Discovery
Health Medical Scheme

INTEGRATED
REPORT 2017

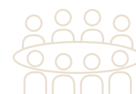
# INTEGRATED REPORT 2017

Discovery Health Medical Scheme's Integrated Report is designed to cater for various readers by grouping information in a logical way according to different levels and areas of interest. The chapters in the Report can be read as standalone pieces for this purpose.


## OUR STAKEHOLDERS AND GOOD CORPORATE CITIZENSHIP 28

This section discusses the Scheme's approach to responsible corporate citizenship and its ethics and values. It also discusses how each of the Scheme's key stakeholders obtain value from the Scheme, within the context of the Scheme's primary responsibility to create value for its members, who are its primary stakeholders.

## GOVERNANCE 44



For readers who are interested in the details of the Scheme's governance, this chapter provides an overview from the Chairperson and a description of the legislation governing the Scheme and its governance structures and framework, including the Board of Trustees and Board Committees. It also reviews notable regulatory and industry matters dealt with during 2017.

## PERFORMANCE 72

For readers who are interested in more about the performance of the Scheme during 2017, this chapter provides management commentary on the Scheme's strategic, operating and financial performance during 2017. It also includes a review of initiatives undertaken by Discovery Health on behalf of the Scheme and its members.

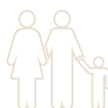
## ABOUT OUR REPORT inside flap

Sets out the assurances provided for this Report and its purpose, scope and boundary, and the Board's statement of responsibilities.

## FINANCIALS 94

Full Annual Financial Statements and notes to the Financial Statements.

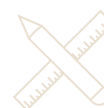
## ABOUT DHMS 02



For current and potential members, this chapter provides an overview of the Scheme and its material matters, key risks and objectives.

It also indicates who leads and governs the Scheme, and provides a snapshot of key performance information.

## RESOURCES AND GLOSSARY 170



A quick reference guide for contact information, feedback, compliments and complaints processes, and guidance on where to find additional information.

Unfamiliar terms in the Report? Find definitions in our Glossary.

# 05 PERFORMANCE

## OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR 74

## DISCOVERY HEALTH MEDICAL SCHEME PERFORMANCE 76

Overview 76

Gross contribution income 77

DHMS average contributions are lower 77

Net claims incurred 78

Gross administration expenditure 78

Accredited managed care services costs 79

Investment results 79

Member disputes and CMS complaints 79

Solvency 80

Prudent financial management 80

Due application of the Scheme Rules 80

Ensuring statutory and regulatory compliance 80

Matters of non-compliance for the year ended 31 December 2017 81

Reserve accounts 83

Outstanding claims 83

Personal Medical Savings Accounts 83

Going concern 83

Auditor independence 83

Operational statistics 84

## DISCOVERY HEALTH'S INITIATIVES FOR THE SCHEME 86

Discovery Health's business model 86

Discovery Health's operations in action 88

Ensuring higher quality healthcare 89

Improving wellness 91

Lowering the cost of healthcare 91

Enabling personalised healthcare and service benefits through technology 92

Maintaining world-class service levels 93

Future focus areas 93

# OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR

**Discovery Health Medical Scheme continues to grow despite challenging economic conditions, and I am proud to report that the Scheme is financially stronger than it has ever been, with a record level of reserves.**

**We have been able to share that strength with our members through benefit amendments for 2018, in particular our increased maternity benefits, and through the lowest contribution increases in several years.**

The Scheme (or DHMS) only has two sources of income: member contributions and the return on members' funds invested. With a limited source of funds, we are constantly focused on ensuring the sustainability of DHMS. This requires that members receive value from our benefit offering, and that we mitigate any adverse impact that the prevailing economic and other macroeconomic factors may have on members in terms of private healthcare funding.

The Board of Trustees (the Board or the Trustees) and the Scheme Office closely monitor metrics and other information to assess the financial wellbeing of our members. We continue to note with concern the rising cost of private healthcare, which continues to be above inflation and has been extensively discussed in interactions with the Competition Commission's Healthcare Market Inquiry (HMI). Also, with South Africa's low economic growth, stagnant employment growth and high household debt, and, as shown in DHMS's own data, increasing retrenchments at large corporates, it is evident that more members are finding private healthcare difficult to afford.

Also impacting financial wellbeing and the affordability of private healthcare is the low increase in rebates for medical aid tax credits, as detailed by the Minister of Finance in the Medium-term Budget Policy Statement 2017 and subsequent announcements in February 2018. Furthermore, the value-added tax (VAT) increase by 1 percentage point to 15%, effective 1 April 2018, further adds pressure on consumers.

In leveraging the Scheme's unmatched ability in the industry to absorb environmental shocks, DHMS will not be passing the VAT increase onto members during the remainder of 2018 and will absorb the increase from our operating surplus. As noted above, the Scheme's reserves are at record levels, and shielding members from unexpected additional contribution increases was deemed appropriate by the Trustees.

The Scheme supports the objectives of universal health coverage and participates in all forums regarding the National Health Insurance (NHI). As the private healthcare sector is undoubtedly a national asset, these discussions are an opportunity for the Scheme to collaborate with the Department of Health and all other stakeholders in determining how best the sector can achieve the objectives of quality and equitable healthcare.

The Scheme works hard with its Administrator and Managed Care Provider, Discovery Health (Pty) Ltd (Discovery Health), to contain the impact of healthcare inflation on our members. This is achieved through a number of initiatives that prioritise quality and cost efficiency measures. For instance, when contracting with service providers, we strive to shift reimbursement agreements towards value-based contracting, thus moving away from the traditional fee-for-service model. This clinical integration improves outcomes and fosters collaboration and innovation in multidisciplinary teams by ensuring the entire cycle of care is contracted for and monitored. We initiated some exciting pilots in this regard in 2017.

PAGE REFERENCE

Read more on **pages 37 – 39**.

Also, to support the ongoing success of the Vested® outsourcing model (Vested model) that emphasises the role of innovation in providing value to our members, the Trustees have established two new operational committees in 2017: an Innovation Committee and a Relationship Management Committee. Respectively, these committees will monitor the work on innovation that Discovery Health engages in on behalf of the Scheme and work to optimise the relationship between the Scheme and Discovery Health.

On the Scheme's second source of income, the return on members' funds invested, we achieved excellent results for 2017, with investment income of R1 433 million (2016: R1 257 million). This contributed to the net surplus for the year of R2 450 million (2016: R1 305 million), thereby safeguarding member funds and Scheme sustainability. Investment income was supported by, among other strategies, the Scheme's offshore hedging strategy that provided effective protection from the strong appreciation of the Rand over the year.

During 2017, the Scheme introduced the Essential Smart plan. With this addition, DHMS has created the Smart Plan Series and changed the name of the Smart Plan, which has been available from the start of 2016, to Classic Smart. The Smart Plan Series shows ongoing excellent performance and growth, with both plans attracting young and healthy members to the Scheme.

The healthcare sector in South Africa continues to be a dynamic environment. DHMS is an active member of the Health Funders Association (HFA), an industry body that represents stakeholders in the private healthcare funding environment. The HFA represents 20 medical schemes, which combined, account for 76% of the open medical scheme environment and 53% of the total market[1]. It considers issues affecting all members and engages with various bodies, institutions and structures to ensure a robust and viable private healthcare industry.

As of 1 January 2018, DHMS amalgamated with the University of the Witwatersrand, Johannesburg Staff Medical Aid Fund (Witsmed). Initiated in August 2017, the amalgamation process was conducted in accordance with the requirements of the Medical Schemes Act 131 of 1998, as amended (the Act), its Regulations and the Scheme Rules. The Council for Medical Schemes (CMS) approved the amalgamation after receiving confirmation that the majority of voting members from both schemes were in favour of the amalgamation and any objection received was considered and addressed. The Competition Commission considered and approved the amalgamation as required by the Competition Act 89 of 1998.

All amalgamation proposals are carefully and thoroughly assessed by the Scheme to ensure that the amalgamation would not result in an adverse impact on the member profile, the claims experience and reserves.

As reflected in our material matters detailed in this Integrated Report on **page 11**, the Scheme Office and Trustees are troubled by the recent governance and ethics failures in organisations across the public and private sectors. While the Scheme's financial exposure to Steinhoff was limited, as part of ongoing adherence to governance and ethical codes, in particular the King IV Report on Corporate Governance for South Africa 2016 (King IV), the Scheme is conducting an extensive review of its internal and external stakeholder environment and is optimising the structure that continually monitors and evaluates related risks.

The governance of the CMS vests in a board appointed by the Minister of Health, referred to as the Council. Dr Clarence Mini has been appointed as the new Chairperson of the Council and we congratulate him and wish him well in this position. The Scheme continues to interact constructively with the CMS and will continue to contribute through the various forums and structures where sector participation is required.

During 2017, the Scheme Office welcomed a new Chief Medical Officer, Dr Unati Mahlati, and bade farewell to its Chief Financial Officer (CFO), Jan van Staden. Mr van Staden departed to pursue his own interests and we wish him well in this. In the interim, the CFO portfolio is managed by our Chief Risk and Operations Officer, Mr Selwyn Kahlberg, who has previously managed the portfolio.

At the end of my first year as the Principal Officer of the Scheme, I extend my thanks to the Trustees, independent Committee members and to the Scheme Office team for their unwavering support during this time, which has been a period of great learning and personal development for me. I also welcome the Trustees appointed and elected to the Board during the course of 2017, and express my appreciation for the way in which they have integrated into the Scheme's governing bodies with great concern for their fiduciary duties and the wellbeing of the Scheme and its members.

Nozipho Sangweni

**DR NOZIPHO SANGWENI**

PRINCIPAL OFFICER

1 *Based on principal members of member schemes.*

# DISCOVERY HEALTH MEDICAL SCHEME PERFORMANCE

## Overview

Discovery Health Medical Scheme delivered a positive net healthcare result of R968 million for the year ended 31 December 2017 (2016: R102 million). The year-on-year increase in the operating result (contribution income less claims and all other Scheme expenses) was mainly attributable to the impact of in-hospital and out-of-hospital risk management initiatives implemented from the end of 2016 in response to a trend of increased utilisation of healthcare services in the 2015 and 2016 periods. Despite volatile investment markets, the Scheme generated healthy investment income of R1 433 million (2016: R1 257 million) contributing to the net surplus for the year of R2 450 million (2016: R1 305 million).

This strong financial performance increased members' funds to R16.7 billion (2016: R14.2 billion) with a solvency level of 27.44% (2016: 26.33%), versus the regulatory requirement of at least 25%. The Scheme's financial strength and ability to pay claims was once again confirmed with a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co (GCR). This is the 17th consecutive year the Scheme has achieved the highest possible rating a medical scheme can attain in the industry in South Africa. In the Trustees' view, DHMS ended 2017 in its strongest financial position in its history, and is very well positioned to continue to meet its members' needs going forward.

**17** Benefit options (2016: 16)

**6** Network efficiency discount options* (2016: 6)

**EXECUTIVE SERIES**
- Executive

**COMPREHENSIVE SERIES**
- Classic Comprehensive
- Classic Comprehensive Zero MSA
- Essential Comprehensive
- Classic Delta* Comprehensive
- Essential Delta* Comprehensive

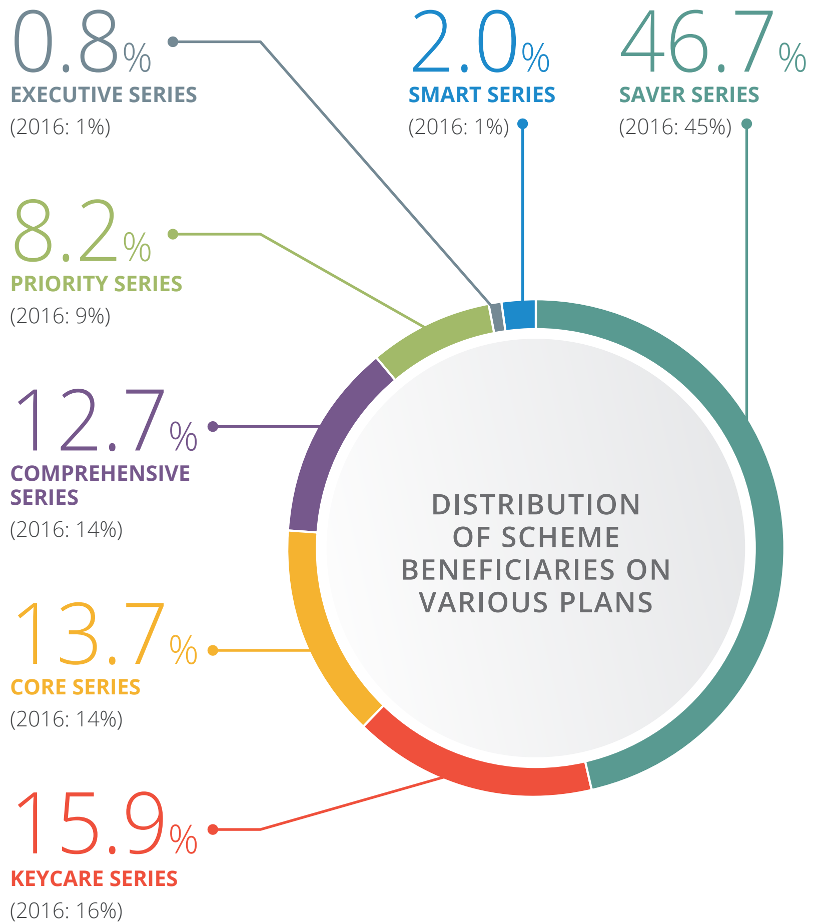
**CORE SERIES**
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

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

**PRIORITY SERIES**
- Classic Priority
- Essential Priority

**KEYCARE SERIES**
- KeyCare Plus
- KeyCare Core
- KeyCare Access

**SMART SERIES**
- Classic Smart
- Essential Smart



## GROSS CONTRIBUTION INCOME

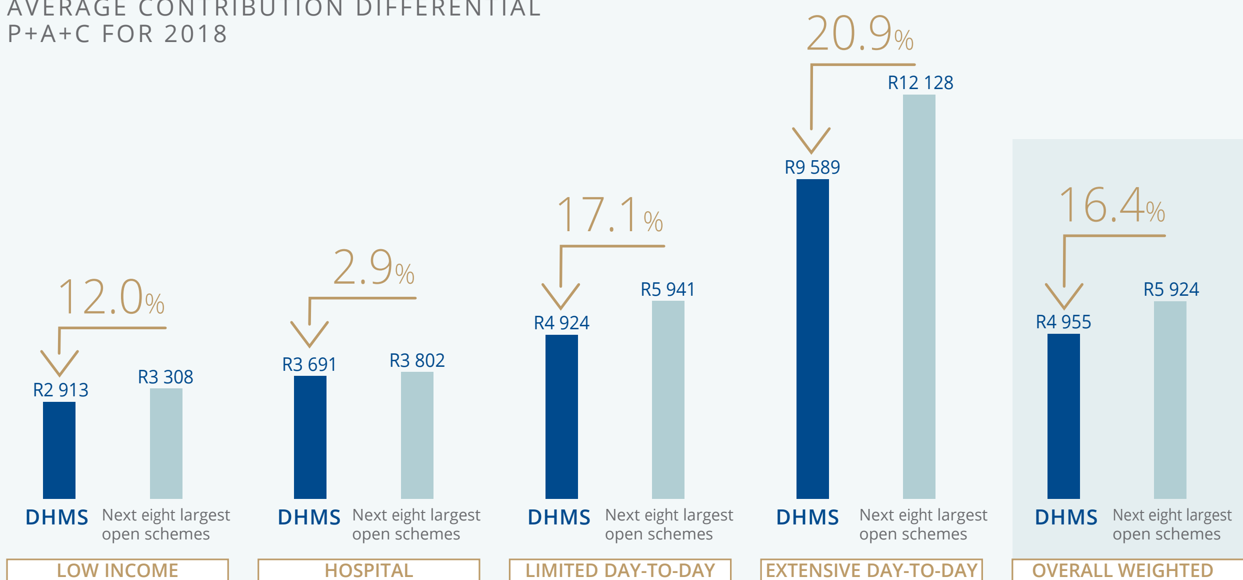
Maintaining the balance between competitive contributions, providing affordable quality healthcare to our members and meeting regulatory reserve requirements remains a challenge.

The Scheme remained highly competitive with average contributions for 2018 being 16.4% lower on a plan for plan basis (for 2017: 14.6%[1]) (based on the rate for a principal member plus one adult beneficiary and one child beneficiary) than the next eight open schemes by size, largely due to our ability to contain the impact of medical inflation. The Scheme's competitiveness was reflected in the lowest contribution increases in several years for 2018, which were the lowest of all but one open scheme competitor and well below the average for open schemes. Net membership and beneficiary growth of 2.08% and 1.59% respectively further demonstrates the Scheme's attractiveness and competitiveness.

The Scheme's commitment to its members and its high levels of efficiency is demonstrated by 86% of contributions received being used for members' direct benefit by funding claims and reserves (to meet regulatory solvency requirements). The remainder is utilised to fund activities to support and benefit members in areas such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

Gross contribution income rose 10.46% to R59.7 billion (2016: R54.1 billion), driven by contribution increases and net membership growth of 2.08%. The most significant net membership growth was recorded in the mid to low tier options, where the Saver series and Smart series recorded net membership growth of 26 034 and 21 726 respectively. The Comprehensive series experienced the largest decline in principal membership of 12 905.

## DHMS AVERAGE CONTRIBUTIONS ARE LOWER[2]




1 *The 2017 comparison is against all nine largest open schemes.*

2 *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a family unit comprising one principal member, one adult and one child dependant (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 discount that a typical member of another scheme would earn by moving to DHMS.*

*DHMS typically compares itself against our next nine largest competitors, but Sizwe's final contribution increases for 2018 were unconfirmed at the time of publishing and so the 2018 comparison excludes Sizwe.*

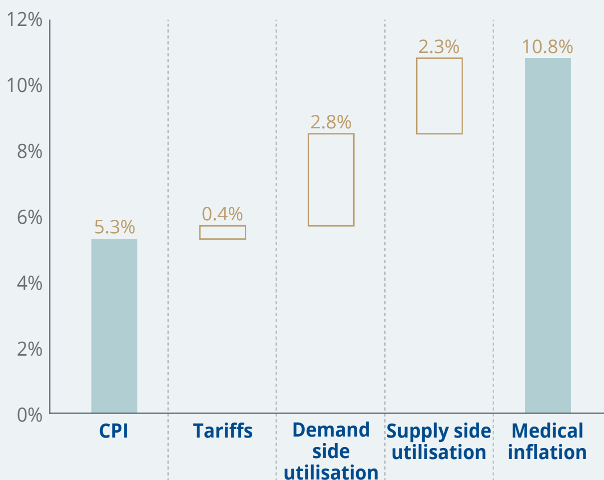
## NET CLAIMS INCURRED

Net claims incurred increased by 9.9% to R40.2 billion (2016: R36.6 billion), which is a lower rate of increase than observed in the prior year.

Escalating healthcare costs remain a concern to medical schemes, with healthcare inflation consistently above the consumer price index (CPI). The main driver of healthcare inflation is higher utilisation of healthcare services due to demand side and supply side effects, with a limited contribution from tariff increases. Supply side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare; demand side utilisation pertains to the deterioration in the demographic profile of beneficiaries, specifically a higher ratio of older and ailing members who need more, higher priced healthcare services. A summary of the composition of medical inflation (annualised over the period 2010 to 2017) is illustrated in the diagram below.

Despite these cost pressures, the Scheme was able to contain the gross claims ratio[1] to 86% (2016: 87%) due to robust risk management interventions implemented by the Scheme's Administrator and Managed Care Provider, Discovery Health.

### AVERAGE ANNUALISED INFLATION RATE (2008 – 2016)



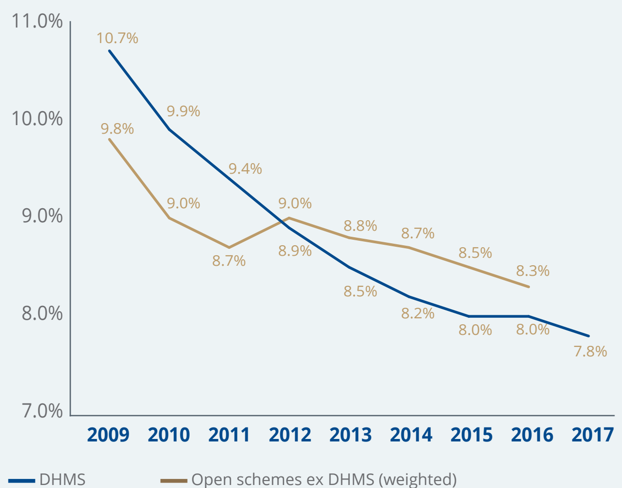

## GROSS ADMINISTRATION EXPENDITURE

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 and Managed Care Provider, Discovery Health. The gross increase in administration fees of 8.7% to R4.5 billion (2016: R4.2 billion) was attributable to the administration fee per member rate increase and growth in average Scheme membership of 2.08%. The administration fee per average member per month increased by 6.5% from R270.49 to R288.05, as significant scale-related administration fee discounts continued to contain administration fee increases to below CPI.

The graph below 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 2016–2017 shows that at 8.0% for 2016, 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 8.3% excluding the Scheme. This ranks the Scheme 17th out of 22 open medical schemes, meaning that DHMS fees are the sixth lowest in the open medical schemes market.

### GROSS ADMINISTRATION EXPENDITURE AS % OF GROSS CONTRIBUTION INCOME




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).*

## ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 9.0% to R1.5 billion (2016: R1.4 billion) was attributable to both the accredited managed care costs per member per month rate increase, and growth in average Scheme membership of 2.08%.

Managed care costs per average member per month increased by 6.8%, from R91.72 to R97.96. Managed care costs as a percentage of gross contribution income continued to decline with the 2017 ratio at 2.57% (2016: 2.60%).

An analysis of the CMS Annual Report 2016–2017 shows that the Scheme's managed care cost as a proportion of gross contribution income was 2.60%, compared to the weighted average of 2.23% excluding the Scheme. Although the managed care costs may appear more expensive relative to other open schemes, it does not consider the complexity of the Scheme's benefits, the breadth of managed care services offered, or the claims cost savings generated by the managed care services. In 2016[1], claims cost savings of R153.29 (2015: R136.29) per average beneficiary per month were realised through claims review processes, implemented protocols, price negotiations and drug utilisation reviews. This equates to a saving of R2.53 (2015: R2.33) for every Rand paid in managed care costs – an exceptional return on investment of 253%.

## INVESTMENT RESULTS

The Scheme's investment portfolio is suitably diversified and managed to optimise returns within its approved risk appetite. Asset allocation is managed and monitored from an asset and liability perspective, while ensuring sufficient liquid funds are available to meet claims and other liabilities as they fall due. Given the short-term nature of Scheme liabilities, a significant portion of its assets are invested in money market and cash investments, with smaller allocations to bonds (local and foreign) and equities. During 2017, the Scheme added two additional equity managers and a listed property asset manager.

The Scheme earned an overall investment return of 10% for 2017 (2016: 8.8%). The Scheme's diversified investment strategy resulted in outperformance of its strategic benchmark.

## MEMBER DISPUTES AND CMS COMPLAINTS

DHMS undertakes a thorough investigation and review of formal disputes lodged by members with the Scheme to resolve as many as possible internally, prior to a member needing to resort to laying a complaint with the CMS. As the Scheme is able to readily access all the relevant information to assist members and work together to assess the merits of a dispute, the internal disputes mechanism is succeeding in reaching an amicable solution in the majority of cases, with a high rate of withdrawals and settlements being achieved.

In 2017, 740 disputes were lodged in terms of Rule 27[2], with 688 or 93% of disputes being settled or withdrawn prior to a hearing. Only 52 cases (7%) proceeded to a hearing before the Disputes Committee.

The number of CMS complaints dropped marginally to 763 in 2017 (2016: 773). This means that only 0.001% of 53 621 046 claims made in 2017 (2016: 52 439 955) resulted in a complaint to the CMS. The ratio of internal disputes to CMS complaints has risen from 39% in 2015 to 51.7% in 2016, and ultimately to 97% in 2017.

*1 Source: The Value Added Assessment report; figures are only available for the preceding year.*

*2 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 2017, the Scheme's solvency level of 27.44% (2016: 26.33%) of gross annual contributions was R1.5 billion (2016: R719 million) more than the statutory solvency requirement.

| R'000 | 2017 | 2016 |
|---|---|---|
| Total members' funds per Statement of Financial Position | **16 684 435** | 14 234 461 |
| Less: cumulative unrealised net gain on remeasurement of investments to fair value | **(298 722)** | – |
| Accumulated funds per Regulation 29 | **16 385 712** | 14 234 461 |
| Gross annual contribution income | **59 710 735** | 54 056 212 |
| Solvency margin<br>= Accumulated funds/gross annual contribution income x 100 | **27.44%** | **26.33%** |

## PRUDENT FINANCIAL MANAGEMENT

The table below shows the high level of contribution management achieved during the year.

| R'000 | Dec 2017 | Dec 2016 |
|---|---|---|
| Gross annual contributions | **59 710 735** | 54 056 212 |
| Total outstanding contributions, excluding December[1] | **23 120** | 24 258 |
| % outstanding | **0.04%** | 0.04% |

## DUE APPLICATION OF THE SCHEME RULES

The Trustees constantly check that the Scheme Rules are appropriately and consistently applied in relation to beneficiary entitlement and healthcare provider reimbursements. This is an integral component of the Board's fiduciary responsibility.

## ENSURING STATUTORY AND REGULATORY COMPLIANCE

The Trustees are committed to ensuring statutory and regulatory compliance, viewing this as one of their most important responsibilities. The Scheme's external auditors and Audit and Risk Committees, as well as the internal auditors and Compliance function, have an ongoing role in monitoring compliance to ensure the Scheme meets all applicable regulatory requirements.

1 *Outstanding contributions for December are excluded as the majority of outstanding contributions are collected within one month. The purpose of this table is to provide a view on the efficient collection of contributions older than 30 days.*

# MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2017

The CMS issued Circular 11 of 2006 (the Circular) that deals with issues to be addressed in the audited financial statements of medical schemes. The Circular requires 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 the year, the Scheme did not comply with the following Sections and Regulations of the Act.

## STATUTORY SCHEME SOLVENCY

Under the Act, medical schemes are required to hold a minimum of 25% of gross annual contribution income as a reserve or accumulated funds (also known as the solvency ratio). The solvency ratio is a measure of a scheme's ability to absorb unexpected changes in claims experience, demographics (e.g. average age, chronic profile, etc.) and legislative environments, and therefore reflects a scheme's financial strength.

During 2017, the Scheme's solvency level dropped below 25% during January. In January, the drop was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year).

At 31 December 2017, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 27.44% (2016: 26.33%), exceeding the statutory solvency requirement of 25%.

## 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 2017 the following plans did not comply with Section 33 (2):

| Benefit plan (R'000) | Net healthcare result | Net deficit |
|---|---|---|
| Executive | (334 418) | (324 005) |
| Classic Comprehensive | (963 232) | (819 810) |
| Classic Comprehensive Zero MSA | (2 763) | (1 514) |
| KeyCare Plus | (535 785) | (212 254) |

The performance of all benefit options is monitored on an ongoing basis with a view to improving financial outcomes, and different strategies to address the deficit in these plans are continually evaluated.

When structuring benefit options, the financial sustainability of all the options is 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 balances 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 on 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.

## INVESTMENT IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a) and (c) 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. DHMS has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs across the industry. The CMS granted DHMS an exemption from these sections of the Act up to 21 April 2018 and the Scheme will be applying for a further extension to this exemption.

The Scheme has no investments in Discovery Limited, the holding company of Discovery Health (Pty) Ltd.

## INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE SOUTH AFRICA

The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by International Swaps and Derivatives Association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied. Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Act.

The Scheme was granted an exemption to invest in offshore derivatives, subject to certain conditions, up to 31 December 2018.

## MINIMUM AMOUNT INVESTED IN CASH [CATEGORY 1 (A) (I) AND 1 (A) (II)]

Explanatory note 2 to Annexure B to the Regulations of the Act requires a medical scheme to have a minimum of 20% of its Regulation 30 assets invested in cash [Category 1 (a) (i) and 1 (a) (ii)]. As at 31 March 2017, the Scheme did not meet this requirement as it held 19.79% in cash [Category 1 (a) (i) and 1 (a) (ii)]. The non-compliance was due to a difference in interpretation between the CMS and DHMS of the relevant clauses of Regulation 30 of the Act. The Scheme has amended its calculation methodology to be aligned with the CMS interpretation.

Prior to Circular 2 of 2018: Personal Medical Savings Accounts and scheme rules, Personal Medical Savings Account (PMSA) assets were included as part of the Scheme's assets during the period July to December 2017. The PMSA assets were included in assessing compliance with the requirement for a minimum of 20% of Regulation 30 assets being invested in cash [Category 1 (a) (i) and 1 (a) (ii)]. After excluding PMSA assets from Scheme assets, there were certain months where this requirement was not met.

As at 31 December 2017, 32.51% of Scheme assets were invested in cash [Category 1 (a) (i) and 1 (a) (ii)] and therefore met the minimum 20% requirement. This requirement has been met using the amended calculation methodology and excluding PMSA assets.

## 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 days; 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 members or their employers to pay contributions within the prescribed period.

The Scheme applies robust credit control processes to deal 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.

## WAITING PERIODS

Section 29A of the Act states the instances when medical schemes may impose waiting periods upon a person in respect of whom an application is made for membership or admission as a dependent. The waiting periods range from a three month general waiting period to a twelve month condition-specific waiting period. During the year under review, there were isolated instances where waiting periods were not applied in accordance with the Act. For the instances identified, the incorrect application of waiting periods has been rectified and a review conducted, which confirmed that no claims were rejected as a result of the waiting periods being incorrectly applied.

## PRESCRIBED MINIMUM BENEFITS

Section 29 (1) (o) and Regulation 8 provides 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 were reprocessed and correctly paid prior to the end of the benefit year.

## RESERVE ACCOUNTS

PAGE REFERENCE

Movements in reserve accounts are set out in the Statement of Changes in Funds and Reserves on **page 104**.

## OUTSTANDING CLAIMS

PAGE REFERENCE

Movements in the outstanding claims provision are set out in Note 6 to the Annual Financial Statements on **page 116**.

## 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 their 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.

The Scheme's liability to members in respect of PMSAs is reflected as a current liability in the Annual Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act. During 2017, the funds backing this liability were invested separately from the Scheme's assets and were managed by two independent asset managers, Taquanta and Aluwani. The average interest earned on these funds was 8.33% in 2017 (2016: 7.64%).

PAGE REFERENCE

See also Personal Medical Savings Accounts on **page 71** and **page 118** for Note 8 in the Annual Financial Statements.

## GOING CONCERN

The Trustees are satisfied that the Scheme has adequate resources to continue its operations in the foreseeable future. Accordingly, the Scheme's Annual Financial Statements have been prepared on a going concern basis.

## AUDITOR INDEPENDENCE

PricewaterhouseCoopers Inc has audited the Scheme's Annual Financial Statements. The Trustees believe the external auditors have observed the highest level of business and professional ethics, and have acted independently. The Audit Committee is satisfied that the auditor was independent of the Scheme.

## OPERATIONAL STATISTICS

### 2017

| 2017 | 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 | Classic Smart | Essential Smart | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of members at the end of the accounting period | 10 354 | 142 380 | 51 077 | 288 252 | 93 620 | 16 435 | 39 949 | 118 499 | 6 896 | 183 647 | 83 749 | 234 680 | 14 598 | 4 887 | 871 | 21 422 | 12 111 | **1 323 427** |
| Number of beneficiaries at the end of the accounting period | 22 602 | 320 053 | 110 099 | 631 879 | 212 763 | 31 609 | 85 100 | 248 249 | 14 343 | 417 520 | 186 693 | 410 463 | 23 251 | 7 008 | 1 910 | 40 178 | 14 226 | **2 777 946** |
| Average number of members for the accounting period | 10 587 | 145 839 | 50 577 | 285 821 | 94 585 | 16 870 | 38 260 | 113 549 | 6 930 | 183 872 | 83 455 | 228 064 | 13 981 | 4 687 | 884 | 19 021 | 8 239 | **1 305 219** |
| Average number of beneficiaries for the accounting period | 23 172 | 328 992 | 109 245 | 625 979 | 214 836 | 32 656 | 81 367 | 237 985 | 14 473 | 417 544 | 186 164 | 399 119 | 22 172 | 6 664 | 1 931 | 35 880 | 9 720 | **2 747 898** |
| Average risk contributions per member per month (R') | 7 285 | 5 787 | 3 295 | 3 117 | 3 938 | 4 981 | 2 598 | 2 565 | 3 568 | 2 785 | 2 707 | 1 688 | 1 427 | 1 096 | 5 707 | 2 314 | 1 295 | **3 109** |
| Average risk contributions per beneficiary per month (R') | 3 329 | 2 565 | 1 526 | 1 423 | 1 734 | 2 573 | 1 222 | 1 224 | 1 708 | 1 226 | 1 214 | 965 | 900 | 770 | 2 612 | 1 227 | 1 098 | **1 477** |
| Average net claims incurred per member per month (R') | 9 391 | 5 806 | 2 402 | 2 326 | 3 141 | 4 256 | 1 708 | 1 583 | 2 249 | 2 198 | 2 188 | 1 559 | 895 | 455 | 5 427 | 1 304 | 448 | **2 568** |
| Average net claims incurred per beneficiary per month (R') | 4 291 | 2 574 | 1 112 | 1 062 | 1 383 | 2 199 | 803 | 755 | 1 077 | 968 | 981 | 891 | 565 | 320 | 2 484 | 691 | 380 | **1 220** |
| Average administration costs per member per month (R') | 317 | 317 | 317 | 317 | 317 | 317 | 317 | 317 | 317 | 317 | 317 | 171 | 92 | 110 | 316 | 317 | 316 | **288** |
| Average administration costs per beneficiary per month (R') | 145 | 140 | 147 | 145 | 139 | 164 | 149 | 151 | 152 | 139 | 142 | 98 | 58 | 78 | 145 | 168 | 268 | **137** |
| Average managed care: Management services per member per month (R') | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | 98 | **98** |
| Average managed care: Management services per beneficiary per month (R') | 45 | 43 | 45 | 45 | 43 | 51 | 46 | 47 | 47 | 43 | 44 | 56 | 62 | 69 | 45 | 52 | 83 | **47** |
| Average family size at 31 December | 2.18 | 2.25 | 2.16 | 2.19 | 2.27 | 1.92 | 2.13 | 2.09 | 2 | 2.27 | 2.23 | 1.75 | 1.59 | 1.43 | 2.19 | 1.88 | 1.17 | **2.10** |
| Loss ratio (%) | 130% | 102% | 76% | 78% | 82% | 88% | 70% | 66% | 1% | 82% | 84% | 97% | 70% | 51% | 97% | 61% | 42% | **86%** |
| Total non-healthcare expenses as a percentage of risk contributions (%) | 6% | 7% | 12% | 13% | 11% | 9% | 16% | 16% | 0% | 15% | 15% | 14% | 11% | 15% | 7% | 17% | 29% | **12%** |
| Average non-healthcare expenses per member per month (R') | 424 | 426 | 410 | 421 | 426 | 426 | 403 | 410 | 420 | 417 | 406 | 239 | 152 | 162 | 423 | 399 | 374 | **382** |
| Average non-healthcare expenses per beneficiary per month (R') | 194 | 189 | 190 | 192 | 187 | 220 | 190 | 196 | 201 | 184 | 182 | 137 | 96 | 114 | 194 | 211 | 317 | **182** |
| Average age of beneficiaries (years) | 44.13 | 41.31 | 39.33 | 32.72 | 37.46 | 46.38 | 35.91 | 30.36 | 36.82 | 34.12 | 38.10 | 29.30 | 35.07 | 31.98 | 39.41 | 30.48 | 33.82 | **34.50** |
| Pensioner ratio (beneficiaries over 65 years) | 22% | 17% | 15% | 7% | 12% | 27% | 10% | 5% | 12% | 8% | 12% | 6% | 11% | 4% | 13% | 3% | 6% | **9%** |
| Average relevant healthcare expenses per member per month (R') | 9 494 | 5 912 | 2 500 | 2 424 | 3 239 | 4 364 | 1 806 | 1 681 | 2 347 | 2 296 | 2 286 | 1 645 | 993 | 558 | 5 544 | 1 412 | 546 | **2 665** |
| Average relevant healthcare expenses per beneficiary per month (R') | 4 338 | 2 621 | 1 157 | 1 107 | 1 426 | 2 254 | 849 | 802 | 1 124 | 1 011 | 1 025 | 940 | 626 | 392 | 2 537 | 749 | 463 | **1 266** |
| Net surplus/(deficit) per benefit plan (R'000) | (324 005) | (819 810) | 305 748 | 1 217 116 | 403 748 | 55 224 | 232 822 | 758 899 | 73 366 | 340 919 | 133 352 | (212 254) | 67 094 | 27 815 | (1 514) | 142 146 | 49 308 | **2 449 974** |

### 2016

| 2016 | 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 | Smart* | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of members at the end of the accounting period | 10 929 | 153 385 | 52 156 | 269 779 | 96 275 | 18 377 | 38 189 | 107 335 | 7 510 | 187 250 | 87 187 | 236 417 | 14 926 | 5 115 | 829 | 11 807 | **1 297 466** |
| Number of beneficiaries at the end of the accounting period | 24 142 | 349 237 | 111 913 | 590 831 | 220 180 | 36 131 | 79 461 | 223 979 | 15 848 | 424 238 | 193 129 | 412 459 | 23 505 | 7 280 | 1 827 | 21 031 | **2 735 191** |
| Average number of members for the accounting period | 11 159 | 157 002 | 51 848 | 267 495 | 97 459 | 18 763 | 36 070 | 102 528 | 7 595 | 185 776 | 86 006 | 227 986 | 14 055 | 4 928 | 831 | 9 090 | **1 278 589** |
| Average number of beneficiaries for the accounting period | 24 760 | 358 278 | 111 469 | 585 472 | 222 823 | 37 058 | 75 442 | 214 655 | 16 023 | 421 822 | 190 699 | 398 756 | 22 064 | 7 002 | 1 828 | 16 659 | **2 704 810** |
| Average risk contributions per member per month (R') | 6 538 | 5 203 | 2 986 | 2 840 | 3 593 | 4 504 | 2 342 | 2 345 | 3 260 | 2 416 | 2 339 | 1 538 | 1 310 | 965 | 5 120 | 2 081 | **2 843** |
| Average risk contributions per beneficiary per month (R') | 2 947 | 2 280 | 1 389 | 1 297 | 1 572 | 2 280 | 1 120 | 1 120 | 1 545 | 1 064 | 1 055 | 879 | 834 | 679 | 2 328 | 1 136 | **1 344** |
| Average net claims incurred per member per month (R') | 8 648 | 5 154 | 2 154 | 2 114 | 2 894 | 3 703 | 1 526 | 1 468 | 2 259 | 2 015 | 1 902 | 1 449 | 754 | 388 | 4 804 | 1 033 | **2 386** |
| Average net claims incurred per beneficiary per month (R') | 3 897 | 2 258 | 1 002 | 966 | 1 266 | 1 875 | 730 | 701 | 1 071 | 887 | 858 | 829 | 480 | 273 | 2 184 | 564 | **1 128** |
| Average administration costs per member per month (R') | 298 | 298 | 298 | 298 | 298 | 298 | 298 | 298 | 298 | 298 | 298 | 160 | 86 | 103 | 298 | 300 | **270** |
| Average administration costs per beneficiary per month (R') | 134 | 131 | 139 | 136 | 130 | 151 | 143 | 142 | 141 | 131 | 135 | 91 | 55 | 73 | 136 | 164 | **128** |
| Average managed care: Management services per member per month (R') | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | 92 | **92** |
| Average managed care: Management services per beneficiary per month (R') | 41 | 40 | 43 | 42 | 40 | 46 | 44 | 44 | 43 | 40 | 41 | 52 | 58 | 65 | 42 | 50 | **43** |
| Average family size at 31 December | 2.21 | 2.28 | 2.15 | 2.19 | 2.29 | 1.97 | 2.08 | 2.09 | 2.11 | 2.27 | 2.22 | 1.74 | 1.57 | 1.42 | 2.20 | 1.78 | **2.11** |
| Loss ratio (%) | 134% | 101% | 75% | 78% | 83% | 85% | 69% | 66% | 72% | 87% | 85% | 99% | 65% | 55% | 96% | 55% | **87%** |
| Total non-healthcare expenses as a percentage of risk contributions (%) | 6% | 8% | 13% | 14% | 11% | 9% | 16% | 16% | 12% | 16% | 16% | 14% | 11% | 15% | 8% | 18% | **13%** |
| Average non-healthcare expenses per member per month (R') | 399 | 401 | 382 | 394 | 401 | 405 | 375 | 384 | 396 | 392 | 377 | 220 | 140 | 149 | 397 | 372 | **358** |
| Average non-healthcare expenses per beneficiary per month (R') | 180 | 176 | 178 | 180 | 175 | 205 | 179 | 183 | 188 | 173 | 170 | 126 | 89 | 105 | 180 | 203 | **169** |
| Average age of beneficiaries (years) | 42 | 39 | 38 | 31 | 36 | 44 | 34 | 29 | 35 | 33 | 36 | 28 | 34 | 30 | 38 | 29 | **34.17** |
| Pensioner ratio (beneficiaries over 65 years) | 19% | 14% | 13% | 6% | 10% | 24% | 8% | 4% | 10% | 6% | 10% | 5% | 9% | 5% | 11% | 3% | **9%** |
| Average relevant healthcare expenses per member per month (R') | 8 758 | 5 264 | 2 246 | 2 205 | 2 986 | 3 814 | 1 618 | 1 559 | 2 351 | 2 107 | 1 993 | 1 529 | 845 | 529 | 4 928 | 1 135 | **2 479** |
| Average relevant healthcare expenses per beneficiary per month (R') | 3 947 | 2 307 | 1 045 | 1 008 | 1 306 | 1 931 | 774 | 745 | 1 114 | 928 | 899 | 874 | 538 | 372 | 2 240 | 620 | **1 172** |
| Net surplus/(deficit) per benefit plan (R'000) | (341 248) | (741 888) | 282 896 | 991 747 | 321 876 | 79 776 | 192 694 | 579 193 | 53 128 | (31 011) | 67 366 | (314 518) | 70 967 | 22 707 | (1 072) | 72 837 | **1 305 450** |

* *The Smart Plan was introduced in 2016, and expanded into a series (Classic Smart and Essential Smart) in 2017.*

DISCOVERY HEALTH'S

# INITIATIVES FOR THE SCHEME

## Discovery Health's business model

Discovery Health's services to the Scheme have always extended beyond traditional administration and managed care services, through an approach that revolves around the principles of innovation and integration in state-of-the-art medical scheme risk management and service delivery.

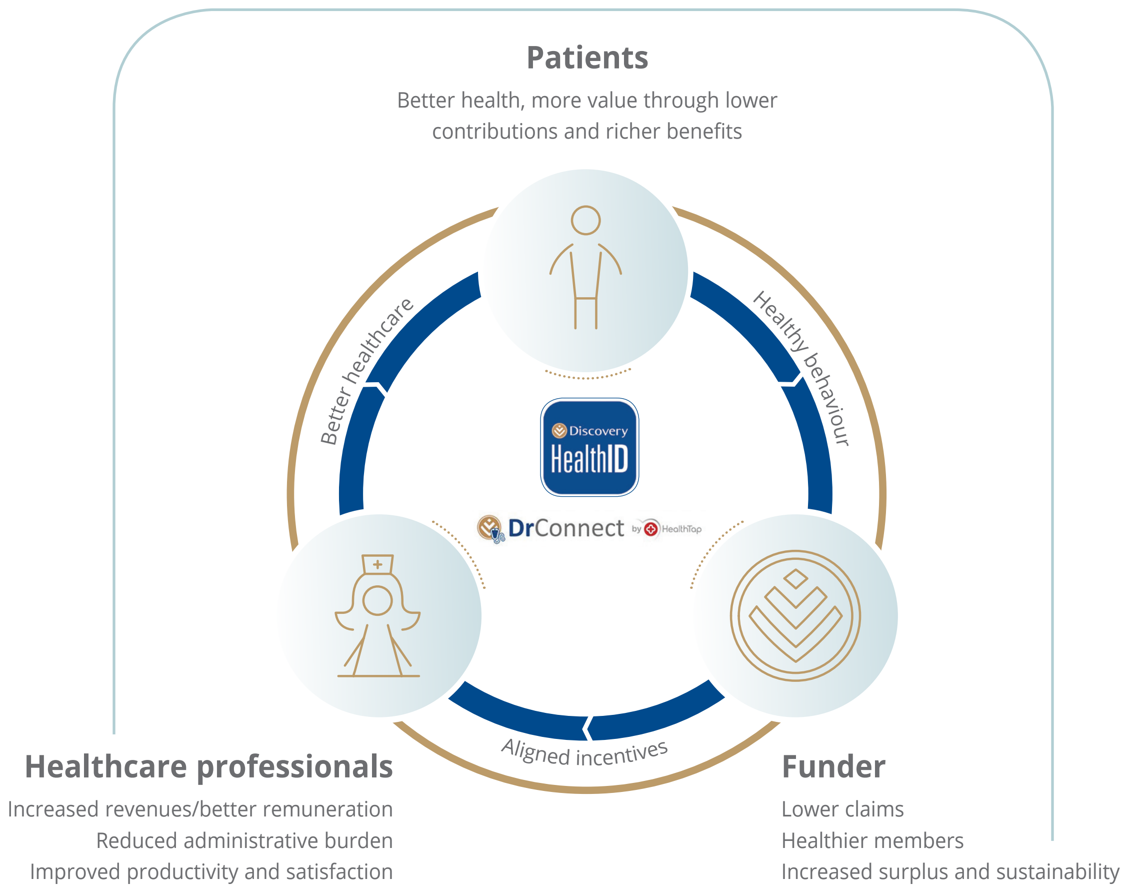
Discovery Health aims to fundamentally change the way the members of DHMS experience the healthcare system by creating an experience that is intuitive and accessible, and is fully supported by a suite of tools and world-class servicing. This holistic approach to health management is underpinned by a robust and flexible systems infrastructure, which is continually being enhanced to ensure that its service offering is value-adding and efficient.

Ongoing investments in digital innovation and a significant focus on improving value in healthcare through efficiency and quality care helps ensure better health outcomes, while maintaining extensive care, support and the latest medical technologies for where and when members need it most. DHMS's full spectrum of plan options enables Discovery Health and the Scheme to offer DHMS members excellent value for money, and the comprehensive and integrated wellness offering helps members to understand and improve their health. The downstream impact of these initiatives is manifested in lower costs for the Scheme and improved quality of care for its members.

## BUILDING A SHARED VALUE HEALTHCARE SYSTEM

Globally, governments and private healthcare funders are grappling with the complex problem of maintaining a fragile balance between access to healthcare, cost and quality. Most healthcare systems face a common set of challenges that contribute to healthcare costs escalating faster than general inflation, making it increasingly difficult to provide access to the high-quality healthcare our society increasingly expects.

Private healthcare financing provided by medical schemes inherently benefits society by protecting individuals and organisations from adverse events. Discovery Health's vision is to amplify the benefits by delivering an integrated value-driven healthcare system, which is centred on meeting the needs of its members and delivering access to the best quality care at outstanding value for all key stakeholders. This vision is realised through a pioneering shared value healthcare model that incentivises people to be healthier, which generates lower claims and higher surpluses for client schemes, and incentivises healthcare professionals through value-based contracting, leading to a healthier society and more members and clients selecting Discovery Health.




## The patient

The patient is at the centre of any healthcare system built on shared value principles. This approach empowers patients, places them at the centre of decision making and delivers the best value to them in terms of financial and health outcomes.

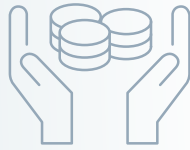
## Healthcare funders

Governments and private healthcare funders such as insurers and medical schemes who pay for healthcare are critical to governance and financial liquidity of the shared value system. Discovery Health is a pioneer and champion of this model in South Africa and intends to further improve on gains made to benefit members and the Scheme.

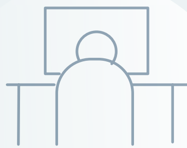
## Providers of healthcare services

This includes doctors, specialists, hospitals, pharmaceutical companies, pharmacies and manufacturers of medical equipment. Discovery Health has made major strides in moving away from a traditional fee-for-service model to value-based payment models that focus on the quality of care and patient outcomes. We have developed and implemented several value-based contracts with health professionals, and are continually engaging with relevant parties to set up favourable value-based remuneration incentives, drive a cost-effective medicine strategy and use technology effectively to improve patient experience and reduce cost of care.

# DISCOVERY HEALTH'S OPERATIONS IN ACTION



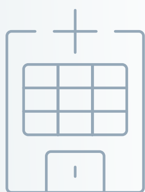
R31.6 million
**CLAIMS PAID**
per hour



264 500
**CLAIMS RECEIVED**
per day

36 200 calls
**PER DAY**

A Discovery baby is born
**EVERY 6 MINUTES**



2 940
**HOSPITAL ADMISSIONS**
approved per day

## WELLNESS

13 900
**WELLNESS SCREENINGS**
per month

47 100
**VITALITY CHECKS**
per month

## DIGITAL SUPPORT

4 400
**DOCTORS USING**
HealthID per month

3.7 million
**SMART PHONE**
logins per month

2 million
**WEB USERS**
as at 31 December 2017

205 800
**SOCIAL MEDIA FOLLOWERS**
as at 31 December 2017

## ENSURING HIGHER QUALITY HEALTHCARE

Discovery Health continuously strives to improve the quality of healthcare available to DHMS members by maintaining a cohesive system in which healthcare professionals work in integrated teams and are paid using innovative alternative reimbursement models based on shared value principles.

Over the years, Discovery Health has also developed comprehensive, best-in-class disease management and care coordination programmes to improve member's access and quality of care, while also lowering the overall cost of healthcare. These include chronic disease programmes for diabetes, renal failure, HIV, mental health, and care coordination programmes aimed at complex patients with multiple conditions. Some examples of these programmes include:

### THE CO-ORDINATED CARE PROGRAMME

The Co-ordinated Care Programme is a voluntary programme designed to coordinate long-term care for very ill members. It resulted in the following outcomes improvements for active enrolled members from 2008 to 2017 inclusive:

- ↓40% reduction in hospital per life per month healthcare costs
- ↓17% reduction in admission rate
- ↓48% reduction in 30-day all cause re-admission rate

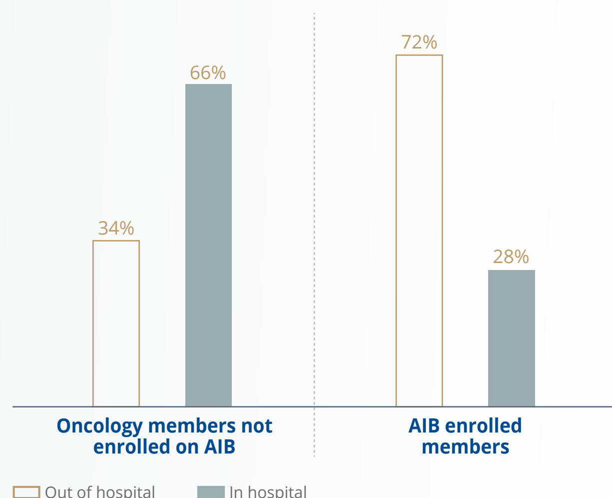
### THE ADVANCED ILLNESS BENEFIT

Discovery Health's internal data shows that the hospital costs of members during the last 12 months of life are four times higher and increase from four to 10 times in their last month of life, typically due to intensive hospital care in the final weeks. Over 60% of our members pass away in hospital, but research shows that more than 80% of people worldwide wish to pass away at home.

To address members' wishes and reduce the Scheme's costs, Discovery Health and DHMS developed and launched the Advanced Illness Benefit (AIB) within the Scheme. This benefit gives members with advanced stages of cancer access to a comprehensive palliative care programme. This includes Discovery HomeCare – where professionally trained Discovery nurses provide high-quality care at home. With unlimited benefits, access to home-based care and a care coordinator, the service has had a significant impact on patients and their families, with over 70% of our members in this programme electing to spend their last weeks at home with their families.

PAGE REFERENCE

Read more about Discovery HomeCare on **page 35**.



## CADCare PROGRAMME

The CADCare programme aims to increase value for money for DHMS and its members in cardiac care. It involves an episode fee for invasive and non-invasive cardiac catheterisation tests, aiming to increase the use of non-invasive methods (instead of the invasive method that carries a higher risk for patients). The programme is gaining traction with positive early results.

NOTABLE **HIGHLIGHTS** INCLUDE:

33%
of cardiologists enrolled

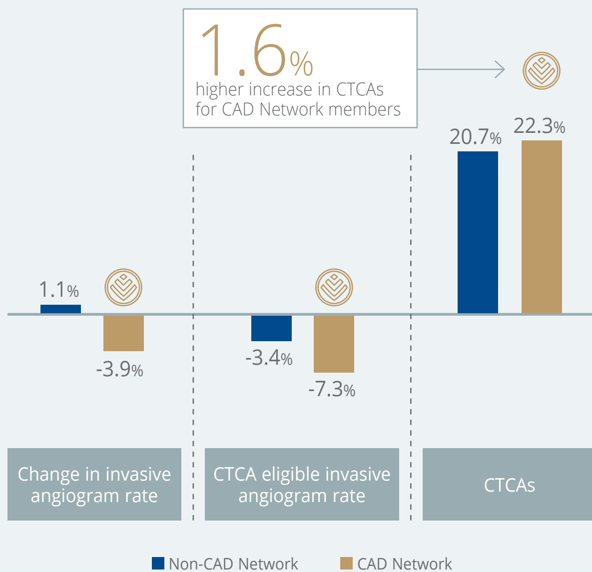
Invasive angiogram rate showed a
3.9% reduction
for the SASCI[1] network against a 1.1% increase for the non-network doctors.

CTCA eligible invasive angiogram rate showed a
7.3% reduction
for SASCI network against a 3.4% reduction for non-network doctors

22.3%
CTCAs for the SASCI network compared to 20.7% for non-network doctors

## CADCare PROGRAMME IS REDUCING DOWNSTREAM RISK AND COST

**CADCare** PROGRAMME **OUTCOMES**




PAGE REFERENCE

Read more about Discovery Health's initiatives for the Scheme, such as DiabetesCare, HealthID and DrConnect on **pages 86 – 93**.

1 *South African Society of Cardiovascular Intervention.*

## IMPROVING WELLNESS

Vitality[1] is Discovery's world leading, internationally recognised science-based wellness programme that incentivises and rewards a healthy lifestyle.

Substantial, peer-reviewed evidence has been published in leading international and local journals that shows the significant impact on health status, health claims and health outcomes of engagement in the Vitality programme. In short, members' health, hospital admissions, and mortality rates improve as they engage more with Vitality. As a result, DHMS benefits significantly from long-term healthcare cost savings and improvements in the Scheme's risk profiles, and associated employers also benefit from improved health status, wellbeing and higher productivity of their employees who engage with Vitality.

### VITALITY HAS HAD A SIGNIFICANT IMPACT ON DHMS

Vitality has achieved savings for DHMS of R11.5 billion between 2008 and 2016. The total Vitality savings are quantified in four components:

#### POSITIVE MEMBER DEMOGRAPHICS

Vitality enables DHMS to attract and retain younger, healthier members.

#### INITIAL ENGAGEMENT SELECTION AND BEHAVIOUR MAINTENANCE

Vitality also enables DHMS to attract and retain people that exercise more when compared to non-Vitality members. It is estimated that this initial and ongoing engagement selection resulted in savings of R3.8 billion for DHMS between 2008 and 2016.

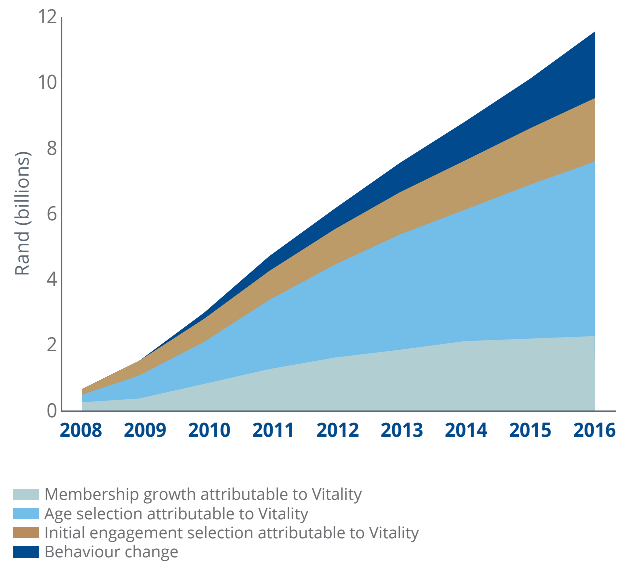
#### BEHAVIOUR CHANGE

Vitality encourages members to increase engagement in healthy behaviour, which results in further savings for DHMS as claims are lower for members who increase their level of engagement with wellness activities.

#### ATTRACTING NEW MEMBERS

Vitality provides a substantial competitive advantage to DHMS and contributes to attracting a strong flow of new members. As new members tend to claim significantly less than existing members, any net new membership growth improves the Scheme's financial position.

### CUMULATIVE VITALITY SAVINGS




## LOWERING THE COST OF HEALTHCARE

To provide access to quality, cost-effective healthcare, Discovery Health works closely with healthcare providers and their professional societies. Discovery Health is shifting away from a traditional fee-for-service model in favour of value-based payment models that are focused on quality of care and patient outcomes. Several value-based contracts with doctors have been developed and implemented, and there is continued engagement with the industry to identify additional methods of reducing healthcare costs.

In addition, Discovery Health continues to grow and maintain provider networks that are efficient, drive adoption of evidence-based and cost-effective generic medicines, and incorporate technology into the healthcare system; together, these measures help to counteract medical inflation without compromising access to and quality of healthcare.

Discovery Health's managed care processes and interventions have resulted in significant savings for DHMS and have had a clear impact on the Scheme's loss ratio and operating surplus.

### MEDICINE SAVINGS

Discovery Health's medicines strategy spans the entire medicines value chain, from price negotiations with manufacturers and agents, to dispensing and claims reimbursement. Key components of this strategy include risk management, provider contracting, claims processing, pharmacy reporting, supply chain integration, clinical database optimisation and legal and regulatory compliance.

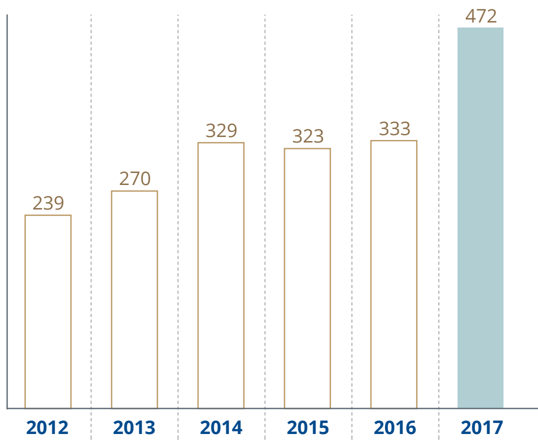
*1 DHMS members have voluntary access to Vitality membership. Vitality is administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.*

*2017 figures not available at the time of publication.*

## FORENSICS

Discovery Health applies advanced data science techniques to proactively detect healthcare fraud and abuse. In addition, the forensics and analytics units have developed various tools and reports for the ongoing detection of potential fraud and abuse against the Scheme, which has led to the recovery of millions of Rands a year.

DHMS SAVINGS AND RECOVERIES (R'millions)



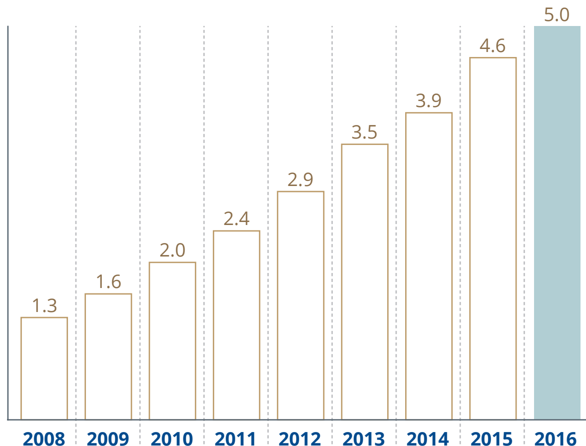

*Includes total savings and recoveries, hospital group settlements and deferred amounts.*

## ALTERNATIVE REIMBURSEMENT MODELS

Discovery Health has negotiated a number of alternative reimbursement models with hospital groups and suppliers of surgical items, generating further savings.

Risk management savings are generated through tariff and medicine savings, funding policies, forensics, alternative reimbursement models and surgical item management. The total managed care savings per year, from these interventions, after allowing for inflation, are:

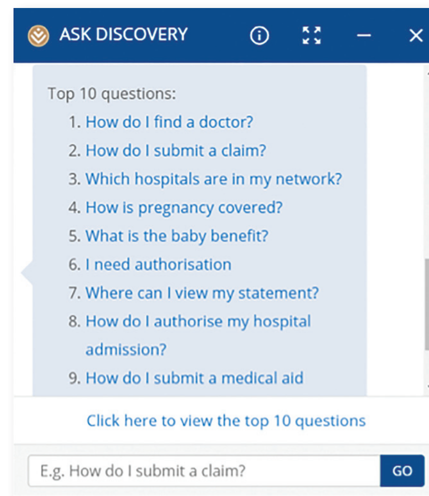
MANAGED CARE SAVINGS PER YEAR Rand (billions)




The cumulative managed care savings for DHMS are estimated to be approximately R27.2 billion between 2008 and 2016, after allowing for inflation.

## ENABLING PERSONALISED HEALTHCARE AND SERVICE BENEFITS THROUGH TECHNOLOGY

Discovery Health is leveraging artificial intelligence (AI) principles to provide automated, personalised service, product information and support. By harnessing the power of big data and using sophisticated analytics, Discovery Health can better understand customer behaviour and provide automated customer service, personalised product information and support. In June 2017, Discovery Health launched and AI-based search tool, 'Ask Discovery', on the DHMS website. This allows Scheme members to ask questions in any format, and the AI tool directs them to the precise section of the website to answer their question.




SINCE LAUNCHING **ASK DISCOVERY** ON 13 JUNE 2017:

Users have asked

**305 000 QUESTIONS**

averaging **4 800** questions a day

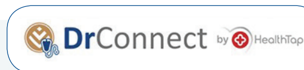
**106 000 PEOPLE HAVE USED THE SERVICE,**

with 1 500 new users every day

The most common questions received to date are **"HOW DO I GET MY TAX CERTIFICATE?"** and **"HOW DO I FIND A DOCTOR?"**

### HealthID

HealthID provides doctors with a more complete view of their patient's health history and test results. This improves patient care and reduces the likelihood of serious medical errors and duplicate or unnecessary pathology tests. In addition, HealthID also reduces a doctor's administrative burden by making it quick and easy to fill in Chronic Illness Benefit applications and providing them with the relevant scheme formulary list.




### DrConnect

The new Discovery DrConnect functionality provides seamless access to high-quality medical information from a worldwide network of over 108 000 doctors. It also facilitates personalised interactions between patients and their doctors.

PAGE REFERENCE

Read more about DrConnect on **page 36**.

### DISCOVERY MEMBER APP

The Discovery Member App allows a user to access and experience all their Discovery products wherever they are.

### SMART SERIES

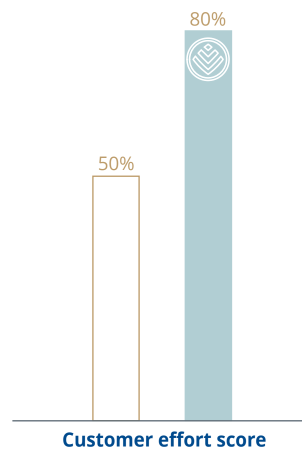
Launched in 2016, the Smart Series incorporates the best of Discovery Health's analytical tools and digital assets to form a seamless integrated digital healthcare plan with smart network providers and medical services for DHMS members. The series offers the best value for money in the South African open medical scheme market, due to its use of digital technology and smart networks to significantly reduce healthcare costs.

The series attracts a tech-savvy and younger generation of members who are empowered to manage their own health plans and spending. Initially launched as the Smart Plan in 2016, it was highly successful and was expanded in 2017 to include both Classic and Essential options. By the end of 2017, Classic Smart had over 40 000 members and Essential Smart over 14 000.

## MAINTAINING WORLD-CLASS SERVICE LEVELS

In 2017, Discovery Health continued to push service excellence in the delivery of quality healthcare in an environment of high medical inflation. In comparison with international benchmarks, Discovery Health's service metrics exceed international best practice benchmarks.

DISCOVERY HEALTH SCORE (80%) VERSUS 2017 INTERNATIONAL BEST PRACTICE BENCHMARK (50%)




*Source: Dimension Data 2017 Global Customer Experience Benchmarking Report*

## FUTURE FOCUS AREAS

Collaboration with the South African Society of Obstetricians and Gynaecologists to better manage safe deliveries, early elective C-sections and the high rates of admissions to neonatal intensive care units.

Enhance public reporting of the hospital experience of patients. The Discovery Health Patient Survey Score will be updated to include reporting on mortality rates and re-admission rates.