Minutes of the 29th Annual General Meeting of Discovery Health Medical Scheme ("DHMS"/ "the Scheme") held on 27 June 2024 at 09:00 at the Maslow Hotel, Sandton

---

1 Welcome and Quorum

The Chairperson of the Board of Trustees ("Board"), Michelle Norton SC, welcomed all present to the 29th Annual General Meeting ("AGM") of Discovery Medical Health Scheme ("DHMS"/" the Scheme"). The Chairperson welcomed those attending in person and virtually with this being the first hybrid AGM to be held by the Scheme. The Chairperson also welcomed a delegate from the Council for Medical Schemes ("CMS"/ "Regulator"), Mr Sibongubuhle Situnda.

The Chairperson briefed the members present at the AGM on the proceedings for the day and commented that:

- The meeting is being streamed live on the Scheme's webpage and a recording of the meeting will be made available after the meeting on the Scheme's webpage.
- Members attending the meeting either virtually or in-person will be given an opportunity to pose questions relating to the business of the AGM. Those attending virtually can post their questions on the chat facility or by selecting the tab "request to speak."
- When asking questions, Members should state their name and surname for the record. Interpreters will be made available to translate for those who wish to speak in a South African language of their choice, other than English.
- For general questions not related to the AGM or inquiries about personal claims experiences, in-person attendees can approach the team seated next to the registration stations outside of the room. Virtual attendees can call the customer care centre or post their questions in the chat facility, where they will receive a response after the AGM has concluded.

The Chairperson confirmed that to ensure that the AGM and all the related processes are conducted in terms of the Scheme Rules and allow Members to participate, the Scheme appointed Forvis Mazars ("Mazars") as an independent third-party service provider to oversee the AGM and specific AGM-related processes, including the nomination process, proxy appointment process and the voting to be conducted at the AGM. The Chairperson called upon Mr Ishan Bhowani from Mazars, to confirm that the minimum number of fifteen (15) Principal Members of the Scheme are present and confirm that the AGM is quorate in terms of the Scheme rules.

Mr Bhowani addressed the meeting and explained that, according to Scheme Rule 25.1.4, a minimum of fifteen (15) principal members must be present, either in-person or virtually, for the meeting to be considered quorate. He informed attendees that if a quorum is not reached within thirty (30) minutes of the AGM's commencement, the meeting would need to be postponed to a date determined by the Board.

Mr Bhowani then conducted a roll call of a sample of Principal Members in good standing, to ensure that the AGM was quorate. Members attending in person were instructed to raise their hands upon hearing their names, while those attending online were instructed to type "present" in the chat facility. This process was implemented to accurately record their presence.

Mr. Bhowani confirmed that at least fifteen (15) Members were present in person and on-line.

The Chairperson proceeded to confirm the meeting quorate and declared the meeting open.

- The Chairperson handed over to Mr Bhowani to explain the voting and voter registration processes. Mr Bhowani clarified that Principal Members in good standing who have registered will receive a blue lanyard, indicating their eligibility to speak and vote at today's AGM. The voter registration desk is located across the main auditorium, with Mazars electoral officers available to assist members. These officials could be identified by the Forvis Mazars branded T-shirts they were wearing.
- Members are required to provide proof of identification and their membership card at the voter registration desk. Upon successful registration, Members will receive a voting access card and will be directed to the voting room by electoral officers to cast their votes electronically using iPads.
- Mr Bhowani emphasised that voting access cards should be deposited in a box located at the exit of the voting venue, urging members not to leave without returning their cards after casting their votes.
- For Members attending virtually, a voting link has been sent to their registered email accounts, which they can use to cast their votes.
- Mr Bhowani provided information, for both Members attending in-person and virtually, in relation to the help facility or options to seek assistance should Members experience any difficulties – technical or other.

Mr Bhowani noted that voting will remain open until 16:00 that afternoon (viz. 27 June 2024).

Mr Bhowani handed over to the Chairperson.

The Chairperson proceeded to declare the voting open.

Confirmation of the Agenda:

The Chairperson presented the agenda of the meeting as communicated to Members.

The Chairperson called upon Members to approve and second the approval of the Agenda. Ms Eva Claudette Sampson proposed the approval of the agenda, and Mr Ronald Michael Whelan seconded the proposal. The Agenda was duly confirmed.

2 Approval of the Minutes of the 2023 Annual General Meeting

The Chairperson directed members to the minutes of the 2023 AGM, which were included in the meeting pack provided to attendees and published on the Scheme's webpage.
The chairperson informed members that the Board of Trustees has reviewed the minutes and considers them to be a true and accurate reflection of the proceedings of the 2023 AGM. Unless there are objections, the Chairperson proposed that the minutes of the 2023 AGM be approved.
The Chairperson called upon members to approve and second the approval of the minutes. Mr Deon van Niekerk proposed the approval of the minutes, and Ms Seipati Bernice Dichabe seconded the proposal. The minutes were thus duly approved.

3 Tabling of the 2023 Integrated Report, including the Scheme's Financial Statements for the year ended 31 December 2023

The Chairperson referred to the financial statements for the year ending 31 December 2023 and advised that these were laid before the meeting in terms of Rule 25.1.5 of the Scheme Rules.

The Chairperson informed attendees that presentations would be followed by a question-and-answer session. A presentation would be made by the Principal Officer of DHMS, Ms Charlotte Mbewu, followed by a presentation by the CEO of Discovery Health ("DH"), Dr Ronald Whelan.

The Chairperson outlined some of the critical considerations that have guided the work of the Board of Trustees over the past year. She emphasised that the AGM serves as a forum where the Board of Trustees accounts to the members for its oversight and management of the Scheme's business, stating that the Board's essential responsibilities are twofold: first, to serve the best interests of Scheme members, and second, to ensure the sustainability of the Scheme.

The Board of Trustees closely monitors circumstances and developments that may pose risks to these objectives and three primary concerns have emerged in this regard. The first is the steady increase in chronic diseases among DHMS members. This trend is not unique to the Scheme but is observed across South Africa and globally, including conditions such as cancer, diabetes, cardiometabolic syndrome, and mental health disorders. The rise in chronic diseases significantly drives the utilisation of healthcare services and medications.

The second consideration is the ever-rising cost of healthcare services. Healthcare cost inflation, which consistently tracks at least three to four percent above the consumer price index, is a global phenomenon. While exciting innovations in technology and medicines can offer life-changing outcomes for members, they also come at a significant cost.

The third consideration is the economic context in which the Scheme operates. Global economic uncertainty, coupled with low growth and high unemployment in South Africa, is impacting the affordability of medical insurance coverage.

The most difficult decisions that the Board of Trustees must make involve balancing the interests of individual members in obtaining comprehensive healthcare coverage at the most affordable price against the collective interest in the Scheme's sustainability. Escalating costs sometimes compel the Board of Trustees to choose between increasing member contributions and adjusting the benefits available on the Scheme's plans.

The current environment necessitates new approaches to addressing the challenges of chronic disease and rising healthcare costs. In this regard, members benefit enormously from the innovative and technological resources and capabilities of the administrator, Discovery Health. Efforts are focused on initiatives such as expanding health screening for members using new technology to promote wellness and prevent disease, providing disease management programs

for members with specific health challenges, and initiating digital solutions to expand access to cost-effective healthcare.

In the past year, the passage of the National Health Insurance ("NHI") legislation has progressed through Parliament and was signed into law by the President of the Republic of South Africa, Cyril Ramaphosa ("President") on 15 May 2024. The Scheme has consistently maintained its position in submissions to Parliament and in petitioning the President not to sign the Bill. The Scheme fully supports the objective of Universal Health Coverage. However, it believes that the NHI Act, in its current form, is not fit for purpose as it poses a threat to the delivery of healthcare services and contravenes the Constitution of the Republic of South Africa in key respects.

Importantly, the implementation of the NHI Act and its key provisions is a long way off. Apart from the time required for the Courts to resolve the many legal challenges to the NHI Act, the President has not yet declared any of its provisions operational. Additionally, National Treasury ("Treasury") officials have publicly stated that the funding required to operationalise the NHI will not be available for many years to come.

The Scheme is a party to one of the many legal challenges to the NHI Act that has been mounted to the courts and the Board of Trustees will continue to take all necessary steps to protect the rights of its members and the viability of the Scheme.

3.1. Presentation by the Principal Officer of the Scheme

Ms Mbewu commenced by providing an overview of the topics that she would be covering in her presentation which included the following:

- Current landscape for members and the Scheme;
- Ensuring the sustainability of the Scheme;
- Guaranteeing superior quality and value for members;
- Regulatory and governance excellence; &
- 2024 and beyond

The presentation highlighted the following aspects:

The current landscape for members and the Scheme

To ensure the sustainability of the Scheme, the Scheme must consider the current landscape within which it operates together with its members. There are three key points to address:

Firstly, within the medical Scheme's environment, there are concerns around the affordability pressures faced by members. The industry is experiencing muted growth, which has knock-on effects on utilisation and the demographic profile of medical schemes. Specific pressures unique to the healthcare environment include an aging membership and an increase in chronic conditions, which place a significant burden on medical schemes.

Secondly, the medical scheme's environment is facing various regulatory challenges, particularly related to the NHI. Additionally, there are ongoing discussions about Low-Cost Benefit Options ("LCBOs"). From a DHMS perspective, we believe in the importance of implementing LCBOs and the industry's efforts to review Prescribed Minimum Benefits ("PMB"), which are a significant burden from a utilisation perspective when medical schemes provide coverage.

Lastly, it is important to consider the impact of interest rates on affordability. Pre-COVID-19, interest rates escalated from 7% to 11.75%. This increase affects household income, which in turn impacts DHMS members' ability to afford medical scheme coverage. Affordability constraints mean that as a medical scheme, DHMS must consider the pressure on household income and how it affects members' capacity to fund their medical coverage.

By highlighting these factors, the Scheme can better understand the operating landscape and address the challenges faced by the scheme and its members.

Furthermore, in South Africa, the increase in the prime lending rate has resulted in a greater household burden related to repaying credit facilities. From an industry perspective, DHMS have observed muted growth, which impacts the ability of medical schemes to attract younger members.

The lack of younger members affects the natural cross-subsidisation that medical schemes depend on. This, in turn, leads to affordability constraints and pressures on contributions.

The Scheme has observed a notable trend in the industry towards consolidation. Looking back to 2004, there were forty-eight (48) open medical schemes in the market. Over the years, this number has decreased significantly to sixteen (16) by 2022, primarily due to mergers and consolidations. This trend reflects a shift towards quality within our environment.

The average age in the industry has been impacted by this consolidation, with an increase of approximately 0.3 years annually. This reflects the muted growth in attracting younger members to the industry. Furthermore, there has been an increase in the chronic disease burden since 2019, evidenced by a 2% rise in the chronic ratio within open medical schemes. This increase indicates a corresponding rise in the number of members requiring access to disease management programs and increased healthcare utilisation support.

The Scheme has observed not only an increase in the chronic disease ratio but also a rise in the number of members living with multiple chronic conditions, particularly in mental health, diabetes, and cardiovascular diseases. In recent years, DHMS data has revealed a significant uptake in mental health conditions among its members, with a 2.1-fold increase since 2023. This underscores the ongoing focus of DHMS on mental health disease management strategies, as CEO Ronald Whelan will elaborate on later.

Having outlined some aspects related to the NHI Act and its policy implications, Ms Mbewu firmly reiterated the Scheme's stance in support of universal health coverage, stating that it is crucial for ensuring equitable access to healthcare across South Africa.

The Scheme's concern with the NHI Act lies in its potential regressive impact on DHMS members. The Scheme has observed the challenges in funding the NHI Act as envisioned, given the current economic constraints that prevent full funding. Consequently, legal challenges have been mounted against the NHI Act, in which the DHMS actively participates to protect the interests of its members and all South Africans.

It's important to note that the implications of the NHI Act, particularly S 33, indicate that medical schemes may only offer complementary cover once the NHI is fully implemented as determined by the Minister of Health through Regulations in The Gazette. This means that during this period, medical schemes will continue to exist and provide benefits to their members. However, DHMS remains concerned about the role of medical schemes in offering complementary cover, as it may lead to unintended anti-selection effects and impact the funding and affordability of healthcare in the long term.

Currently, the Scheme does not foresee an immediate impact on medical schemes. The full implementation and impact of the NHI, as stipulated in S 33, is projected to be at least a decade away, considering ongoing legal challenges and discussions within the public domain, particularly led by the National Treasury who are responsible for the purse strings of the country.

Another critical aspect discussed by Ms Mbewu is the Scheme's ongoing engagement with the National Department of Health ("NDoH") and other regulatory bodies regarding the NHI. While litigation plays a role, the Scheme believes that it is equally important to collaborate with stakeholders involved in this process. This collaboration is essential for South Africa to successfully implement universal health coverage, requiring cooperation between the private and public sectors for the benefit of the country as a whole. It's crucial for DHMS members to understand both the legal challenges and the collaborative efforts underway to shape the future of healthcare access in South Africa.

When discussing DHMS's broader participation as a medical scheme, Ms Mbewu highlighted that the Scheme has actively engaged in the process concerning LCBOs and made substantive submissions. The Scheme strongly believes that introducing a LCBO will expand access to medical schemes, particularly enhancing primary care coverage.

Additionally, The Scheme is involved in the CMSs review of PMBs. This review not only assesses the current PMB package but also explores the potential inclusion of primary healthcare benefits within the PMB framework. DHMS commends the CMS for its comprehensive approach to engaging stakeholders across the healthcare sector. This inclusive process allows for input from all relevant parties, facilitating informed recommendations and collaborative decision-making.

According to Ms Mbewu, the Scheme eagerly anticipates the outcomes of these reviews and remains committed to contributing constructively to the evolution of healthcare policy in South Africa.

Ensuring the sustainability of the Scheme

When evaluating the sustainability of the Scheme, focus is on two key aspects: membership sustainability and financial strength. These factors are critical to ensuring that the Scheme can meet current and future claims obligations. From 2018 to 2023, the Scheme has shown stability in its membership, with a 1.7% increase in new principal members. However, there is a notable trend where the number of lives covered per policy has been declining over time. This trend will be further detailed in the presentation, highlighting its potential unintended consequences.

Financial strength is crucial to ensure we can pay both current and future claims. In this regard, the Scheme has continued to maintain stability in this area, underscoring its ability to meet its financial commitments. It is essential to assess how this new growth compares to the rest of the industry. Today's presentations will provide insights into the broader industry trends and how DHMS measures up in this context. By focusing on these key metrics, we aim to ensure the long-term sustainability of the medical scheme, securing the interests of our members and maintaining financial robustness.

Ms Mbewu was pleased to report that the new members joining DHMS are notably younger than those joining the industry overall. On average, new members enrolling in the Scheme are 25.9 years old, compared to an average age of thirty-seven (37) for the rest of the industry. Monitoring this demographic trend is crucial because younger members typically have lower healthcare utilisation. This lower utilisation helps cross-subsidise our risk pools, benefiting the entire Scheme membership. It also positively impacts the contribution increases needed for future years. Additionally, younger members generally come with a better chronic health profile compared to the pre-existing membership of the Scheme. This demographic advantage helps maintain the overall health and sustainability of DHMS. By attracting younger members, the Scheme can better manage its risk profile and ensure the long-term viability and affordability of the Scheme for all members.

From a market share perspective, the Scheme has successfully maintained its position which reflects the quality of the benefits we offer. Examining our benefit design, we observe that the majority of our members remain within the same benefit option they chose the previous year. This consistency indicates the high quality and suitability of our benefit options, meeting the diverse needs of our members effectively. The continued preference for DHMS and the stability in benefit option choices underscore the strong alignment between the Scheme's offerings and the expectations of its members. This reaffirms the value and effectiveness of the Scheme's benefit design and the underlying benefits provided.

Ms Mbewu addressed the net healthcare results of the Scheme as she delved into the financials of the Scheme. Notably, the deficit recorded in the 2023 financial year was a budgeted loss. Members may recall the discussions held during last year's AGM about the WELLTH Fund and its implementation, which was to be funded from DHMS's reserves. Additionally, certain aspects related to deferrals were mentioned at last year's AGM. These factors have culminated in the lost position experienced in the 2023 financial year.

The Scheme maintains continued solvency, with a solvency ratio of 30.6%, which has decreased since the COVID-19 years as utilisation has returned to normal levels. This solvency translates to R27.2 billion in reserves. Members will recall that medical schemes are required to maintain a solvency ratio of at least 25%, which positions the Scheme well to meet regulatory requirements and future claims, particularly in the event of catastrophic events. Additionally, the Scheme has maintained its AAA credit rating.

From an expense breakdown perspective, members were informed that 91.7% of contributions, referred to as Insurance Service Revenue in the financial statements, are allocated towards funding claims. This underscores the primary purpose of medical schemes. The remaining contributions fund the operations and administration of the Scheme, ensuring efficient service delivery, support for financial advisors, and proper functioning of the Scheme to meet member needs. This demonstrates that the vast majority of contributions are used directly for member healthcare.

The presentation of the 2023 financial statements differs from previous years. This change is due to the introduction of IFRS 17, a new accounting methodology for the presentation and disclosure of insurance contracts. Since medical schemes are considered insurance contracts, this change has affected the Scheme's financial reporting. It is important to note that this change is not unique to DHMS but affects the entire industry, including all medical schemes and insurance entities. However, members should be reassured that the nature and operating model of the medical Scheme remain unchanged due to this new methodology. Additionally, the solvency of the Scheme and the calculation thereof have not been impacted by the implementation of IFRS 17.

The following Key points were communicated to members:

1. The Scheme still maintains sufficient reserves.

2. The solvency requirements are still being met.

These aspects confirm the Scheme's stability and ability to continue meeting its financial obligations.

Ms Mbewu reviewed the financial statements, which represent the financial position of the Scheme as of December 31, 2023, audited by PricewaterhouseCoopers (who were present at the AGM). It is noteworthy that the insurance liability to future members, representing the reserves or accumulated funds of the Scheme, has grown from ZAR 25.3 billion in 2022 to ZAR 26.9 billion in 2023. When examining the rest of the Scheme's financials:

- Contributions can be located as specified in the new format.
- The Insurance Service Result, equivalent to the former Net Healthcare Results, stands at a ZAR 2.1 billion loss. This loss encompasses the claims covered by the Scheme, including components related to the WELLTH Fund.

This information highlights the Scheme's commitment to transparency and accuracy in reporting while adapting to the new IFRS 17 standards.

To sustain the Scheme's affordability and uphold the interests of all members, tough decisions must be made by the Board of Trustees regarding how to effectively manage utilisation across these benefit options. This deliberation involves balancing affordability, sustainability, and ensuring continued access to healthcare services for the Scheme's members. These considerations often create tensions as the Board of Trustees strives to navigate the complexities of pricing, access, and quality, all while safeguarding the Scheme's future sustainability.

Across DHMS, when addressing inflation, the Scheme meticulously dissects its components to pinpoint the origins of medical inflation. This approach allows the Scheme to craft tailored strategies and initiatives aimed at addressing tariffs, supply-side utilisation, risk management—including disease management protocols—and non-healthcare expenses. The Scheme's goal is to reduce medical inflation from CPI plus 5% to a more manageable range, achieving a medical inflation rate of 10-5%. This effort translates into contribution increases for the 2024 financial year ranging between 9% and 13%, striking a balance between affordability and sustainability. Simultaneously, the Scheme undertook measures within its benefit options to mitigate these challenges. Notably, the comprehensive series was streamlined from five benefit options to two. This consolidation aimed to prevent members from opting for lower-priced benefit options, such as Essential and Delta, solely to access higher-cost benefits like the Oncology Innovative Benefits (OIB). The enhancement of the Classic Smart Comprehensive Plan was also pivotal, providing members with medical savings benefits.

Similarly, the KeyCare series faced challenges due to higher chronic burden and utilisation rates compared to other DHMS options. To optimise the KeyCare range while ensuring affordability and preserving benefits, ongoing adjustments have been implemented. This strategic approach has been continuously monitored since 2019, reflecting cumulative changes in chronicity and utilisation patterns across the KeyCare and KeyCare+ options.

To address affordability and utilisation while ensuring sustained access to care for all members', concerted efforts have been made to enhance benefit coordination. This initiative aims to optimise care delivery by encouraging members to seek care from a single General Practitioner ("GP") instead of multiple providers. Additionally, efforts have been focused on optimising hospital networks and addressing anti-competitive aspects related to PMB, particularly concerning in-hospital procedures.

The Scheme has been proactive in providing alternative points of care and settings. Leveraging technological innovations allows members to access care more affordably, while maintaining high standards of quality and healthcare outcomes. For instance, the introduction of "Virtual Urgent Care" and access to Internet Cognitive Behavioural Therapy ("ICBT") for depression treatment underscores these efforts. Virtual urgent care, available to members after hours, enhances accessibility without compromising on care quality. These measures not only manage utilisation effectively but also ensure extensive access to care options that enhance overall member health outcomes.

Regarding contribution increases for the 2024 financial year, DHMS introduced differentiated rates across its benefit options to align with varying utilisation patterns. This approach aimed to address specific pressures and circumstances unique to each plan. Despite these adjustments, DHMS remains more cost-effective compared to the broader market, boasting an 11.1% differential in average contribution increases when compared to the next seven (7) largest open schemes.

The Board of Trustees rigorously monitors administrative expenditures, particularly those paid to its administrator, DH. DHMS pays 7.8% of its gross contribution income to DH, ensuring that managed care fees remain below 10%. This diligent oversight aims to tightly control expenditures while maximising value generation. Independently reviewed and confirmed by Deloitte, this approach results in DHMS members obtaining value of ZAR 2.08 for every ZAR 1 spent on administration and managed care expenses on services provided by DH.

Ms Mbewu emphasised that DHMS is content with its current membership size. While acknowledging challenges regarding the chronicity of the Scheme, she expressed satisfaction with the profile of new members joining DHMS. Ongoing efforts in managed care programs aim to ensure that the Scheme delivers appropriate care options, particularly for members managing chronic conditions or in pre-disease stages.

Ms Mbewu further asserted that DHMS is committed to providing comprehensive coverage across all life stages, from infancy through old age, addressing various healthcare challenges and emphasising preventive care. This commitment includes

ensuring access to a robust network of healthcare providers. Across South Africa, DH members have access to 5,933 GPs, with 2,220 GPs specifically contracted within the "key care" network for members in that option.

The WELLTH Fund is a cornerstone of DHMS screening and prevention benefits, available to all its members. In addition to a robust GP network, DHMS offers access to a specialist network comprising 5,300 contracted specialists, covering approximately 93% of all registered specialists in South Africa.

DHMS places significant emphasis on its in-hospital cover ratio, meticulously tracking its ability to fully cover claims received, particularly within the hospital environment where the majority of healthcare costs accrue. According to the CMS industry report of 2022, DHMS outperforms the broader medical scheme environment in terms of coverage ratios. Instances where full coverage isn't achieved typically arise from members choosing to receive treatment outside of DHMS's designated service provider (DSP) networks. The Scheme boasts comprehensive programs such as maternity care, oncology benefits, specialised centres of care, and assisted reproductive benefits, underscoring its commitment to meeting diverse member needs.

Highlighting the impact of medical scheme membership across all life stages, Ms Mbewu observed that the top 10 highest member claims in the 2023 financial year totalled ZAR 69 000 000, with each claim spanning ages from 0 to 60. This underscores the importance of medical scheme enrolment across various life phases, demonstrating that healthcare needs arise throughout one's life and not solely in older age.

Regulatory and governance aspects

The Scheme operates under the regulatory oversight of the CMS, with governance provided by a Board of Trustees chaired by Michelle Norton SC. The Board is entrusted with overseeing the day-to-day operations of DHMS and ensuring strict adherence to regulatory frameworks established by the CMS for all medical schemes.

Regulatory compliance and governance are central to all internal engagements within DHMS. The scheme is structured to uphold robust governance frameworks that align with the requirements outlined in KING IV, aiming to meet and exceed governance standards.

In fulfilling its responsibilities, the Board of Trustees carefully considers all facets of DHMS's operations to ensure effective governance and fiduciary duties. This approach underscores the Board's commitment to maintaining the Scheme's integrity and ensuring it operates in the best interests of its members.

Looking into 2024 and beyond

The WELLTH Fund will continue into the 2024 period, focusing on ensuring access to care and maintaining robust screening and preventative programs. DHMS is committed to finding innovative and alternative mechanisms for population health management, implementing appropriate managed care protocols, and developing effective disease management programs to address the chronic profile of the Scheme.

Ms Mbewu reminded members who attended the 2023 AGM on a discussion about challenges faced by the Scheme regarding the utilisation of screening benefits, particularly since the COVID-19 lockdown and informed members that there had been a noticeable decline in the use of these benefits. In 2023, the Scheme observed a significant improvement in member engagement with health checks increasing by 7%, mammograms by 5%, and prostate screenings by 8%. This indicates that members are becoming more proactive in understanding their health profiles and taking necessary precautions for better health management.

As a result of the WELLTH Fund program, DHMS identified 6,400 members with chronic diseases requiring management, including diabetes, cancer, mental health conditions, and cardiovascular issues. This identification allows the Scheme to unlock a comprehensive basket of care tailored to these specific chronic health conditions, ensuring members receive the necessary support and treatment.

The WELLTH Fund has shown substantial impact, with at least seven-hundred million rand (ZAR 700 000 000) paid in claims and 520,000 Scheme members activating and utilising their Funds. Analysis of member spending reveals that dentistry and GP visits are the primary areas where the Fund is utilised. The richness of these care baskets, provided in an out-of-hospital setting, offers members access to multidisciplinary benefits. This comprehensive approach to care management ensures that members are better controlled, leading to a reduced need for hospitalisation. Consequently, this results in lower overall costs for the Scheme. For instance, the diabetes care program has achieved a 6% reduction in overall costs, which is quite significant for the medical scheme.

From a care improvement perspective, the Scheme aims to ensure better care coordination Global literature, along with the Scheme's internal data, demonstrates that individuals who access their care through a single practitioner tend to have better health outcomes. This is because a single practitioner understands their overall healthcare journey and history. Consequently, the Scheme is developing various benefits and programs that encourage members to access care through a primary care GP. This approach results in fewer emergency visits and hospital admissions, as there is a single point of entry into the healthcare system, and a GP who understands the member's holistic healthcare needs and journey.

Ms Mbewu highlighted one of the programs available to members, illustrating how it has enabled the Scheme to deliver excellence in care. This includes reducing the length of hospital stays for the Scheme's members and decreasing the number of hospital admissions. As a result, members who experience complications and require readmission benefit from improved management and reduced overall healthcare utilisation.

Continuing to discuss the various programs the Scheme has in place, Ms Mbewu reiterated the benefits of the care program for DHMS members, which include access to healthcare services outside of regular working hours. Additionally, the doctors participating in this program can write prescriptions and deliver medications. Notably, one in four consultations occurs after working hours, and at least 50% of these consultations are funded through the Scheme's risk benefits.

In conclusion, Ms Mbewu emphasised that the Scheme strives to balance the headwinds affecting it while exploring various healthcare innovations. The goal is to introduce these innovations sustainably, ensuring high-quality healthcare outcomes for the benefit of the Scheme and its members.

3.2. Presentation by the CEO of Discovery Health (Pty) Limited, Dr Ron Whelan

Delighted to provide an overview of DH's performance in support of the DHMS Dr Ronald Whelan presented on behalf of the 6,000 employees and contractors across DH. This dedicated team provides day-to-day and month-to-month services to DHMS members, and DH is proud of the work they do. The DH business is structured around six main functional areas, servicing 2.7 million members. These functions include:

- Actuarial Function
- Benefit Design and Innovation
- Policy and Regulation
- Systems
- Service and Operations Excellence
- Disease Management and Managed Care

Dr Whelan's focus was on policy and regulation, specifically discussing the NHI and DH's perspective on it. Additionally, attention was given to managed care initiatives and service and operations excellence initiatives, concluding with some thoughts on innovation.

Policy and Regulations/NHI Update

Dr Ronald Whelan, representing DH, provided a clear and consistent viewpoint on the NHI over the past few years. The key points presented were:

- DH unequivocally supports universal health coverage and believes that a workable NHI is central to achieving this goal. However, it must be feasible and effective. DH further believes that South Africa must do more to drive universal health coverage.

- The implementation of NHI will be complex and protracted, with no immediate impact on medical schemes for the next few years due to significant funding and legal constraints. It may take years or even decades before the NHI can be fully implemented.

- There are significant funding constraints. The South African economy and fiscal situation are constrained, requiring additional funding and private sector collaboration to make the NHI work.

- DH is committed to continued constructive and proactive engagement with policymakers. However, the Scheme will not shy away from its obligations to fight for the interests of medical scheme members and the broader population.

These points illustrate DH's stance on the NHI.

South Africa operates in a resource-constrained environment. The country's healthcare spend per capita is low compared to benchmark countries with universal health care access. For instance, South Africa's GDP per capita is $15,000, whereas the UK's is $57,000. Consequently, the UK, with its extensive resources, can afford to invest more in healthcare. The UK spends 11.1% of its GDP on healthcare, compared to South Africa's 8.5%.

South Africa also has fewer doctors and healthcare professionals compared to similar countries, with a ratio of 2-6 times fewer professionals, indicating a significant healthcare capacity constraint.

Challenges Surrounding the Implementation of the NHI

- **Unequal Healthcare System**: South Africa has an unequal healthcare system where 50 million people rely on the public sector, and 9 million people rely on medical schemes. Public sector funding is about R400 per life per month, whereas in the medical scheme environment, it is around R2,300-R2,400 per life per month. To level up public sector funding, over a trillion rand would be needed. It is also unconstitutional to reduce medical scheme members' funding to lower levels.

- **Single Central Fund**: The NHI proposes a single central fund for healthcare, amounting to around R550 billion. This is a substantial amount to be managed in one central pot overseen by the Minister of Health, the NHI Board, and the CEO. There are significant risks in managing such an excessive amount in a single fund, especially given that only 17 countries globally have a single fund for healthcare, typically small, fragile, or high-income countries.

- **Funding Constraints**: According to the National Department of Health ("NDoH"), South Africa will need over R200 billion per annum in additional healthcare funding. Raising this amount through tax is challenging due to the narrow tax base, comprising 6.5 million registered taxpayers and 3.5 million actual taxpayers. Personal taxes would need to increase by 31%, VAT by 6.5% (from 15% to 21.5%), or other payroll taxes by tenfold. These unprecedented tax increases are unachievable.

- Even if the additional R200 billion were raised, it would not significantly improve healthcare. Public sector healthcare expenditure would increase from R407 per life per month to R714 per life per month, roughly half of what it costs to deliver prescribed minimum benefits (R1,300 to R1,400 per life per month). Medical scheme members would see a reduction in funding from R2,332 per life per month to R714 per life per month, a 69% reduction, which is likely untenable and unconstitutional under Section 27 of the Constitution.

- **Complex Implementation**: Implementing the NHI requires extensive health system reform, expected to take many years. Discrepancies exist between what is articulated in the NHI Act and the NDoH's communication on implementation. Timelines extend into 2032-2033, with the first major funding step being the centralisation of provincial health budgets. Early phases involve setting up the structure, constituting the organisation and entity, and appointing the Board and CEO, which will be a complex process.

- In summary, DH emphasises that significant implementation and legal complexities exist in rolling out the NHI. There are two current legal challenges, one through Solidarity and the other through the Board of Healthcare Funders, which will take time to resolve. No near-term changes to healthcare funding and access will affect medical schemes soon. No tax changes will occur until a money bill is published by the National Treasury, which is yet to happen. Importantly, there will be no changes to medical scheme benefits until the NHI is fully implemented, as articulated in Section 33 of the NHI Act. Even when fully implemented, medical schemes will have an important role.

Operations and Service Excellence

Dr Ronald Whelan provided an overview of DH's operations and services, emphasising the Scheme's obligation to deliver the best possible service to DHMS members. These members are served daily by the extensive DH team.

<u>Overview of Beneficiaries:</u>

- The average age of a principal member of the Scheme is forty-eight (48) years.

- The oldest member is one-hundred and six (106) years old, with ninety (90) members over one-hundred (100) years old, demonstrating the longevity of DHMS members.

- 46% of policies are single policies, while 54% are family policies. There is a gradual increase in individual policies, likely driven by affordability pressures.

- On average, the Scheme processes 56 million claims per year, equivalent to twenty-three (23) claims per member per year.
- The chronic disease ratio across DHMS has increased to 32%, meaning roughly one in three members lives with a chronic condition. This drives both scheme and servicing costs, as chronic members have 2.6 times higher service demand than those without chronic conditions.
- 52% of policies are Saver Plans, indicating their value and the importance of maintaining their affordability.
- Notably, one in three members who leave the Scheme return within two years.

Operational Footprint:

- DH operates offices in four main regions: Gauteng, Eastern Cape, Kwa-Zulu Natal, and Western Cape.
- The operations team comprises 3,857 people who manage day-to-day operations.
- The Scheme serves 7 million members, supported by almost 45,000 healthcare professionals, over 7,000 employer groups, and 6,500 financial advisers.
- DHMS supports 720,000 hospital admissions and 30,000 new births annually, with 900,000 members living with chronic diseases.

Service Metrics:

- DH receives 8.5 million calls annually, averaging approximately 25,000 calls per day.
- The business structure supports the full member life cycle, from new member onboarding to wellness, prevention benefits, and managed care.
- A new member is activated every 25 seconds, and the Scheme conducts nearly 35,911 health checks per month.
- On an average working day, DHMS sees 2,785 hospital admissions.

Operational Structure:

The Scheme's structure includes various specialist functions such as:

- **Discovery Care:** Provides advanced medical and clinical advisory support, including complex funding decisions.
- **Specialised Operations:** Focuses on new business underwriting and nondisclosure.
- **Call Services:** Manages the call centre operations daily.
- **Functional Enablement:** Ensures efficient systems and processes.
- **Service Lab:** Ensures global best practices and drives service level improvements. Over 200 people are employed in the service lab.

Customised Service Platform - Evolve:

The Evolve platform, customised for DH, includes forty-two (42) data models designed to:

- Drive efficient pathways through the DH ecosystem for a streamlined and efficient member journey.
- Provide the best possible customer experience through models like the affinity matching model, which matches members with the most appropriate call center.
- Optimise clinical care by identifying the most streamlined pathways, highest quality providers, and most efficient care.

Stakeholder Ratings and Awards:

- Member ratings: 8.7

- Broker ratings: 8.6
- Provider ratings: 9.2
- Employer ratings (with comments from doctors): 9.5
- First Call Resolutions: 77%, therefore 80% of calls are resolved on the first call.

The Scheme implements Lean and Six Sigma operational systems to ensure efficiency, quality, outcomes, and continuous improvement. The Scheme is proud of its industry awards and consistent recognition as a leading medical scheme administrator across various industry surveys in broker and provider categories. Recently, the Scheme won a gold award at the International Insurance Awards for its connected ecosystems and marketplaces through the new DH app. However, these achievements are secondary to the primary goal of providing the best possible service to DHMS members.

Quality, access and cost optimisation

Dr Whelan updated the members on the Scheme's efforts, through services rendered by DH, to improve quality access and cost efficiency, particularly through managed care initiatives.

Value Creation and Cost Efficiency:

Dr Whelan illustrated the annual value that DH creates for DHMS. Using a waterfall chart, he demonstrated how DH aims to enhance cost efficiency across the Scheme. This includes extensive work on establishing the best possible tariffs for hospitals, doctors, pharmacies, and network arrangements. DH's efforts in population health management are directed towards efficient management of the population, including surgical items, prostheses, and medicines. Notably, DH has kept chronic disease medical inflation at 3.8%, but high-cost drug inflation remains around 8% per annum, requiring ongoing negotiations with pharmaceutical partners to ensure member access to these essential drugs.

Fraud and forensic activities result in significant financial recoveries, amounting to R400 to R500 million annually. The "halo effect" of these activities generates an estimated value of R2 to R2.5 billion annually for the scheme. These efforts contribute to R9 billion in yearly savings, leading to 11.1% lower average contributions for DH compared to the next seven open medical schemes. This aligns with Ms Mbewu's earlier statistic of R2.08c worth of value for every rand spent on administration and managed care fees by DHMS annually.

Challenges in Managed Care:

The Scheme faces headwinds, including an aging member base and an increasing prevalence of chronic diseases, which have risen by over 50% since 2015. Predominantly, these chronic conditions include diabetes, cardiovascular diseases (hypertension and hyperlipidaemia), mental health issues, and oncology. Oncology registrations have increased from 1.3% in 2015 to 1.8% in 2023, adding 16,000 cancer patients to the scheme.

Cost inflation pressures are significant, with hospital spend growing by 6.5% per annum, radiology expenditure by 9.8%, pathology by 9.3%, oncology by 12.8%, and high-cost drugs by 7.8%.

Managed Care Strategies:

According to Dr Whelan DH's managed care strategies are structured around five main areas, underpinned by smart benefit design focusing on quality, access, and affordability. These include:

- Corporate Contracting
- Health Professionals Risk Management
- Population Health Management
- Clinical Policy, Medicines, and Medical Devices
- Fraud, Waste, and Abuse Management

Network Plans and Value-Based Care:

Currently, 1.1 million of the 2.7 million lives in DHMS are on network plans, with 60% of new joiners opting for these plans due to their affordability and quality assurance. The network plans facilitate tariff negotiations with hospitals, passing savings

directly to members. DH maintains various networks, including 6,700 specialists, 145-day clinics, and nearly 3,000 pharmacies, all curated for cost efficiency and quality.

Value-based care initiatives and programs focus on chronic dialysis, orthopaedic surgeries (especially knee replacements), cardiovascular care, maternity, spinal care, and day clinic procedures. Hospital-based value contracting evaluates hospitals on efficiency, patient experience, and clinical outcomes, with a hospital care rating index available on the Discovery website.

Healthcare Professional Engagement:

DH maintains strong, collaborative relationships with healthcare professionals through initiatives such as the Future of South Africa Healthcare, engaging with entities like CMS, HPCSA, Pharmacy Council, and Health Products Regulatory Authority. DH participates in approximately one healthcare conference per week and has invested over R300 million in training sub-specialists since 2006 through the Discovery Foundation.

Population Health Management:

DH's population health management initiatives target major spending areas, including diabetes, mental illness, cardiovascular disease, and oncology. These initiatives adopt a predictive and risk-based approach, detecting problems early and managing members based on their risk levels. The initiatives are supported by sophisticated data models, comprehensive chronic care benefits, and a digital healthcare delivery system.

High-Cost Drugs and Oncology Program:

DHMS's market-leading oncology program provides significant value to members, offering unlimited palliative care at home, treatment benefits at 120 chemotherapy facilities, 52 radiation units, and access to 190 oncologists. Dr Whelan highlighted the funding challenges of high-cost oncology drugs, with examples like a 52-year-old male with malignant melanoma incurring R4.3 million in Keytruda therapy costs. The top five oncology drugs include Keytruda (R148.9 million for 209 members), Darzalex (R39.2 million for 64 members), Venclexta (R13.7 million for 62 members), Tagrisso (R12 million for 26 members), and Lynparza (R11 million for 26 members).

DH continues to negotiate with pharmaceutical companies to reduce these costs, ensuring members have access to necessary treatments while maintaining financial sustainability.

Innovation

In conclusion, Dr Whelan spoke briefly about the importance of innovation at DH. He emphasised that innovation is crucial for the scheme to continue driving greater accessibility, quality, and cost efficiency. DH's approach to innovation is guided by global trends and the needs of its members, distilled into five main themes:

- **Healthcare in the Palm of Your Hand:** Members increasingly expect healthcare to be accessible and can be managed via smartphones.
- **Healthcare at Home:** Members prefer receiving healthcare services at home, avoiding the need for travel. This approach provides accessibility and convenience, making it easier for members to manage their health.
- **Personalised and Precise Healthcare:** Members desire healthcare that is tailored to their specific needs, ensuring treatments are both personalised and precise.
- **Value and Values:** Especially among younger members, there is a demand for organisations that prioritise both value and values, reflecting a commitment to ethical practices and social responsibility.

The New DH App:

The DH app offers a range of features to meet these needs. Members can consult with a doctor within minutes, order medicines, and access a cognitive behavioural therapy solution through Silver Cloud, which is the gold standard for treating mild to moderate depression and anxiety. Given the 20% increase in mental health conditions across the Scheme, this digital therapeutic tool, which can only be accessed through recommendation by psychologists or doctors, is particularly valuable.

Digital Health Ecosystem:

DH has developed a comprehensive digital health ecosystem, integrated with HealthID, the electronic health record system used by over 5,000 doctors in South Africa. HealthID enhances the quality of care provided to DHMS members, synchronising medical details based on member consent.

Cost Efficiency and Quality of Care:

There is a significant opportunity to improve cost efficiency and quality of care through day clinics. In the US, 53% of surgeries are performed in day clinics, compared to less than 10% in South Africa. DH is also working with partners to reduce pathology costs, providing bedside pathology services at a fraction of the cost. Additionally, DH has established a broad network of retail-based primary care clinics across pharmacy partners and retailers, increasing convenience and quality of care for members.

Personalised and Precise Care:

DH has developed sophisticated mechanisms for providing personalised and precise care to DHMS members. By combining DH data with Vitality data in a single database, DH has used machine learning models to create optimal pathways for longer and healthier lives. This system offers each of DHMS's 2.1 million adult members a personalised health pathway.

The data-driven approach has shown that physical activity and health actions reduce healthcare costs and improve mortality rates. These insights are delivered through the DH app, which presents members with three "next best actions" tailored to their health needs, including health actions and physical activity goals. Members who complete these actions benefit from improved health outcomes, and the Scheme benefits from reduced healthcare costs.

Shared Value Model:

Dr Whelan concluded by discussing the Scheme's commitment to a shared value model, which is a partnership between members, the Scheme, and society. This virtuous cycle ensures that actions beneficial to members also benefit the scheme and society. DH is anchored in values and a clear purpose: to make people healthier and enhance and protect their lives. This commitment is demonstrated daily, reflecting DH's dedication to both value and values.

The Chairperson proceeded to open the floor for questions on the 2023 financial statements and the presentations provided.

Questions and Answers:

Mr Ronald Silbermann, a long-time member of the Classic Comprehensive Cover, shared his perspective and concerns during the session. He appreciated the presentations acknowledging it as well-executed but characterised it as the marketing policy of Discovery. Mr. Silbermann, who has been with the scheme since its inception 30 years ago, provided insights into how members feel about the changes over the years and their impact on members' lives, particularly for senior citizens.

Mr Silbermann expressed gratitude for the treatment his wife received for cancer, though he faced significant difficulties in the early stages, requiring face-to-face meetings with relevant departments to resolve issues. He raised concerns about certain blood tests not being covered by the medical aid despite being prescribed by professional doctors, often with the excuse of PMB (Prescribed Minimum Benefits) being cited.

Mr Silbermann highlighted confusion over two specific provisions in his policy:
Self-Payment Gap: He expressed frustration about the self-payment gap, feeling that members effectively pay twice—once for the medication and again as it is added to the gap. He noted that the above-threshold benefit, which was previously open-ended, has changed. He acknowledged the need for sustainability, driven by younger members, but emphasised that senior citizens are at a stage in life where they need healthcare and support.

Vitality Points: He shared difficulties with using Vitality points, noting that before the introduction of Discovery Bank, it was easier to manage. Now, one needs a Discovery Bank account to benefit fully from Vitality, which has caused dissatisfaction.

Mr Silbermann also expressed dissatisfaction with the call centre experience, citing long waiting periods before calls are answered, background noise, calls being cut off, and the need to start explanations from the beginning repeatedly. He pointed out that there was no presentation addressing the problems that members encounter.

Response:

The Chairperson reiterated that from the perspective of the Board of Trustees, DHMS is aware of its responsibility to manage funds that belong to its members. The Chair further stated that the Scheme's goal is to use funds effectively to meet members' needs while ensuring the Scheme's sustainability in the medium to long term.

The Chairperson further acknowledges that the challenges faced by the Scheme today are significantly different from those of 10 or even 20 years ago. The burdens include increased chronic disease prevalence, higher utilisation rates, and very high medical inflation. Members must understand that these factors form the context within which the Scheme operates.

According to the Chairperson the Scheme is particularly concerned to hear about the difficulties Mr Silbermann experienced when seeking advice during his wife's health issues. It is crucial for members to receive the necessary support during such times.

The Chairperson assured Mr Silbermann that the Board of Trustees is dedicated to ensuring that the Scheme operates effectively and remains sustainable while meeting the evolving needs of its members. The Chairperson appreciated Mr Silbermann's feedback and assured him that the Scheme will continue to work towards improving their services and support for all members.

To address Mr Silbermann's specific concerns:

1. **Call Center Issues**: Dr Ronald Whelan pointed out that particularly for the Comprehensive Plans and Executive Plans, DH provides an extensive and highly comprehensive set of benefits. This is evident from the higher proportion of members with chronic diseases and complex health conditions enrolled in these plans. The Scheme holds about 87% of the higher chronic disease and more complex populations within the comprehensive and executive cover segments. This highlights the robustness of the benefits provided under these plans.

   In the South African medical scheme environment, all members pay the same contributions within their respective plan levels, regardless of age. This means that as members age and their healthcare needs increase, their contributions remain the same as those of younger members within the same plan.

   Addressing service failures and prescribed treatments, Dr Whelan acknowledges the importance of feedback and sincerely apologises on behalf of the Scheme for any service issues encountered. Dr Whelan emphasised that service failures, such as dropped calls or inadequate responses, are taken seriously, and efforts are continuously made to improve. The scheme monitors service levels closely across all channels and uses various models to identify and address service disruptions. Infrastructure challenges, such as power and internet connectivity issues, are recognised, but the scheme is committed to building redundancy into the system to mitigate these problems. Every call is recorded, and a root cause analysis is conducted to ensure continuous improvement.

   Regarding prescribed treatments and diagnostics, DHMS operates on a strong evidence-based clinical foundation. All benefits are deeply researched and evidence-based. Additionally, the scheme collaborates with doctors and provider partners to address the nuances of medicine that may not be fully covered by research or textbooks. This collaborative approach includes an exception process for managing more complex cases.

   In terms of partnerships with providers like Lancet, the scheme works diligently to provide efficient care to members while reducing costs. Efforts in the pharmaceutical space include collaborating with pharmaceutical partners to lower drug prices, thereby reducing the financial burden on both the scheme and its members. This partnership approach aims to deliver the best possible quality care in the most efficient manner.

   Finally, regarding the feedback on Vitality points and the integration with Discovery Bank, Dr Whelan assured Mr Silverman that this will be communicated to the relevant colleagues at Vitality and Discovery Bank for consideration.

2. **Screening Procedures**: According to Ms Mbewu regarding the limitations introduced for Above Threshold Benefits (ATB), the decision was not made lightly. The Board of Trustees had to carefully balance the various challenges faced by the Scheme.

   The proposals made to the Board considered multiple factors, including the potential impact on members and the overall sustainability of the scheme. Extensive analysis was conducted to understand how many members would be affected and to evaluate the significance of this impact.

   It was concluded that while the population impacted by the ATB changes within the comprehensive plan range is relatively small, the financial value of these changes is significant for the scheme. Moreover, behavioural aspects contributing to these occurrences were identified and needed addressing.

   The adjustments to ATB were introduced to manage and contain these behavioural patterns in a way that would not be detrimental to the broader membership. The aim was to preserve the integrity of the comprehensive plans while ensuring the long-term sustainability of the scheme.

According to Ms Mbewu the Board of Trustees believes these measures are necessary to protect the interests of all members and maintain the Scheme's financial health.

Mr Cornelius Schutte asked the following questions -

- Ms Mbewu to provide the Scheme's perspective on the ideal solvency ratio, and outline DH's strategy to achieve this target.
- Mr Ron Whelan to provide an update on the actions DH is taking to improve its cost competitiveness, given its current position as the fourth least expensive option in its sector.

Response:

Ms Mbewu responded and stated that Mr Schutte's observation is correct regarding the reduction in the scheme's solvency ratio from 35% to 30-31%. The significant reserves built up during the COVID-19 pandemic were due to the reduced healthcare-seeking behaviour, resulting in lower claims and higher reserves. However, as healthcare-seeking behaviour has returned to normal, the scheme has seen an increase in claims, with 91% of contributions currently being paid towards claims, compared to below 90% during the pandemic. This increase in claims is attributed to the resumption of non-emergency admissions that were previously deferred.

The challenge for the scheme is to avoid having excess capital while balancing inflationary pressures and ensuring contributions are responsive to increases in tariffs and other costs. To address this, DH implemented a deferral strategy, tapping into the reserves over time, leading to the reduction in solvency levels.

The regulatory requirement for solvency mandates that for every R1 of contributions, the scheme must maintain R0.25. Maintaining this strictly at R0.25 poses a risk of non-compliance if the solvency ratio falls below 25%. Therefore, the scheme aims to maintain a solvency ratio of around 26.7-27% to ensure compliance and financial stability.

Dr Whelan responded that while DH is not the absolute lowest cost administrator, it is one of the lowest across the environment. The approach to cost management focuses on generating a return on investment from administrative and managed care fees. Achieving this requires the best possible skills, systems, and service teams. DH invests heavily in these areas, employing a high-calibre team of 6,200 professionals, including actuaries, doctors, economists, and other healthcare experts.

This team works on managing the largest part of the scheme's expenditures—actual healthcare costs. The investment in skilled professionals and innovative systems is aimed at ensuring value for members and controlling healthcare costs effectively.

Moreover, DH prioritises innovation, not only for the benefit of its members but also to advance the broader healthcare system. This commitment to innovation is integral to maintaining cost efficiency and delivering high-quality healthcare services.

In summary, the scheme's approach to solvency and cost management is designed to ensure financial stability, compliance with regulatory requirements, and the provision of value-driven healthcare services to its members.

Mr Roelof van der Merwe, who has advanced lymphedema and prostate cancer, was blocked by the Advanced Illness Benefit team leader from accessing institutional care. He acknowledges and approves of DH's innovations and encourages continued excellence in areas where they are performing well. He lost his Gold member status on Vitality due to not being a Discovery Bank client and is dissatisfied with this change. Additionally, he expresses significant frustration with the call centre. He has also received threatening letters from a member of the executive committee regarding potential legal action due to his recent hospital treatments, implying he is taking advantage of hospital fees, and feels he has been unfairly blocked from receiving help due to frequent claims.

Response:

In response, the Chairperson noted Mr van der Merwe's question by asserting that the Board acknowledges his observations about the call centre and will be reviewing its activities closely. Regarding his personal journey, arrangements will be made for someone to meet with him after the meeting to discuss his claim experience in detail, as it involves personal information.

Ms Renita Moonsamy notes a slight disconnect between the scheme's objectives and the administrator's role. The scheme has excelled in cost containment, efficiency, access to quality, and member-managed care services, with significant improvements over the past five years. However, there is a lack of clarity on the proactive measures being put in place to address future events similar to COVID-19, from both fiscal and membership management perspectives.

Regarding managed healthcare and strategic planning, there are concerns about the reliance on AI and data training models, which are still in their infancy. Decisions based on these models may not be fully accurate, and Ms Moonsamy emphasises the need for continued human intervention in data application to management decisions.

Innovation and strategic direction are also key points. While the scheme has introduced new products like value-based care for diabetes and cardiac management, more needs to be done to subcategorise members based on various factors to better project risk factors and prepare accordingly. Specifically, with the increasing need for mental healthcare, Ms Moonsamy questions the scheme's influence on the industry to create necessary infrastructure, such as bed space and new medications. While current management efforts are commendable, there is a need for a clearer picture of the strategic vision and how current innovations are driving forward-thinking initiatives.

Response:

The Chairperson addressed future risk management, assuring that any decisions made by the Board of trustees regarding increasing contributions or changing benefits are based on a comprehensive actuarial review. This review considers short-term, medium-term, and long-term future prospects, ensuring that all decisions are well-thought-out and aligned with the scheme's objectives.

Dr Ronald Whelan discussed the Scheme's approach to AI data training, emphasising a population health management strategy. He highlighted the alignment with DHMS in driving more effective population health management, particularly concerning chronic diseases and preventive actions based on lifestyle and health-seeking behaviours.

Dr Whelan mentioned the cautious approach to integrating emerging technologies and greater personalisation of healthcare, with over a year of extensive actuarial and clinical work, and input from international and local experts. He assured that no clinical pathways are being prescribed and that all actions are monitored for accuracy and safety.

The Scheme is committed to thorough analysis, investigation, and research, ensuring that new tools and technologies are integrated responsibly, similarly to how they evaluate new drugs and technologies before establishing funding guidelines. The focus is on sequencing actions correctly and promoting the right habits to benefit members without causing harm.

The Chairperson proceeded to address questions that were received by Members attending the AGM virtually.

A question was received via the online platform from Mr Mduduzi Nhlebela asked" How *is cutting out two primary GP's to one a cost factor optimisation?"*

Response:

In her answer Ms Mbewu explained that the decision was made to balance access to care with the need for coordinated care. Research indicates that healthcare outcomes are better when members consistently see a single GP rather than multiple GPs. This approach also leads to better utilisation, which is particularly important given the higher utilisation rates and chronicity within the KeyCare package compared to other packages offered by DH. The measure aims to maintain access to care while considering the financial impact on the scheme.

Ms Nellie Brand-Jonker enquired "*Why is medical inflation currently at 5% when in previous years the difference with CPI was around 3%? Will this trend continue and impact our increases next year?"*

Response**:**

The Chairperson stated that factors influencing medical inflation are largely beyond the Scheme's control, although efforts are made to address them innovatively. Ms Mbewu explained that medical inflation is influenced by several factors. Tariff increases generally align with CPI year on year. However, demand-side factors, such as the chronicity and diagnosis of diseases, and supply-side factors, such as new, higher-priced health technologies, contribute to the overall inflation. Innovations in diagnostics and treatments drive up costs.

The Scheme employs risk management initiatives to mitigate the impact of medical inflation, including addressing fraud, waste, and abuse, and keeping non-healthcare expenses below CPI. Post-COVID-19, there has been an increase in utilisation

rates within the scheme due to the ongoing impact of the disease, contributing an additional 1.5% to medical inflation. These factors combined result in fluctuations in medical inflation.

Mr Dylan Dominic Busa asked, "*What is the Scheme's stance on the NHI, and what are the details surrounding the litigation action the Scheme plans to take against it?*"

Response:

The Chairperson clarified that the Scheme fully aligns with the objectives of the NHI Act and supports the concept of a National Health Fund. However, the Scheme has concerns about specific provisions in the Act and plans to challenge these through litigation. The challenge focuses on two main constitutional issues:

1. **Lack of Clarity:** The Act does not provide certainty about what services the fund will cover, how these services will be accessed, or how the fund will be administered. This lack of detail raises significant concerns.
2. **Right to Healthcare:** Section 27 of the Constitution guarantees everyone the right to access healthcare services, and the government must progressively realise these rights according to available means. The Scheme argues that the Act, by potentially removing existing access to healthcare services for medical scheme members, could be retrogressive. Additionally, if the Act is not clear and its implementation is not feasible, it could negatively impact everyone's access to healthcare services.

Thus, the challenge is not solely focused on the rights of medical scheme members but on the broader issue of ensuring everyone has access to healthcare services.

The Chairperson acknowledged that there were no further questions from the virtual attendees and continued to take questions from Members attending in-person.

Mr Priss Moima[1] enquired whether DHMS and DH can align with the NHI and the NDoH in the implementation of the NHI considering that the scheme has highlighted its support of universal health cover.

According to the Chairperson DHMS and DH have actively engaged at all stages of formulating the NHI legislation, making submissions to parliamentary committees. The Scheme has emphasised their support for universal health coverage but have highlighted serious flaws in the legislation that could impact both scheme members and all users of NHI health services. Despite extensive efforts and detailed submissions, these concerns were not addressed as the bill passed through the National Assembly and the National Council of Provinces unchanged. DHMS and DH have petitioned the President, reiterating their concerns. Moving forward, the Scheme stresses the importance of collaboration between medical schemes and the administrators of the NHI Fund to address these issues effectively.

Mr Jabulana Mabobo enquired about communication with Members in relation to the NHI and what is envisioned and the differences that will arise with the involvement of the Government.

Response:

The Chairperson indicated that the reason behind the Members not having been communicated with effectively in regard to the arising changes with the NHI is as a result of the Government and NHI Act has not certainly highlighted the benefits of the Act, the benefits that will arise for Members as well as the funding for the NHI.

Ms Sharon Henderson enquired about the Trustees considering extending the age of child dependents who are considered as "children". She further enquired what the Scheme is considering in terms of its reserves and considering using the reserves to assist Members when they are experiencing financial constraints.

Response:

The Chairperson advised her that affordability as well as dependents will be taken into account when benefit reviews are conducted and reviewed by the Board of Trustees. Ms Mbewu further added that there are limitations that are experienced due to the Medical Schemes Act. There are initiatives that the Scheme attempt to implement to relieve members from an affordability perspective and these need to remain within the realms of the Act.

[1] This is the gentleman who is not a DHMS principal member but was able to ask a question at the AGM.

The Chairperson closed the floor for questions relating to the financial statements in the interim and advised members that there will be an additional opportunity to pose questions in relation to the business of the AGM.

4 Governance

4.1. The Scheme's Trustee Remuneration Policy and approval of the 2024 Trustee Remuneration:

The Chairperson introduced the Chairperson of the Scheme's Remuneration Committee Mr Bongani Hlophe. Mr Hlophe's role is to provide context on two crucial agenda items requiring members attention for approval through voting. The first pertains to the trustee remuneration policy, recommended by the Remuneration Committee chaired by Mr Hlophe and approved by the Board of Trustees for presentation at this AGM. Members participation in the non-binding advisory vote on this policy is pivotal as it informs the Scheme's approach to trustee remuneration now and in the future.

The second item is the proposed trustee remuneration rate for 2024, set at R4515 (exclusive of VAT), which also requires members approval. This rate reflects a 6% adjustment from the previous year, derived from the Scheme's September budget cycle.

The policy underscores the Board of Trustee's oversight responsibility, delegated to the Remuneration Committee comprising two trustees, including the Chairperson, and two independent members such as Mr Hlophe. It adheres to Circular 41 guidelines from the CMS, detailing considerations like meeting frequency, duration, and preparation time in determining remuneration.

The Scheme's methodology employs a professional fee structure based on hourly rates, distinguishing between ordinary trustees and committee Chairpersons. For instance, preparation time for a board meeting averages 28 hours, with an hourly rate applied to each trustee's commitment, resulting in budget allocations tailored to their roles.

Importantly, the policy excludes training costs, consulting fees, and incentive participation while reimbursing trustees for reasonable expenses incurred in fulfilling their duties.

In terms of expenses, trustees are reimbursed for reasonable costs incurred during their duties, such as parking fees. Discussing the policy framework and methodology for determining the rate, Mr Hlophe delved into how the scheme differentiate between Chairpersons and trustees.

Starting with the Chairperson of the Board, the Scheme's approach is guided by established methodologies, including those from Circular 41. Preparation for a Board meeting typically spans about two days, with an allocated 20 hours for preparation. Given our average 8-hour Board meetings, this totals 28 hours per meeting. With 8 scheduled meetings annually, this sums up to 224 hours. Applying the proposed hourly rate results in a budget of 1,011,000 rand for the Board of Trustees Chairperson.

For trustees, preparation time averages a day before meetings, with an allocated 8 hours per session. With an average of 8 meetings annually, trustees dedicate approximately 128 hours per year to their responsibilities. Multiplying this by the proposed rate yields a budget of 578,048 rand for each trustee.

Turning to committee chairs, exemplified by the audit committee meeting four times yearly, preparation typically involves about 11 hours per meeting, totalling 62 hours annually. This equates to a budget of 279,992 rand per committee chair based on the proposed remuneration rate.

This structured approach underscores the Scheme's adherence to Circular 41 guidelines and ensures fair compensation aligned with their operational needs and regulatory obligations.

In conclusion, Mr. Hlophe encouraged members to vote for the approval of both the trustee remuneration policy and the proposed 2024 trustee remuneration rate.

Questions

Ms Mbali Manana raised the remuneration for Trustees and them also being remunerated in their capacity as Committee Members. She enquired what the selection criteria is for Board of Trustees becoming members on the Committees.

Response:

In response to Ms Mbali Manana's inquiry regarding the remuneration of trustees serving on committees beyond their Board roles, Mr Hlophe reiterated the scheme's policy that trustees are compensated for their work on subcommittees. He

provided an example of the Board's participation in committees such as Remco, underscoring that trustees are required to be committee members as part of their eligibility criteria.

The Chairperson addressed the selection criteria for committee assignments, emphasising the importance of aligning trustees' skills and expertise with the specific mandates of each committee. For instance, trustees with clinical medical backgrounds are considered suitable for the Clinical Governance Committee, while those with a blend of clinical and actuarial risk skills are ideal for the Products Committee. This approach ensures that committees benefit from a diverse range of relevant expertise.

Mr Cornelius Schutte highlighted that per the annual report, Trustees account for ZAR 12 million of the budgeted funds and ZAR 8 billion on administration. He further asked why time is spent discussing the Trustees remuneration, rather than the Administrative costs of the Scheme, which are the part of the Scheme's largest expenses.

In addition, he enquired about the appointment of Trustees by members and the risk of appointing a Trustee who lacks the skills and is being remunerated per the approved Trustee remuneration.

Response:

The Chairperson indicated that the issue of Administration costs has been addressed in detail and will continue to be addressed extensively moving forward.

Regarding the query about member Trustees being elected without members' knowledge of their knowledge and skills, Mr Hlophe clarified that all Trustees, whether appointed or elected, bear the same fiduciary duties. He affirmed that the remuneration Principals are consistently applied across Trustees, regardless of their method of selection. Any performance-related concerns are handled internally within the Board, ensuring accountability and alignment with the scheme's objectives.

This structured approach reflects the Scheme's commitment to effective governance and strategic alignment of trustee roles within its committees.

Ms Mbewu added that it is good practice and good governance to table the Trustees remuneration to the members to ensure that there is a level of accountability.

5 Motions

The Chairperson advised that there is only one item for tabling this year which reads as follows "Trustees to conduct a review of key care plan plus benefits with particular focus on reinstating unlimited or increasing the number of casualty visits per year allowing the selection of two primary care physicians the administration involved in service providers and members as well as the casualty visit fee available by members."

Principal members who were in attendance either virtually or physically were required to vote either for or against the motion or to abstain from voting.

6 General

The Chair invited questions relating to matters of the AGM.

Mr Edward Sepirwa emphasised the importance of avoiding a blanket approach when assessing cases, cautioning against dismissing matters as cosmetic or non-urgent. He stressed the need for thorough evaluation and proper therapy, advocating for intentional aftercare treatment for members. Mr. Sepirwa called for Trustees to take a more proactive role in ensuring comprehensive and attentive care for all members, reflecting a commitment to prioritising individual needs and effective healthcare management.

Response:

The Chairperson and the Dr Ronald Whelan asserted that the contributions and cautions made by Mr Edward are noted with great pleasure. Dr Whelan added that Health ID is utilised by doctors to access benefits for the members and to follow-up with health-checks for the members. Ms Mbewu further added that there is a proactive intervention by the Scheme to assist members and beneficiaries to navigate their health concerns through the healthcare system and issues especially where a multidisciplinary approach is required.

Mr Stanley Mangena enquired about the issue of the NHI, and the legal battle associated. He requested clarity on the possible implications on the Scheme, should the litigation be unsuccessful. In addition, he asked whether there have been any engagements with employer groups who subsidise employees' premiums regarding the matter as it would raise a risk that employees would have to start paying higher premiums.

Response:

In response to a question about the potential impact on medical Schemes if the Scheme were to lose the litigation battle against the state regarding the NHI Act, the Chairperson explained that under the current Act, once the NHI is fully implemented, medical schemes would only cover expenses for services not provided by the NHI. The extent of this impact would hinge on the specific services covered by the NHI and the mechanisms for accessing those services by registered users.

Section 33 of the Act stipulates that this provision will only become operational upon full implementation of the NHI, which the Chairperson noted is likely a distant prospect. In the interim, the government is expected to continue developing the necessary infrastructure for the NHI, as it has already begun in some areas. Therefore, while there is a potential future threat to medical scheme coverage under the Act in its current form, the Chairperson emphasised that this scenario is not imminent or expected in the near to intermediate future.

The critical factors leading up to potential changes include the establishment of NHI infrastructure, determination of benefits provided, and the funding mechanisms to support these benefits. These considerations will shape the landscape for medical schemes and their members in the evolving healthcare environment.

Ms Mbewu added that employers have been raising their own concerns about the implications of the bill on their employee base. Dr Whelan added that the concerns about the economic effect of the bill as well as the impact on scarce skills, such as healthcare professionals and the impact that this will have on their practices.

A question was posed by Mr Thamsanqa Xaba on whether is a reason that excess payments for procedures are not paid directly to specialist doctors when required and payments are facilitated by the member.

Response:

In response to questions about costs incurred by the Scheme, the Chairperson emphasised that they maintain a vigilant oversight over expenditures. This careful monitoring ensures that financial management remains stringent without compromising on essential actions required to facilitate maximum participation of members. In addition, when a claim has been made by a member, there is a key challenge with assessing whether the member has made payment to the specialist doctor prior to claiming the co-payment from the Scheme or whether the payment still needs to be made directly to the specialist doctor. The primary relationship of the Scheme is with the member.

The Chairperson proceeded to acknowledge a question raised by a member on the virtual platform.

Mr Ebrahim Hoosen asked "*CMS highlighted DHMS as having high AGM costs. What is the scheme doing to address this?"* Mr Silbermann further enquired whether the Scheme considered the costs of hosting the AGM at the Maslow, as opposed to 1 Discovery Place, as it was previously hosted in the prior year.

The Chairperson highlighted that CMS provided insight into how Schemes could increase participation by members. She further explained that the Regulator was engaged on the reason for the increased costs of the 2022 AGM as the intention was for the AGM to be an in-person one. It was later decided, that due to COVID-19 restrictions at the time, to decide to host a virtual AGM. Several costs had already been incurred at the time. One consideration is that during an election year, it is advisable for the Scheme to utilise a venue that is independent and distinct from the administrator's venue. In responding, Ms Mbewu emphasised the importance of protecting Trustees from accusations of conflicts of interest. She highlighted that holding elections at the premises of an employer group could create perceptions of favouritism towards related parties. Therefore, it is advisable for the Scheme to use an independent venue separate from the administrator's venue during election years, aiming to mitigate potential conflicts of interest.

The Chairperson noted that there are no further questions and proposed to move to the voting. She added that questions that were posed online and not attended to during the meeting, would be engaged with after the business of the AGM has been concluded.

7 Voting and closure of the AGM

The Chairperson noted that voting will remain open strictly until 16:00.

Matters to be voted on include the following:

7.1. 2024 Trustee Remuneration

7.2. Non-binding Advisory vote on the Trustee Remuneration Policy

7.3. The Motion placed before the meeting

7.4. Trustee Election

There being no further business, the Chairperson thanked all members for attending and engaging with the Scheme and declared the AGM closed.

[*Note: the use of sign language interpreters was used throughout the proceedings of the AGM*]