 December 2019, the Scheme did not consider there to be any 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 not be sufficient to cover future liabilities.

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. In contemplating solvency, the return goals of the Scheme, as well as the risk associated with all assets and asset classes are considered. Diversification is across securities, issuers, asset classes, geographic regions as well as managers within asset classes where practical. The Scheme diversifies its investment portfolio by investing in short-term deposits, money market, bond, listed property and equity portfolios managed by reputable asset managers.

The Scheme's investment objective statement is:

- Maximise targeted investment returns, which is dependent on contribution increases implemented over the next year and the evaluation of the solvency level above the statutory minimum requirement from time to time.
- The return target will be reviewed at the end of every year taking into account the actual returns achieved, projected operating surplus and finalised contribution increases.
- The return target is subject to a low risk appetite for:
  - solvency reducing below 25% due to poor investment returns; or
  - achieving returns in any year that are lower than the return assumed by the actuary in the pricing budget.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure performance in accordance with the agreed mandates.

Breakdown of investments

The investments are split between the following in the Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

R'000	Segregated Funds	Collective Investment Schemes	Policy of Insurance	Total
31 December 2019				
Investments	**21 189 476**	**1 117 978**	**884 002**	**23 191 456**
Offshore bonds	**–**	**536 884**	**339 272**	**876 156**
Equities	**4 182 545**	**–**	**–**	**4 182 545**
Yield-enhanced bonds	**6 620 669**	**–**	**–**	**6 620 669**
Inflation-linked bonds	**1 125 768**	**–**	**–**	**1 125 768**
Listed property	**586 400**	**–**	**–**	**586 400**
Money market instruments	**8 674 094**	**581 094**	**544 730**	**9 799 918**
Cash and cash equivalents	**794 043**	**1 197 239**	**–**	**1 991 282**
	21 983 519	**2 315 217**	**884 002**	**25 182 738**
31 December 2018				
Investments	19 672 453	526 801	320 513	20 519 767
Offshore bonds	–	526 801	320 513	847 314
Equities	4 038 399	–	–	4 038 399
Yield-enhanced bonds	5 631 601	–	–	5 631 601
Inflation-linked bonds	1 104 552	–	–	1 104 552
Listed property	573 096	–	–	573 096
Money market instruments	8 324 805	–	–	8 324 805
Cash and cash equivalents	3 863 605	1 911 876	–	5 775 481
	23 536 058	2 438 677	320 513	26 295 248

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Breakdown of investments *continued*

MONEY MARKET PORTFOLIOS:

***Local portfolios*:**

The two local money market portfolios are managed by independent asset managers. The investment mandate is for an actively managed portfolio 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 + 130 basis points per annum over rolling one-year periods.

The local money market portfolios comprise approximately 42% (2018: 41%) of the Scheme's Financial assets at fair value through profit or loss.

YIELD-ENHANCED BOND PORTFOLIOS:

***Local portfolios*:**

The Scheme has two 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 asset types such as, listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is STeFI three month index + 150 basis points per annum.

The second portfolio is a specialist yield-enhanced bond 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 STeFI.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty and sets exposure limits to unrated investments. These portfolios comprise approximately 29% (2018: 27%) 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 aims to produce a positive total return, consisting of both income and capital gains, over rolling three year periods, regardless of market conditions, by investing primarily in fixed interest bearing instruments and related derivatives. The majority of these assets are denominated in major currencies and exposure to minor currencies is managed on a cautious basis. The fund is benchmarked against three month USD LIBOR.

The primary objective of the second portfolio is the long-term growth of capital and income and is a policy of insurance referencing participatory interests in a foreign collective investment scheme investing in fixed income instruments. The benchmark for this portfolio is the Barclays Capital Global Aggregate.

These portfolios comprise approximately 4% (2018: 4%) of the Scheme's financial assets at fair value through profit or loss.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Breakdown of investments *continued*

***Inflation-linked bonds*:**

The Scheme has two inflation-linked bond portfolios, each managed by an independent asset manager.

The primary mandate of the first portfolio is aimed at generating inflation-linked bond returns on initial capital invested. The benchmark is the JSE Composite Inflation-Linked Index (CILI).

The second portfolio is a fully discretionary, actively managed portfolio of inflation-linked and fixed income instruments. The portfolio only invests funds in domestic instruments. The benchmark for this portfolio is the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV Index).

These portfolios comprise approximately 5% (2018: 5%) 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 Shareholder weighted index (SWIX) adjusted to exclude tobacco (as per the Scheme's responsible investment policy) and capping the exposure of any benchmark constituent to 15%. The performance of the passive portfolio is measured against the FTSE/JSE SWIX 40 (J400) adjusted to exclude tobacco (as per the Scheme's responsible investment policy) and capping the exposure of any benchmark constituent to 15%.

These portfolios comprise approximately 17% (2018: 20%) of the Scheme's Financial assets at fair value through profit or loss.

Listed property:

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. Prior to July 2018 the benchmark was the FTSE/JSE SA Listed Property Index. From July 2018, the benchmark was changed to a custom benchmark being 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 6 holdings in the portfolio.

This portfolio comprises approximately 3% (2018: 3%) of the Scheme's Financial assets at fair value through profit or loss.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Breakdown of investments *continued*

The following table compares the fair value and carrying amounts of 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	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
31 December 2019						
Investments						
– Offshore bond portfolio	**876 156**	**–**	**–**	**–**	**876 156**	**876 156**
– Listed equities	**4 182 545**	**–**	**–**	**–**	**4 182 545**	**4 182 545**
– Yield-enhanced bond portfolio	**6 620 669**	**–**	**–**	**–**	**6 620 669**	**6 620 669**
– Inflation-linked bond portfolio	**1 125 768**	**–**	**–**	**–**	**1 125 768**	**1 125 768**
– Listed property	**586 400**	**–**	**–**	**–**	**586 400**	**586 400**
– Money market portfolios	**9 799 918**	**–**	**–**	**–**	**9 799 918**	**9 799 918**
Cash and cash equivalents	**–**	**1 991 282**	**–**	**–**	**1 991 282**	**1 991 282**
Trade and other receivables	**–**	**17 196**	**2 543 229**	**–**	**2 560 425**	**2 560 425**
Personal Medical Savings Accounts	**–**	**–**	**–**	**(5 522 613)**	**(5 522 613)**	**(5 522 613)**
Trade and other payables	**–**	**–**	**(892 671)**	**(659 297)**	**(1 551 968)**	**(1 551 968)**
Derivative financial instruments	**60 490**	**–**	**–**	**–**	**60 490**	**60 490**
	23 251 946	**2 008 478**	**1 650 558**	**(6 181 910)**	**20 729 072**	**20 729 072**

	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying a mount	Fair value amount
31 December 2018						
Investments						
– Offshore bond portfolio	847 314	–	–	–	847 314	847 314
– Listed equities	4 038 399	–	–	–	4 038 399	4 038 399
– Yield-enhanced bond portfolio	5 631 601	–	–	–	5 631 601	5 631 601
– Inflation-linked bond portfolio	1 104 552	–	–	–	1 104 552	1 104 552
– Listed property	573 096	–	–	–	573 096	573 096
– Money market portfolios	8 324 805	–	–	–	8 324 805	8 324 805
Cash and cash equivalents	–	5 775 481	–	–	5 775 481	5 775 481
Trade and other receivables	–	8 315	2 349 587	–	2 357 902	2 357 902
Personal Medical Savings Accounts	–	–		(5 040 832)	(5 040 832)	(5 040 832)
Trade and other payables	–	–	(871 726)	(3 748 327)	(4 620 053)	(4 620 053)
Derivative financial instruments	142 856	–	–	–	142 856	142 856
	20 662 623	5 783 796	1 477 861	(8 789 159)	19 135 121	19 135 121

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are through its trade and other receivables, investments and cash.

TRADE AND OTHER RECEIVABLES

Trade and other receivables comprise of insurance receivables and other receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt.

EXPOSURE TO CREDIT RISK

The carrying amount of trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis. The tables below highlights Trade and other receivables which are due and past due (by number of days).

Based on past experience, the Scheme believes that no provision for impairment is required in respect of Contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

Provision for impairment

INSURANCE RECEIVABLES

For insurance receivables, the Scheme establishes an allowance for impairment that represents its estimate of incurred losses. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparty.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures; and
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet
- identified.

The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

OTHER RECEIVABLES

The Scheme applies the IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for other receivables.

To measure the expected credit losses associated with other receivables, these have been grouped based on shared credit risk characteristics and the days past due. Other receivables comprise sundry accounts receivable and interest receivable and are all current and not in a past due status. No expected loss rate is assigned to receivables that are not past due. Any loss associated to these receivables is negligible and no provision raised. No further analysis is presented.

R'000	Current	Total
31 December 2019		
Expected loss rate	**0%**	
Gross carrying amount – other receivables	**17 196**	**17 195**
Sundry accounts receivable	**15 158**	**15 157**
Interest receivable	**2 038**	**2 038**
31 December 2018		
Expected loss rate	0%	
Gross carrying amount – other receivables	8 315	8 315
Sundry accounts receivable	5 294	5 294
Interest receivable	3 021	3 021

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Credit risk continued

The movement in the provision for impairment, for each component of insurance receivables has been presented below:

R'000	Contribution receivables	Member and service provider claims receivables	Other risk transfer arrangements	Broker fee receivables	Forensics receivables	Total
Balance as at 1 January 2018	11 493	267 541	–	947	9 969	289 950
Increase in provision for impairment	3 240	98 972	–	317	1 341	103 870
Amounts utilised during the year	–	(61 421)	–	–	–	(61 421)
Balance as at 31 December 2018	14 733	305 092	–	1 264	11 310	332 399
Balance as at 1 January 2019	**14 733**	**305 092**	**–**	**1 264**	**11 310**	**332 399**
Increase in provision for impairment	**3 089**	**100 014**	**–**	**71**	**2 409**	**105 583**
Amounts utilised during the year		**(64 206)**				**(64 206)**
Balance as at 31 December 2019	**17 822**	**340 900**	**–**	**1 335**	**13 719**	**373 776**

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Credit risk continued

	Total member and service provider claims receivables											
R'000	Active member claims receivables	Withdrawn member claims receivables	Service provider claims receivables	Total	Contribution receivables	Other risk transfer arrange-ments	Broker fee receivables	Other insurance receivables	Forensics receivables	Related party	Other receivables	Total
31 December 2019												
Not past due	**4 864**	**7 659**	**2 132**	**14 655**	**2 103 081**	**4 253**	**120**	**96 129**	**64 663**	**16 383**	**17 196**	**2 318 480**
Past due 30 – 60 days	**4 925**	**9 462**	**8 241**	**22 628**	**21 411**	**–**	**583**	**–**	**8 126**	**–**	**–**	**52 748**
Past due 61 – 90 days	**5 762**	**10 772**	**474**	**17 008**	**5 074**	**–**	**58**	**–**	**3 288**	**–**	**–**	**25 428**
Past due 91 – 120 days	**3 487**	**10 055**	**289**	**13 831**	**3 060**	**–**	**50**	**–**	**4 334**	**–**	**–**	**21 275**
Past due 121 – 150 days	**3 921**	**12 080**	**1 047**	**17 048**	**(5 892)**	**–**	**42**	**–**	**5 277**	**–**	**–**	**16 475**
Past due 151 – 180 days	**3 929**	**12 957**	**399**	**17 285**	**–**	**–**	**32**	**–**	**2 343**	**–**	**–**	**19 660**
181 days to more than one year	**48 465**	**238 847**	**53 588**	**340 900**	**–**	**–**	**1 335**	**–**	**139 900**	**–**	**–**	**482 135**
Gross Receivables	**75 353**	**301 832**	**66 170**	**443 355**	**2 126 734**	**4 253**	**2 220**	**96 129**	**227 931**	**16 383**	**17 196**	**2 934 201**
Provision for impairments	**(48 465)**	**(238 847)**	**(53 588)**	**(340 900)**	**(17 822)**	**–**	**(1 335)**	**–**	**(13 719)**	**–**	**–**	**(373 776)**
Trade and other receivables neither past due nor impaired	**26 888**	**62 985**	**12 582**	**102 455**	**2 108 912**	**4 253**	**885**	**96 129**	**214 212**	**16 383**	**17 196**	**2 560 425**
31 December 2018												
Not past due	4 542	7 247	3 062	14 851	1 987 295	5 498	126	39 097	63 743	14 387	8 315	2 133 312
Past due 30 – 60 days	3 951	8 959	2 271	15 181	14 630	–	11	–	15 112	–	–	44 934
Past due 61 – 90 days	4 529	9 625	5 537	19 691	5 946	–	7	–	4 604	–	–	30 248
Past due 91 – 120 days	3 466	11 176	2 009	16 651	11 068	–	5	–	5 647	–	–	33 371
Past due 121 – 150 days	3 252	11 729	1 341	16 322	958	–	20	–	11 566	–	–	28 866
Past due 151 – 180 days	2 987	12 378	838	16 203	–	–	45	–	707	–	–	16 955
181 days to more than one year	39 103	225 686	40 303	305 092	–	–	1 264	–	96 259	–	–	402 615
Gross Receivables	61 830	286 800	55 361	403 991	2 019 897	5 498	1 478	39 097	197 638	14 387	8 315	2 690 301
Provision for impairments	(39 103)	(225 686)	(40 303)	(305 092)	(14 733)	–	(1 264)	–	(11 310)	–	–	(332 399)
Trade and other receivables neither past due nor impaired	22 727	61 114	15 058	98 899	2 005 164	5 498	214	39 097	186 328	14 387	8 315	2 357 902

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Credit quality

The credit quality of trade and other receivables that are neither past due nor impaired as presented on page 148 can be assessed by reference to historical information about counterparty default.

CONTRIBUTIONS DEBTORS

The Scheme collects over 95% of outstanding contributions in the month following the contributions being due. Therefore, we can establish that the credit quality of contribution debtors is high and no additional disclosure of the credit quality is provided.

ACTIVE MEMBER CLAIMS DEBTORS

A provision for impairment covering 64% (2018: 63%) of the debtors has been raised and the Trustees are satisfied that this is adequate.

WITHDRAWN MEMBER CLAIMS DEBTORS

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 79% (2018: 79%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

OTHER INSURANCE RECEIVABLES AND OTHER RECEIVABLES

These debtors mainly comprises 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 as at 31 December were as follows:

R'000	**2019**	2018
– Offshore bonds	**876 156**	847 314
– Yield-enhanced bonds	**6 620 669**	5 631 601
– Inflation-linked bonds	**1 125 768**	1 104 552
– Money market instruments	**9 799 918**	8 324 805
– Cash and cash equivalents	**1 991 282**	5 775 481
– Derivative financial instruments	**60 490**	142 856
	20 474 283	21 826 609

Exposure to credit risk

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 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 151.

Derivative counterparties are limited to high credit quality financial institutions.

The Scheme's credit risk policy guides the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure;
- Industry exposure; and
- Expected loss.

Compliance with the limits are regularly monitored with 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 value stated above.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Exposure to credit risk *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.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Exposure to credit risk *continued*

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 1% (2018: Less than 1%) 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+**	**B- to B+**	**CCC+ to CCC-**	**CC+**	**Not rated**
2019											
At fair value through profit or loss:	**18 422 511**	**310 316**	**3 561 834**	**10 798 617**	**665 504**	**603 053**	**22 322**	**628**	**–**	**–**	**2 460 237**
– Offshore bond portfolio	**876 156**	**–**	**181 161**	**5 670**	**83 284**	**586 568**	**22 322**	**–**	**–**	**–**	**(2 849)**
– Yield-enhanced bond portfolio	**6 620 669**	**–**	**1 744 709**	**3 409 178**	**323 308**	**5 189**	**–**	**628**	**–**	**–**	**1 137 657**
– Inflation-linked bond portfolio	**1 125 768**	**294 323**	**358 811**	**450 018**	**3 786**	**1 372**	**–**	**–**	**–**	**–**	**17 458**
– Money market portfolios	**9 799 918**	**15 993**	**1 277 153**	**6 933 751**	**255 126**	**9 924**	**–**	**–**	**–**	**–**	**1 307 971**
Cash and cash equivalents	**1 991 282**	**3 000**	**711 007**	**1 251 750**	**–**	**–**	**–**	**–**	**–**	**–**	**25 525**
Total*	**20 413 793**	**313 316**	**4 272 841**	**12 050 367**	**665 504**	**603 053**	**22 322**	**628**	**–**	**–**	**2 485 762**
% per rating band		**1.53%**	**20.93%**	**59.03%**	**3.26%**	**2.95%**	**0.11%**	**0.00%**	**0.00%**	**0.00%**	**12.18%**
2018											
At fair value through profit or loss:	15 908 272	848 086	2 513 284	10 122 846	843 034	128 160	59 490	38 135	–	–	1 355 237
– Offshore bond portfolio	847 314	–	106 662	33 387	120 238	43 064	59 490	37 186	–	–	447 287
– Yield-enhanced bond portfolio	5 631 601	–	1 510 232	3 048 027	118 253	57 460	–	949	–	–	896 680
– Inflation-linked bond portfolio	1 104 552	848 086	38 436	213 613	4 417	–	–	–	–	–	–
– Money market portfolios	8 324 805	–	857 954	6 827 819	600 126	27 636	–	–	–	–	11 270
Cash and cash equivalents	5 775 481	–	3 396 132	1 717 095	37 315	–	–	–	–	–	624 939
Total *	21 683 753	848 086	5 909 416	11 839 941	880 349	128 160	59 490	38 135	–	–	1 980 176
% per rating band		3.9%	27.3%	54.6%	4.1%	0.6%	0.3%	0.2%	0.0%	0.0%	9.1%

* *Excludes derivative financial instruments*

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Exposure to credit risk *continued*

The Scheme's investments in securitisations and collective investment schemes ("funds") are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers. The Scheme does not control these funds as it has no voting rights, is not able to call meetings and in addition, has no ability to direct the relevant activities of these funds. As the Scheme does not control these funds, its investments in these structured entities are not consolidated in the Scheme's financial statements.

All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the Statement of Financial Position and no other material risks relating to these investments have been identified other than those already disclosed in previous sections of this Report.

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and description	2019 R'000	Authorised programme size	% of Authorised programme size	Fair value hierarchy		Debt ranking		Credit rating		Underlying assets	
				Level	%	Ranking	%	Rating	%	Asset	%
Asset-backed commercial paper	**34 823**	R3.5 billion	0.99%	Level 2	100%	Senior Secured	100%	AA	100%	Diversified portfolio of money-market instruments	100%
Residential mortgage-backed securitisations	**793 513**	R3.0 billion	0.30%	Level 1 Level 2	89% 11%	Senior secured Secured	73% 27%	AAA AA- to AA+ A+ NR	74% 16% 0% 10%	Residential mortgages	100%
Asset-backed securitisations	**470 076**	R18.5 billion	2.54%	Level 1 Level 2	83% 17%	Senior secured Secured Senior Unsecured	73% 26% 0%	AAA AA- to AA+ NR	75% 11% 11%	Equipment leases Unsecured loans Vehicle loans	21% 16% 63%
Commercial mortgage-backed securitisations	**83 742**	R10 billion	0.84%	Level 1	100%	Secured	100%	AAA	100%	Commercial mortgage loans	100%

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Exposure to credit risk *continued*

Name and description	2019 R'000	Portfolio size	% of portfolio size	Fair value hierarchy	Credit rating	Fund
Collective investment schemes	**846 472**	13 510 113	6.27%	Level 2	AA+	Nedgroup Investments Money Market Fund Class C2
	312 809	29 725 582	1.05%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C2
	581 094	43 756 848	1.33%	Level 2	AA	Nedgroup Investments Core Income Fund Class C2
	33 330	14 073 000	0.24%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C20
	864	30 077 964	0.00%	Level 2	AA+	Investec Money Market Fund
	1 208	37 720 000	0.00%	Level 2	AA+	Stanlib Corporate Money Market Fund
	1 277	20 814 258	0.01%	Level 2	AA+	Investec Corporate Money Market Fund
	1 279	71 461 683	0.00%	Level 2	NR	ABSA Money Market Fund
	536 884	2 528 982	21.23%	Level 2	BBB	Investec Target Return Bond Fund

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Name and description	2018 R'000	Authorised programme size	% of authorised programme size	Fair value hierarchy		Debt ranking		Credit rating		Underlying assets	
				Level	%	Ranking	%	Rating	%	Asset	%
Asset-backed commercial paper	46 272	R3.5 billion	1.32%	Level 2	100%	Senior secured	100%	AA	100%	Diversified portfolio of money-market instruments	100%
Residential mortgage-backed securitisations	594 085	R172.9 billion	0.34%	Level 1	85%	Senior secured	92%	AAA	68%	Residential mortgages	100%
				Level 2	15%	Secured	8%	AA+	13%		
								A+	3%		
								NR	15%		
Asset-backed securitisations	367 901	R31.2 billion	1.18%	Level 1	82%	Senior secured	92%	AAA	68%	Equipment leases	21%
				Level 2	18%	Secured	8%	AA- to AA+	12%	Unsecured loans	17%
								A to A+	7%	Vehicle loans	61%
								NR	12%		
Commercial mortgage-backed securitisations	9 091	R3.0 billion	0.30%	Level 1	100%	Secured	100%	AA	100%	Commercial mortgage loans	100%
Collateralised loan obligations	19 741	R3.4 billion	0.58%	Level 1	100%	Senior secured	33%	AAA	67%	Vehicle loans	100%
						Senior unsecured	67%	AA-	33%		

Name and Description	2018 R'000	Portfolio size	% of portfolio size	Fair value hierarchy	Credit rating	Fund
Collective investment schemes	837 293	R14.2 billion	5.90%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	584 087	R22.0 billion	2.65%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C2
	1 291 547	R40.7 billion	3.17%	Level 2	AA	Nedgroup Investments Core Income Fund Class C2
	1 111	R28.8 billion	0.00%	Level 2	AA+	Investec Money Market Fund
	700	R39.1 billion	0.00%	Level 2	AA+	Stanlib Corporate Money Market Fund
	649	R20.4 billion	0.00%	Level 2	AA+	Investec Corporate Money Market Fund
	3 366	R114.9 million	2.93%	Level 2	NR	Nedgroup Investments Core Income ABIL Retention Fund Class A
	526 404	R3.1 billion	17.07%	Level 2	A	Investec Target Return Bond Fund

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 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.

Approximately 98% (R2.1 billion) (2018: 98% – R2.1 billion) of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

A maturity analysis for financial liabilities carried at amortised cost, excluding liabilities arising from insurance contracts is provided below:

R'000	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
As at 31 December 2019			
Personal Medical Savings Accounts (Note 8)	**5 522 613**	**–**	**–**
Trade and other payables (Note 9)	**659 297**	**–**	**–**
Derivative financial liabilities (Note 7)	**14 689**		
	6 196 599	**–**	**–**
As at 31 December 2018			
Personal Medical Savings Accounts (Note 8)	5 040 832	–	–
Trade and other payables (Note 9)	3 748 327	–	–
	8 789 159	–	–

Fair value estimation

FINANCIAL INSTRUMENTS

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short-term nature.

PERSONAL MEDICAL SAVINGS ACCOUNTS

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

Statement of responsibility by the Board of Trustees | Report of the Audit Committee | Statement of Financial Position | Statement of Comprehensive Income
Statement of Changes in Funds and Reserves | Statement of Cash Flows | Accounting Policies | Notes to the Financial Statements

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 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**
2019				
Current assets				
– Offshore bonds	**876 156**	**–**	**876 156**	**–**
– Equities	**4 182 545**	**4 172 291**	**10 254**	**–**
– Yield-enhanced bonds	**6 620 669**	**4 055 864**	**2 564 805**	**–**
– Inflation-linked bonds	**1 125 768**	**1 098 520**	**27 248**	**–**
– Listed property	**586 400**	**585 580**	**820**	**–**
– Money market instruments	**9 799 918**	**4 411 112**	**5 388 806**	**–**
– Derivative financial instruments	**75 179**	**–**	**75 179**	**–**
	23 266 634	**14 323 367**	**8 943 267**	**–**
2018				
Current assets				
– Offshore bonds	847 314	–	847 314	–
– Equities	4 038 399	3 846 675	191 724	–
– Yield-enhanced bonds	5 631 601	2 860 079	2 771 522	–
– Inflation-linked bonds	1 104 551	1 093 806	10 745	–
– Listed property	573 095	573 095	–	–
– Money market instruments	8 324 805	2 167 161	6 157 644	–
– Derivative financial instruments	142 856	–	142 856	–
	20 662 621	10 540 816	10 121 805	–

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.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

31 Financial risk management report *continued*

Fair value hierarchy for financial assets measured at fair value *continued*

The table below details the valuation techniques and observable inputs for assets falling under Level 2:

Description R'000	**Fair value as at 31 December 2019**	Fair value as at 31 December 2018	Valuation techniques	Observable input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**3 468 209**	3 629 582	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**5 389 626**	6 157 644	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	**10 254**	191 724	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
Derivative financial instruments	**75 179**	142 856	Discounted cash flow valuation, Black-Scholes model	Published index levels, published exchange swap curve, published interest rate curve, published credit spread curve, implied volatilities
	8 943 267	10 121 805		

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	**2019**	2018
Total members' funds per Statement of Financial Position	**19 209 355**	17 646 355
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**–**	–
Accumulated funds per Regulation 29	**19 209 355**	17 646 355
Gross annual contribution income	**69 855 135**	64 649 012
Solvency margin = Accumulated funds/gross annual contribution income x 100	**27.50%**	27.30%

At 31 December 2019, the Scheme's regulatory capital level of 27.5% (2018: 27.3%) was R1,75 billion (2018: R1,48 billion) more than the statutory capital requirement of 25%.

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

32 Critical accounting estimates and judgements

Critical accounting estimates and assumptions

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Outstanding claims provision

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 30.

Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 11.

Impairment of assets

The critical estimates made by the Scheme are set out under Note 31 and judgements relating to the impairment of assets are set out under Note 4.

33 Non-compliance matters

Circular 11 of 2006 (the Circular) 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 2019, the Scheme did not comply with the following Sections and Regulations of the Act.

- **Sustainability of benefit plans**

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

  For the year ended 31 December 2019 the following plans did not comply with Section 33 (2):

R'000	Net healthcare result	Net (deficit)/ surplus
Benefit plan		
Executive	**(318 405)**	**(309 257)**
Classic Comprehensive	**(1 178 521)**	**(1 055 160)**
Classic Comprehensive Zero MSA	**(8 304)**	**(7 091)**
Coastal Saver	**(136 331)**	**38 527**
Coastal Core	**(43 061)**	**55 421**
KeyCare Plus	**(668 465)**	**(396 536)**

  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 Regulator are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy on the sustainability of plans has to 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 the 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.

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

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

33 Non-compliance matters *continued*

- **Investments in employer groups and medical scheme administrators**

  Section 35(8) (a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide. CMS has granted DHMS exemption for a period of three years effective from 1 December 2019.

- **Suspension of member's membership**

  Section 29(2)(a) of the Act provides that a medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependents except on the grounds of failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules.

  During the year under review, there was an instance where a debit order collection file was not sent to the Scheme's bank to enable the Scheme to receive member contributions. Contributions were not received via debit order for 1,865 members, resulting in 252 members being suspended, in terms of the Scheme's credit control processes. The debit order file was submitted within one day and the suspension of the respective members lifted with no further impact on these memberships.

- **Disclosure of personal information**

  Regulation 15D(a)(vi) and 15J(2)(b) requires the Scheme to ensure that there are provisions for ensuring confidentiality of clinical and proprietary information, including the diagnosis and treatment pertaining to any beneficiary.

  During the year under review there were instances where confidential member information was distributed to unauthorised third parties. The respective members were notified of the distribution and additional procedures implemented to reduce the risk of unauthorised distribution.

- **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 Medical Schemes Act 131 of 1998. CMS has granted DHMS exemption for a period of three years effective from 1 December 2019.

- **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 the suspension of membership for non-payment.

- **Broker fees paid**

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

  In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.01% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the Administrator has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

- **Direct or indirect borrowing of money**

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

Notes to the Financial Statements *continued*
for the year ended 31 December 2019

33 Non-compliance matters *continued*

- **Amounts debited to scheme bank account**

  Section 26(4) provides that no amount may be debited to a scheme bank account other than
  - payments by a medical scheme of any benefit, payable under the rules of a medical scheme;
  - costs incurred by the medical scheme in the carrying on of the business as a medical scheme; or
  - amounts invested by the Board of Trustees.

  During the year under review a total of R1.4 million was debited to the Scheme's bank account that was not related to the Scheme. This debit arose from the incorrect allocation of bank accounts for certain payments. The amount has subsequently been refunded to the Scheme and additional controls implemented to mitigate this occurring again.

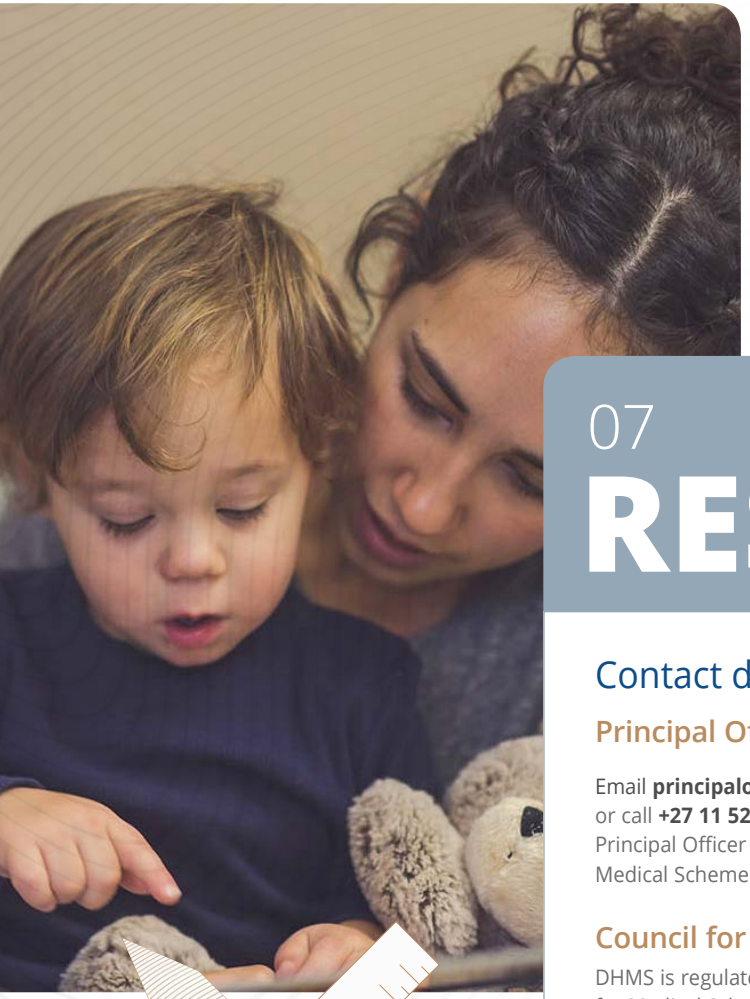
- **Prescribed Minimum Benefits**

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

- **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 were claims were not paid within 30 days. These instance represent less than 1% 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 the claims are paid accordingly.



07

RESOURCES

Contact details

Principal Officer

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

Council for Medical Schemes

DHMS is regulated by the Council for Medical Schemes (CMS). The CMS can be contacted by telephone on 0861 123 267 or via email on information@medicalschemes.com.

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 lodge a complaint, compliment or dispute, we encourage you to follow the process on the website.

Complaints, compliments or disputes.

Important sources of information

- **Who to contact and how,** when you need something as a member
- **How to choose the best plan** for you and your family
- **Information about the various health plans** offered by the Scheme
- **More information about DHMS,** and the **Scheme Rules**
- **Terms useful for medical scheme members to know**
- **The Medical Schemes Act 131 of 1998,** as amended
- **The CMS website**
- **The International Integrated Reporting Framework** and related resources
- **The King IV Report on Corporate Governance for South Africa 2016 (King IV)**

Feedback on our Integrated Report

We welcome any comments or 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?
- Was this Report presented in a format that worked for you, and if not, what you would prefer?

Email your feedback to **dhms_stakeholders@discovery.co.za.**

Reporting fraud or unethical behaviour

As the Scheme's Administrator and Managed Care Provider, Discovery Health (Pty) Ltd provides a fraud hotline and investigates 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. You can also email our fraud department at forensics@discovery.co.za to investigate the matter. You may remain anonymous if you prefer.

Toll-free call: **0800 0045 00**

Toll-free fax: **0800 00 77 88**

Email: **discovery@tip-offs.com**

Post: **Freepost DN298, Umhlanga Rocks, 4320**

REGISTERED ADDRESSES

ACTING PRINCIPAL OFFICER

Charlotte Mbewu-Sanqela
Discovery Health Medical Scheme, 1 Discovery Place, Sandton, 2146

REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS

Discovery Health Medical Scheme, Ground Floor, The Ridge, Corner of Rivonia Road and Katherine Street, Sandton, 2146
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, Cnr Fredman Drive and Rivonia Road, Sandton, 2196

INVESTMENT MANAGERS

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

ALUWANI CAPITAL PARTNERS (PTY) LTD

EPPF Office Park, 24 Georgian Crescent East, Bryanston East, 2152

FAIRTREE CAPITAL (PTY) LTD

Willowbridge Place, Cnr Carl Cronje Drive & Old Oak Road, Bellville, 7530

FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD

3rd Floor, Great Westerford Building, 240 Main Road, Rondebosch, 7700

INVESTEC ASSET MANAGEMENT (PTY) LTD

36 Hans Strijdom Avenue, Foreshore, Cape Town, 8001
100 Grayston Drive, Sandown, Sandton, 2196

LIBERTY GROUP LIMITED

1 Ameshoff Street, Braamfontein, 2001

MAZI ASSET MANAGEMENT (PTY) LTD

4th Floor North Wing, 90 Rivonia Road, Sandton, 2196

SESFIKILE CAPITAL (PTY) LTD

2nd Floor, 18 The High Street, Melrose Arch, Johannesburg, 2076

STANLIB ASSET MANAGEMENT (PTY) LTD

17 Melrose Blvd, Melrose Arch, Johannesburg, 2076

TAQUANTA ASSET MANAGERS (PTY) LTD

7th Floor, Newlands Terraces, Boundary Road, Newlands, 7700

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