Discovery
Health Medical Scheme
Integrated Report
2020
We exist for our members
Discovery Health Medical Scheme registration number 1125

Why join DHMS?

We exist for our members.

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

We place members at the centre of care and ensure that it is their healthcare that matters. We engage in many quality of care initiatives and monitor these carefully, striving to ensure our members have access to the safest, most efficient and effective healthcare available in South Africa.

As a non-profit organisation, we strive to ensure that our limited sources of income are used optimally for the funding of member claims and benefits.

Safeguarding our members' interests

ROBUST GOVERNANCE

DHMS is a non-profit organisation governed by an independent Board of Trustees. Our robust governance structures and processes protect members' interests and ensure the Scheme creates outstanding value for them and our other stakeholders, through our business model. Members elect at least half of our Trustees at any time, ensuring direct representation.

THE COUNCIL FOR MEDICAL SCHEMES (CMS)

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

How we measure our performance

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

Our value story

How we create, protect and limit the erosion of value for our members is largely determined by our operating context and meeting the needs of all our stakeholders. We assess these factors to determine our material matters, which inform the development of our strategic themes and the management of our residual risks.

Our business model depicts how we make use of and impact on the core capitals relevant to our business activities, as a provider of best practice medical schemes governance and thought leadership in our industry.

COVID-19

The impact of the pandemic on our members and other stakeholders, and the healthcare system as a whole, has been dramatic. Our condolences to those who have lost loved ones and colleagues, and our thanks to our frontline healthcare workers for their heroic work in caring for our members and the nation.

The effects of the COVID-19 crisis on the Scheme and our response to it in caring for our members, is discussed in our Chairperson's Statement and Principal Officer's Review. The pandemic also features in our material matters, strategic themes and risks, and our performance.

Leadership reviews

Our Chairperson's Statement and Principal Officer's Review provide a strategic overview of the Scheme's story for the year, which is detailed in subsequent chapters.

Our place in society

We take our corporate social responsibility seriously, which is underpinned by our ethics, values and culture, and support of Treating Customers Fairly principles. We take great care in engaging with and meeting the needs of all our key stakeholders, including members, healthcare providers, financial advisers, employees and regulatory bodies.

IN THIS REPORT

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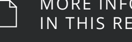

MORE INFORMATION IN THIS REPORT

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01

ABOUT DHMS

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 758 340 beneficiaries at 31 December 2020, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.0%[1].

DHMS is a non-profit entity governed by the Medical Schemes Act (the Act)[2] and regulated by the Council for Medical Schemes (CMS). The Scheme belongs to its members and an independent Board of Trustees (the Trustees or the Board) oversees its activities.

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd through a formal contractual arrangement. Through our partnership with Discovery Health, and with healthcare providers, we strive for seamless integration of services to provide quality care for our members, and the highest possible cost efficiency; in the context of severe socio-economic conditions and a fragmented and inflationary healthcare system.

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

1 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2020 (www.medicalschemes.co.za/publications/#2009-2010-wpfd-annual-reports).*

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

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Why join DHMS?

Quality of care is key to our membership proposition

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

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

We exist for our members

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

We'll be here for you

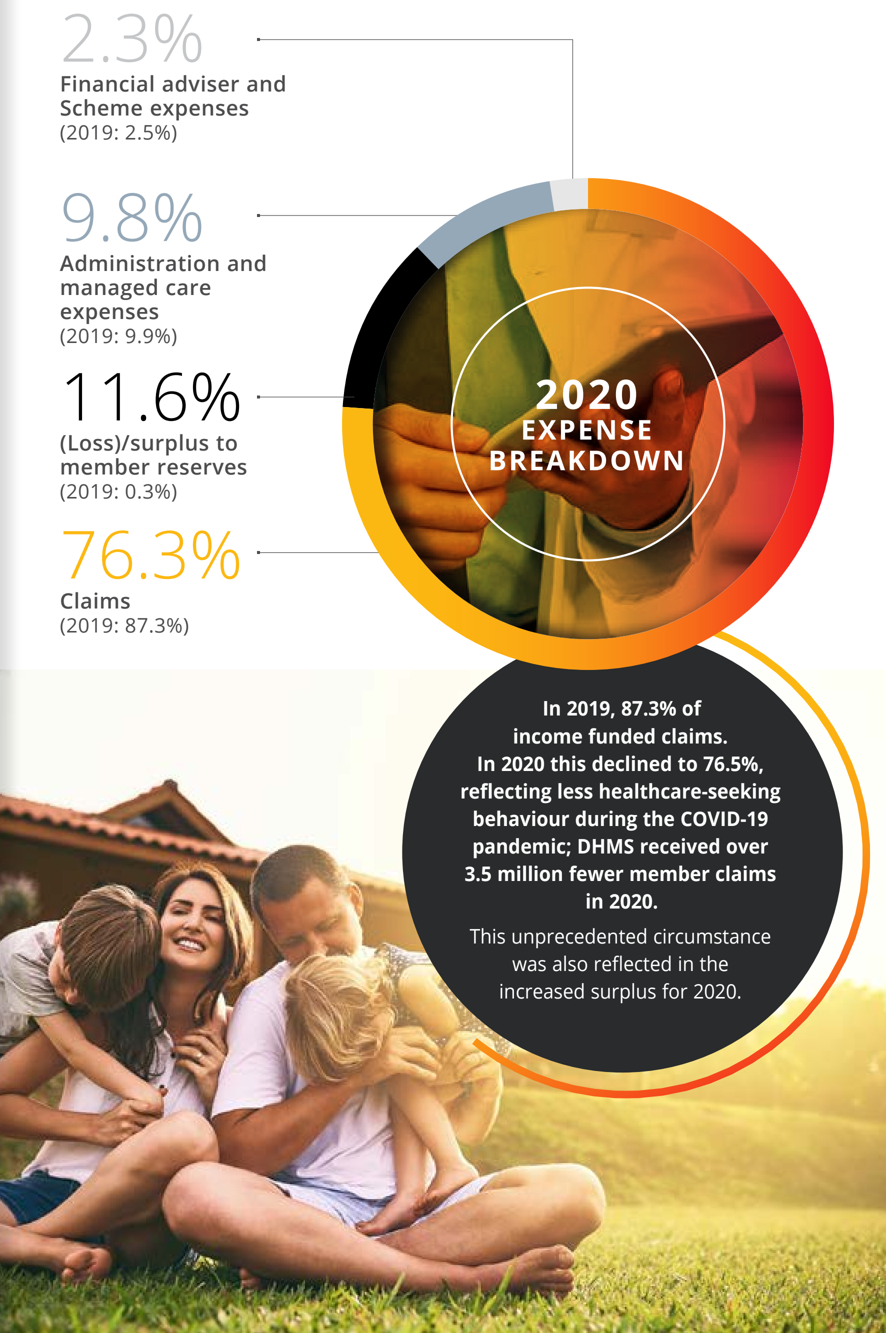
Financial strength and sustainability are key factors to consider when selecting a medical scheme. Sound financial control and risk management enable the Scheme to maintain its required solvency reserve levels, which ensures its ability to pay claims even when they are unexpectedly high.

We make sure your investment in membership takes care of you

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

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

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



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02 About our report

Our Integrated Report demonstrates the accountability of the Board of Trustees of Discovery Health Medical Scheme to our members; in the context of our core service to our members, which is best practice in medical schemes governance and thought leadership in our industry.

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

The COVID-19 pandemic has added substantial economic, social and psychological pressure in an environment that was already characterised by high uncertainty, above-inflation increases in healthcare costs and significant regulatory change and policy shifts. In this context, our Report sets out the Scheme's efforts to work in the best interests of our members, while balancing the needs and expectations of our various stakeholders. Achieving this balance underpins the Scheme's financial, operational and relational wellbeing. In turn, as the largest open medical scheme in the country, this supports the overall capacity and viability of the private healthcare industry and the betterment of the national healthcare system.

Board of Trustees responsibilities and approval

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

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

SIGNED ON BEHALF OF THE TRUSTEES ON THE 14 APRIL 2021

Neil Morrison **Chairperson**

Johan Human **Trustee**

Charlotte Mbewu **Principal Officer**

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Scope and boundary

This Report covers the benefit year from 1 January 2020 to 31 December 2020, also referred to as the 2020 financial year (the year). In addition, it discusses material developments in early 2021 up to the date of approval of this Report by the Trustees.

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

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

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

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Process disclosures

REPORTING FRAMEWORKS

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

We note the amended IIRF and are working to incorporate its recommendations. To this end, we have remodelled our business model, to distinguish more clearly between the Scheme's core capital inputs, output, and between the value outcomes that pertain specifically to our members and to our other stakeholders. We have also employed our material matters to improve the connectivity of our Report, especially related to the constraints to our core capital inputs, and how we are managing these through our strategy and in mitigating our residual risks to drive differentiated value outcomes for our members and other stakeholders.

> This Report assesses our propositions, interactions and outcomes related to key stakeholders, which underpin our ability to create, preserve and limit any erosion of value for our members.

MATERIALITY DETERMINATION

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

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

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

AUDITOR INDEPENDENCE

PricewaterhouseCoopers Inc have audited the Scheme's Financial Statements. Rotation of the designated partner forms part of the independence assessment, and the current audit partner assumed the role for the audit of the financial year ended 31 December 2019. The Audit Committee is satisfied that the auditor is independent of the Scheme.

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

INTEGRATED REPORT PREPARATION AND APPROVAL

Scheme management prepares the Integrated Report, under the direction of an experienced and expert executive responsible for gathering, vetting, drafting and co-ordinating the approval of qualitative and quantitative information submitted by the relevant information owners. The executive is supported by specialist internal functions such as governance, regulatory, clinical, financial, actuarial, risk management and strategy development and implementation; as well as external specialists in integrated reporting and report preparation.

Following a detailed review by the Audit and Stakeholder Relations and Ethics Committees, the Audit Committee recommends the Integrated Report to the Trustees for approval. External auditors provide independent assurance of the Financial Statements.

COMBINED ASSURANCE

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

The model is based on three lines of defence:

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

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

THIRD LINE: management and the Trustees obtain external assurance on the Scheme's financial performance and internal control frameworks from the Internal Audit function, external audit and an independent actuarial firm.

Internal reporting related to the assurance process provides insight and data that are applied in preparing the Integrated Report.

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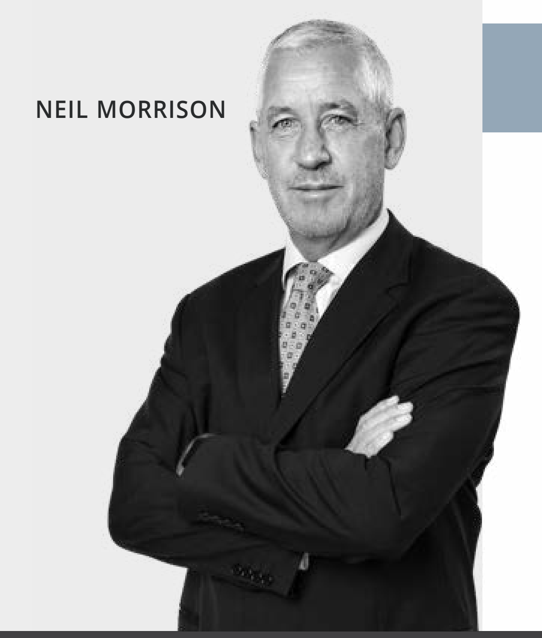
LEADERSHIP REVIEWS



NEIL MORRISON

Our Chairperson's Statement

The healthcare industry has borne the brunt of COVID-19 in many ways, including the heavy toll on frontline workers. The Trustees are deeply grateful for their heroic work in caring for our members, and the nation.

COVID-19 has had an unprecedented socio-economic impact on the country. Although the domestic and global economies have begun to recover, some analysts predict that this is unlikely to be linear or U-shaped, but rather a K-shaped recovery. This means some industries and sections of the population will recover rapidly and even thrive, while others deteriorate further. This threatens to deepen inequality and poverty here at home and worldwide.

The DHMS strategy, and the innovations implemented on our behalf by Discovery Health, have assisted us to respond quickly and decisively to the changing landscape. We have ensured that our members are still able to access quality healthcare, seamless services and additional support. Ongoing engagement with our members has been supported through our website, a new WhatsApp channel, and in-hospital advice about benefits.

COVID-19 remains at the forefront of our deliberations as we work to ensure that our members have access to appropriate treatment and care; and vaccines. Our promise to our members to be thought leaders in our industry, and to be agile and responsive to their needs, came together in the World Health Organisation (WHO) Global Outbreak Benefit, launched quickly after the onset of the pandemic. We also provided members with extensive and reliable information and support, and offered innovative and effective benefits such as virtual consultations to keep both members and healthcare providers safe.

We also sought to balance member needs with the stark financial reality of COVID-19 and affordability constraints, by offering some contribution relief to members and SMMEs.

The effective collaboration between government, business and both the public and private healthcare industries in response to the pandemic has been encouraging. This bodes well for our work in 2021 as the nation seeks to achieve population immunity and respond to other significant challenges, such as a third wave. We look forward to making COVID-19 vaccines available to our members as soon as possible, in line with the rollout prioritisation of the National Department of Health. The Scheme will focus on ensuring access to the efficient administration of safe and effective vaccines. To this end, the Scheme has sufficient reserves in place to fund COVID-19 vaccines for all our members that require it.

COVID-19 has resulted in an unprecedented decline in utilisation, largely due to the postponement of non-urgent hospitalisation and patient aversion to potential risk of infection in some healthcare settings. Consequently, like many other medical schemes, DHMS ended 2020 with a financial surplus. However, this situation is expected to reverse in 2021 and 2022 as pent-up need for care is released and schemes must budget for additional COVID-19 care costs and vaccines, along with the normalisation of claims.

"COVID-19 remains at the forefront of our deliberations as we work to ensure that our members have access to appropriate treatment and care; and vaccines.

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We also foresee disease severity increasing due to postponed healthcare screening and treatment. This places DHMS in an unusual situation, as we will need to plan and budget for the next two to three years, given the likely erosion of our surplus combined with a worsening claims experience.

The pandemic places even more focus on the Scheme's long-term approach to population health management, in particular non-communicable diseases. DHMS, together with Discovery Health, have over several years implemented managed care programmes underpinned by value-based care principles, such as DiabetesCare, to support our members and optimise clinical outcomes.

Our unexpected claims experience in 2020 enabled us to forgo any increase in contributions for the first six months of 2021. We will need to implement an increase in July and have committed to contain that to a maximum of 5.9%, subject to approval by the CMS. We hope that this goes some way to assisting members through this difficult time.

Every year, the Trustees assess the value provided by Discovery Health through their administration and managed care services to the Scheme. The methodology we apply has been independently reviewed and confirmed as reasonable[1]. Since the assessment began in 2014, Discovery Health has provided more value to our members than the Scheme has paid for. In the 2019[2] financial year, Discovery Health added nominal value of R7.09 billion (2018: R7.34 billion). Put differently, for every R1 paid, our members received R2.03 in value.

This year we look forward to welcoming the members of Quantum Medical Aid Society, subject to approval by regulators and the members of both schemes. QMAS proposes to amalgamate with DHMS, and we held a Special General Meeting to obtain our members' approval for this beneficial arrangement.

Regulatory engagement and advocacy are important aspects of the Scheme's work. During 2020, we contributed to many CMS-led discussions such as those pertaining to the Low-Cost Benefit Option framework, currently being developed. Through this mechanism we hope to make private healthcare accessible to more people. While National Health Insurance engagements were postponed due to the pandemic, they should resume in 2021. We hope that the beneficial working relationships and the value of closer public-private partnership in the past year, will enable effective and constructive advances towards universal healthcare in South Africa.

Another important development underway is the Section 59 investigation into fraud, waste and abuse (FWA) practices in our industry. In February 2021, the Investigation Panel released their interim report for comment. We note the Panel's confirmation of the legality, and indeed necessity, of the Scheme's efforts to combat FWA and recover funds for our members. We were deeply concerned by the allegations of racial bias made to the Panel about these procedures, and have engaged closely with Discovery Health, who conducts FWA investigations and recoveries on behalf of the Scheme, and with the Panel's report. We note the Panel's confirmation that it has found no evidence of explicit bias and we support the submission by Discovery Health, based on independent expert review, that there is in fact no racial bias in any form in its FWA activities.

The Trustees are accountable for the oversight and governance of the Scheme, to ensure our members are served with excellence and innovation, in fulfilment of our purpose and in realising our vision. To this end, we continue to be vigilant to ensure compliance, and we regularly review our governance practices to align them to global best practice.

In closing, I thank my fellow Trustees and our Independent Committee Members, who have given dedicated and thoughtful service to the Scheme and our members. Adv Joan Adams and Dr Susette Brynard, whose terms were due to expire in 2020, have agreed to remain as Trustees until we hold elections, and our AGM, which were postponed due to lockdown regulations. The CMS exempted the Scheme accordingly, and these will go ahead during 2021.

I must also thank our Principal Officer, Charlotte Mbewu, who has been a steady hand at the helm in these turbulent times. Ms Mbewu was our Chief Financial Officer and appointed Acting Principal Officer in 2019, and the Trustees were delighted to confirm her appointment as Principal Officer from 1 July 2020. We welcome Joy Malete, appointed as our Chief Financial Officer on 12 April 2021. We are pleased to have a person of her experience and expertise on board given the challenges ahead. The Principal Officer is supported by a dedicated, highly skilled team. The Trustees thank each of them for their resilience and commitment to our members, and to the Scheme's long-term financial, operational and relational wellbeing.

Finally, our deep condolences to our member and stakeholder community who have lost loved ones and colleagues through the COVID-19 pandemic. The Scheme will continue to do everything in our power to minimise the impact and severity of the disease, by ensuring our members have access to appropriate benefits and by delivering innovative supportive measures.

MR NEIL MORRISON
Chairperson

1 *The Scheme engaged Deloitte Actuarial Consultants to perform an actuarial peer review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2018 to 2019 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed.*

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

Our Principal Officer's review of the year

CHARLOTTE MBEWU

Our unwavering focus on our purpose, and knowing that we exist for our members, held us in strong stead amid the devastation caused by the COVID-19 pandemic. This inspired us to find effective and innovative ways to support and care for our members in unprecedented circumstances.

> Heightened awareness of the criticality of managing chronic conditions will support the expansion of our care programmes.

The Scheme, working closely with Discovery Health, introduced innovative initiatives and expanded benefits in response to COVID-19. We extended the WHO Global Outbreak Benefit, adding to this basket of care as new understanding and developments in diagnostic testing, treatment and care became available. For members who could not self-isolate at home, we provided dedicated facilities and services in an effort to reduce the spread of the disease. Healthcare workers were available to assist members with symptom management and monitoring in these facilities. We also made pulse oximeters (devices to track oxygen saturation levels) available to high-risk members, which decreased mortality rates. By leveraging digital platforms we were able to meet the needs of our members, while keeping them and their doctors as safe as possible.

The pandemic required a shift in care models. We rapidly facilitated the move to digital health and a shift from hospital to outpatient care settings, including home-based. Strong adoption of the virtual facilities we made available motivated the launch of Connected Care, an ecosystem of benefits, services and connected digital capabilities to help our members manage their health and wellness at home. While our members still have access to hospital facilities when needed, the success of our Day Surgery Network and the adoption of virtual consultations indicate the effectiveness these new care models in meeting specific healthcare needs in a changing care environment. In assessing the value of these new services, we continue to ensure that they support optimal healthcare outcomes.

Heightened awareness of the criticality of managing chronic conditions, strongly implicated in morbidity and mortality related to COVID-19, have reinforced the importance of screening and promotion of health-seeking behaviour, which will support the expansion of our care programmes. The demographic profile of our members has gradually worsened over the last several years, exacerbating health risk for members as new diseases emerge. Ongoing health management through managed care will therefore remain a cornerstone of our approach.

Besides these specific benefits, the impact of the pandemic on the affordability of cover prompted the Scheme to assist members and employers in financial difficulty. Qualifying members with positive balances in their medical savings accounts could use these to cover their contributions, and qualifying SMMEs could defer employee contributions for a specified period.

More broadly, and also likely to be exacerbated by the longer-term socio-economic impact of the pandemic, mental wellbeing is a growing concern for the Scheme. This has been underlined as claims associated with mental health conditions continue to increase, consistent with the global trend. In 2020, the Scheme expanded the benefits for major depression, beyond the prescribed minimum, to include chronic medicines funded from the risk benefit. Recognising that certain people suffering from depression tend to require re-admission to care facilities, we have enhanced the mental health disease management programme to encompass more comprehensive and holistic care co-ordination.

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Other benefits introduced in 2021 include a Spinal Care Programme and a colorectal surgery centre of excellence. Both of these aim to improve outcomes in these common and often devastating health events. We have also introduced a continuous glucose monitoring benefit, and enhanced access to coaching and management, for members registered on our Diabetes Care management programmes. Diabetes, if untreated, can result in blindness, kidney failure and heart attacks and our care programme aims to protect against these complications. The telemetric glucose monitoring devices can also monitor conditions like chronic obstructive pulmonary disease, congestive cardiac failure and pneumonia, so this benefit extends to members with these conditions. We will also launch an assisted reproductive therapy benefit in 2021, available to members depending on the plan they have chosen.

The Scheme engages frequently and constructively with our regulators and policymakers for positive change in our industry, and to co-create a stronger national healthcare system. We are grateful for the support we received from the CMS, especially during the pandemic, which enabled us to quickly introduce measures to support our members. We also note that the Minister of Health's performance scorecard includes specific targets and deadlines to achieve universal health coverage and to oversee the implementation of the Presidential Health Compact interventions, designed to strengthen the healthcare system. We applaud the drive by the Department of Health to achieve these imperatives, to the benefit of all South Africans.

> The Scheme engages frequently and constructively with our regulators and policymakers for positive change in our industry.

We look forward to resuming our engagements on the NHI Bill, and hope to present to the Portfolio Committee on Health. We also note the Portfolio Committee's interest in the investigation into allegations of racial discrimination and unfair practices by medical schemes and administrators related to combatting fraud, waste and abuse in our industry. Discovery Health submitted a response to the interim report on 5 April 2021, and we await the final report and recommendations. We welcome the Investigation Panel's findings that no evidence of any bias, racial or otherwise, was found in the processes and systems employed by Discovery Health on the Scheme's behalf, and its recommendation that no changes to the Medical Schemes Act are needed regarding the powers of schemes to recover member funds fraudulently disbursed. We also welcome the Panel's acknowledgement of the serious adverse consequences of FWA on medical scheme members' funds, the affordability of healthcare insurance cover and the broader South African health system.

The impact of the COVID-19 pandemic and related national lockdowns were, unsurprisingly, the most notable factors affecting the Scheme's financial performance in the year. The Scheme experienced a net decline in membership of 1.57% in 2020 and only marginal growth of 0.06% in 2019, reflecting the weak economic conditions and the contraction of the employment market even before the advent of the pandemic. In 2020, in line with the experience of other medical schemes, utilisation dropped substantially, as non-urgent hospitalisation was postponed or cancelled. This resulted in a net surplus for the year of R9 006 million (2019: R1 563 million), based on a positive net healthcare result of R7 451 million (2019: R136 million) and investment income of R1 690 million (2019: R1 698 million). The Scheme's solvency level remains healthy at 36.93%. This has allowed the Scheme to defer its annual increase to July 2021, but necessitates careful forecasting and planning for the next two to three years given that utilisation is expected to return to prior levels, and possibly with a mix of more severe cases.

In 2021, we look forward to an amalgamation with Quantum Medical Aid Society (QMAS). The CMS has approved the exposition of the amalgamation documents and Competition Commission approval is underway, following which members will be asked to approve the amalgamation at a Special General Meeting. Amalgamating with QMAS bodes well for the Scheme in light of QMAS's demographic profile and reserves. This means that adding its approximately 3 200 members will not dilute DMHS's reserves.

Mrs Joy Malete was appointed as our Chief Financial Officer from 12 April 2021, and we are delighted to have a person of her calibre join the Scheme Office team.

The support of my team, the Trustees and our Independent Committee Members, and our administrator and managed care provider, Discovery Health, has been invaluable this year. Together, we have enabled the Scheme to assist our members in weathering the COVID-19 storm. This has tested our promise to our members, and our other stakeholders, to not only provide best practice governance but also thought leadership in our industry. We have demonstrated our ability to move quickly and innovatively to meet and exceed the healthcare needs of our members. We have also, I believe, supported the country's effective management of the pandemic and given credence to our commitment to assist in building a better healthcare system for all South Africans.

Challenges will no doubt continue into the future, but the Scheme is in robust health and our members can be assured of our unwavering dedication to fulfilling our purpose and working hard to realise our vision.

C Mbewu

MS CHARLOTTE MBEWU
Principal Officer

04 OUR VALUE STORY

Our operating context

All medical schemes in South Africa are non-profit entities that operate according to social solidarity principles, in a highly complex and tightly regulated industry.

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

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

- Ensuring that medical schemes are financially sound, with a sufficient number of members contributing to them.
- Ensuring medical schemes do not unfairly discriminate against any person on arbitrary grounds.
- Investigating complaints in relation to the affairs of medical schemes.

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

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

Schemes derive income only from member contributions and investment returns. They price their benefit plans for the following year based on industry factors, utilisation of healthcare services, financial performance, and financial and actuarial forecasts. The pricing of contributions is a function of balancing affordability with other imperatives. These include holding sufficient reserves to weather times of economic difficulty and unexpected claims, providing for increased utilisation and escalation in the cost of treatment, optimising benefits, and equitable treatment of all scheme members.

Medical schemes operate under the principle of social solidarity: schemes must accept all members who wish to join; members are community risk rated so there is no differentiation of pricing based on, for example, the status of an individual's health; and members' funds are pooled to provide healthcare funding in an equitable manner.

Industry trends amplified and accelerated by COVID-19

As one of the most notable events of our lifetimes, given its global reach and widespread health, economic and social effects at macro and micro levels, COVID-19 has had a material impact on the healthcare industry. The burden on frontline healthcare workers and facilities during the waves of the pandemic has been extensively reported, with high volumes of people needing hospital care. This placed tremendous pressure on the healthcare industry.

By contrast, many other healthcare facilities and practices saw substantially decreased utilisation, as members deferred non-emergency and elective care. This resulted in severe financial pressure for some healthcare providers during 2020.

The pandemic has highlighted the need for ongoing vigilance around further potential shocks to the healthcare system. New viruses emerge regularly, and the lessons learned from the COVID-19 experience need to be applied to combat other threats. Some of these emerging diseases are linked to the effects of climate change and environmental degradation, requiring greater awareness and modelling of the broader drivers of disease.

Notwithstanding the extraordinary challenges, other aspects of the industry have improved. The uptake of digital healthcare to ensure ongoing access to healthcare services, including virtual consultations, has been unprecedented.

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

Demand for some medical equipment and vaccines has been high, and the rapid innovation the crisis has provoked is likely to spur continued growth and development.

Besides the development and adoption of digital health options, the pandemic has presented opportunities to shift care settings from hospital to outpatient services, including in the home environment. Importantly, it has also reinforced healthier lifestyles, including safer behaviours. It was notable that no influenza activity was reported from any southern hemisphere country during the 2020 flu season[1], and heightened awareness of ways to prevent communicable diseases like the flu could decrease this regular burden on the healthcare system.

The need for co-operation and information sharing has also established stronger relationships between stakeholders, particularly the public and private sectors. This should stand the healthcare industry in good stead as we work together to manage COVID-19 and its extended impact over the next few years, as well as in moving towards universal healthcare coverage in South Africa.

In particular, close and constructive working relationships with our regulatory authorities will be key to supporting the healthcare system, and the country, not only to emerge from the pandemic but also to consolidate some of the positive developments over the longer term. During 2020, the CMS strongly supported the industry in its response to COVID-19, including Prescribed Minimum Benefits (PMBs) for the testing and treatment of the disease. The Scheme continues to engage with the CMS and other regulators on the PMB review, Low-Cost Benefit Option (LCBO) reforms, and the development of National Health Insurance (NHI). Through the CMS and the Health Funders Association (HFA) and in other forums, we are also involved in various working groups for the national vaccine rollout.

It is predicted that the direct and indirect impacts of COVID-19 on healthcare systems will be profound and sustained. These impacts have been described as initial COVID-19 related morbidity and mortality, followed by resource restrictions impacting urgent non-COVID conditions, interrupted care impacts on chronic conditions, and a sustained period relating to mental illness, burnout and economic injury.

Adapted from Victor Tseng, MD https://twitter.com/VectorSting/status/1244671755781898241.

At the end of 2019 there were 76 medical schemes registered with the CMS, consisting of 18 open schemes and 58 restricted schemes, covering over 8 953 000 beneficiaries. These schemes paid out approximately R185.9 billion in total healthcare benefits[2] in 2019 (2018: R172.2 billion). The average age of scheme members in 2019 increased by 0.2 years to 33.3 from 33.1 in 2018, and the proportion of pensioners increased to 8.7% from 8.5%[3].

Aging scheme membership, the increasing burden of non-communicable diseases, and stagnant membership growth, reflecting economic stresses and demographic trends, are factors that have been evident over several years. These have negative implications for cross-subsidisation within scheme risk pools, and for the healthcare industry as a whole. The economic impact of the COVID-19 pandemic is likely to exacerbate this trend, at least in the short term, pending more decisive economic recovery.

In response, containing costs while maintaining benefits and driving value-based healthcare are key drivers for medical schemes. The fragmentation in the South African healthcare system has a significant impact on health outcomes as healthcare providers frequently operate in silos. This means private healthcare consumers experience barriers to integrated health information, difficulty in navigating the healthcare system and poor co-ordination of care across disciplines and processes. The development of managed care programmes that target specific conditions, supported wherever possible by innovative reimbursement mechanisms, serve to reduce fragmentation and improve cost management, as does the increasing adoption of digital healthcare.

The impact of fraud, waste and abuse in the industry is substantial, as it is in healthcare globally. The Global Health Care Anti-Fraud Network estimates that USD260 billion (approximately six percent of global healthcare spending) is lost to fraud each year[4]. In South Africa, the Section 59 Investigation Panel has acknowledged in their interim report that schemes and administrators must continue their efforts to curb it and to recover member funds, but it also confirmed that they act in accordance with the Act as they do so.

1 *Source: The National Institute for Communicable Diseases' Communicable Diseases Communiqué, July 2020, Vol. 19 (7).*
2 *Total healthcare benefits paid refers to the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members.*
3 *Source for industry information: Annexures to the CMS Annual Report 2019–2020 (https://www.medicalschemes.co.za/publications/#2009-3506-wpfd-2019-20-annual-report), which do not include data for 2020.*
4 *Source: Global Health Care Anti-Fraud Network, http://www.ghcan.org/global-anti-fraud-resources/the-health-care-fraud-challenge/.*

Our material matters

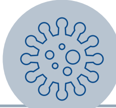
We exist for our members, which puts their health and wellness at the heart of what is most important for the Scheme.

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

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

To ensure we can continue to fund the healthcare needs of our members, the financial sustainability of the Scheme and the affordability of contributions must be maintained in a context of challenging economic conditions, healthcare system reform and healthcare inflation, the drivers of which include demand- and supply-side factors and the prevalence of fraud, waste and abuse in the industry. COVID-19 has amplified these complexities, while also accelerating the adoption of solutions by stakeholders that will help us in managing them.

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



COVID-19 PANDEMIC

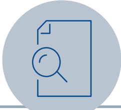
- Ensuring rapid and equitable access to effective vaccines for our members, in alignment with national guidelines and priorities.
- Closely monitoring developments in COVID-19 disease management and funding health technologies and treatments where evidence and safety protocols are sufficient.
- Supporting appropriate digital health capabilities and alternative settings of care to ensure our members continue to have uninterrupted access to essential healthcare services including at times when lockdown restrictions are in place.
- Actively communicating with and supporting our stakeholders as they work to manage the impact of COVID-19 in their lives and workplaces.
- The impact of the COVID-19 pandemic on the South African healthcare system as well as the economic environment.
- Adapting our investment strategy to the short- and long-term economic and market conditions of the pandemic.

MEMBER NEEDS

- Balancing our membership's health, wellness and access needs with quality of appropriate care imperatives in relation to affordability in the face of medical inflation in excess of CPI and an economy strained by the pandemic.
- Promoting a patient-centred, value-based healthcare model and reducing fragmentation and variability in the quality of care.
- Empowering our members to participate actively in their healthcare, and enhancing digital health platforms and tools to enable members to access quality care in their homes.
- Working to understand our individual members better and support their healthcare and service journeys through the use of effective communication, information and data, with due consideration of data security and privacy.
- Increasing burden of disease and an aging membership base, resulting in high levels of utilisation and increasing costs, together with the longer-term impact of climate change on health.

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Opportunities to partner with government, business and the industry to rapidly drive healthcare imperatives and co-create a stronger healthcare system.
- Engaging with stakeholders including member advocacy groups, healthcare professionals and regulators to develop a mutual understanding and a collaborative approach to benefit design, in the context of healthcare inflation and the need for equitable access to advanced high-cost health technologies and treatments.
- Ethical leadership, fairness and social responsibility towards a better society.
- The impact of inadequate governance and controls in the broader business and political environment.
- Best practice governance and oversight to obtain innovation, efficiency, excellence and best possible value from our administrator and managed care provider.



MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- The future of private healthcare in South Africa, including opportunities to innovate, compete effectively and support the journey towards universal healthcare.
- Regulatory complexity and policy uncertainty affecting member protection, the delivery of quality healthcare, affordability and social solidarity.
- Robust and fair fraud, waste and abuse management to protect member funds while treating stakeholders with respect and fairness.

DIFFICULT ECONOMIC CONDITIONS

- Slow economic growth, increasing cost of living and rising unemployment exacerbated by the reduction of available jobs in the formal sector, potentially increasing the burden on the public healthcare system.
- Rising healthcare costs making medical scheme contributions less affordable, contributing to stagnant membership growth and shifts to more affordable benefit options, with an impact on Scheme stability and sustainability.

Our business model

Sustaining the Scheme's financial, operational and relational wellbeing serves the current and future healthcare needs of our members – the ultimate outcome of our business model.

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

This core service is how we create sustainable value for our members in line with our purpose. Furthermore, as a funder that connects our members into the private healthcare value chain, the quality of our relationships with all our stakeholders is essential to realising our vision in the interests of our members and a better healthcare system.

The Scheme's business model is therefore people-led, capability driven and relationship based. This is clearly reflected in the core capital inputs on which we depend, and the value outcomes we generate for our members and employer groups. In turn, these outcomes rely on our value propositions to our other key stakeholders. Our material matters reflect the risks to these capital inputs, and the opportunities we have to drive better outcomes for our members and all our stakeholders.

Responding effectively to our material matters is a function of meeting the objectives associated with our strategic themes and mitigating our residual risks. This enables us to deliver the value outcomes our stakeholders expect, over time, which promote the financial, operational and relational wellbeing of the Scheme for the benefit of our members.

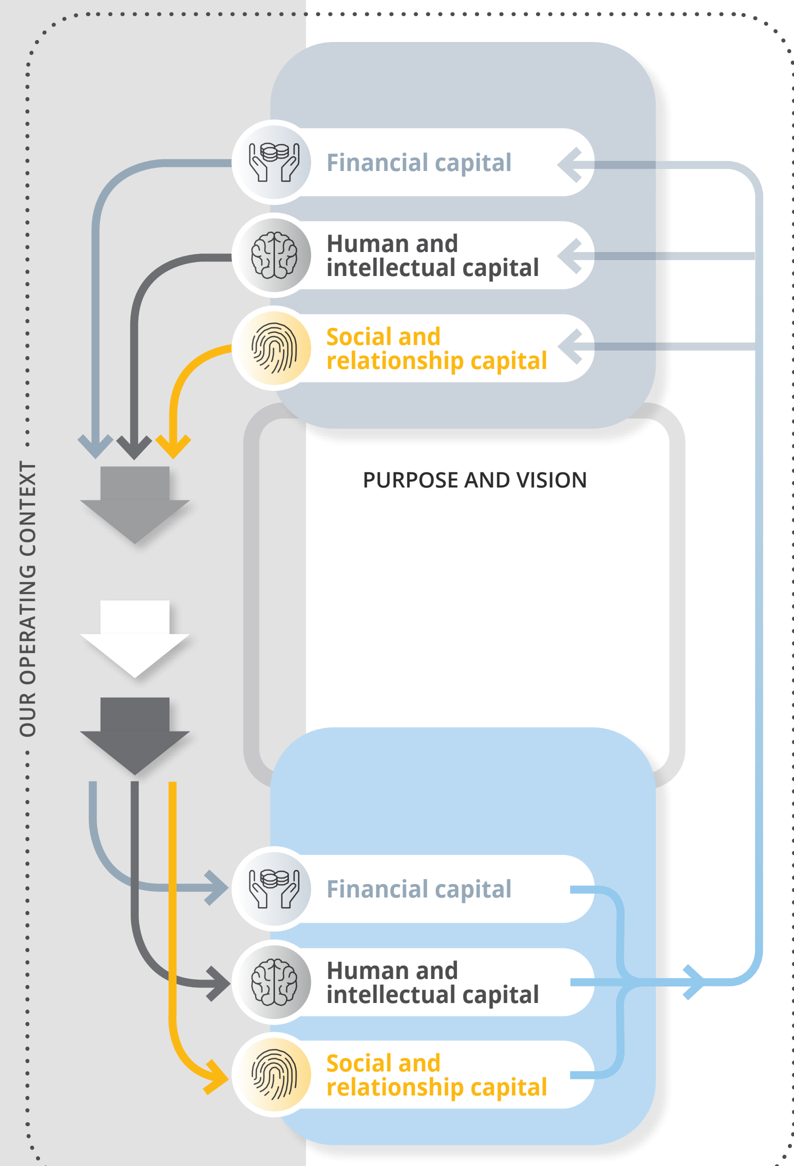
We apply global best practice in outsourcing administration and the provision of managed care, in the best interests of our members.

Fundamental to understanding the Scheme's business model is that we use the Vested® outsourcing model to govern our working relationship with our accredited administrator and managed care provider. The model aligns the transactional and relational governance elements of this relationship with global outsourcing best practice.

Vested outsourcing applies an outcomes-driven approach characterised by:

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

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



LINKS TO MATERIAL MATTERS, INDICATING KEY RISKS AND OPPORTUNITIES IN MANAGING OUR INPUTS

CORE CAPITAL INPUTS

Financial capital

- **Member contributions** of R74.5 billion (2019: R69.9 billion).
- **Investment income** of R1 690 million (2019: R1 698 million), generated from members' funds.

COVID-19 PANDEMIC
- Impact on healthcare system and economic environment.
- Adaptive investment strategy.

MEMBER NEEDS
- Access to affordable quality care in the face of healthcare inflation.
- Managing high utilisation, increasing costs, burden of disease.

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS
- Equitable access to high-cost health technologies and treatments.
- Best practice governance for innovation, efficiency, excellence and value.

DIFFICULT ECONOMIC CONDITIONS
- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

Human and intellectual capital

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

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS
- Best practice governance for innovation, efficiency, excellence and value.

Social and relationship capital

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

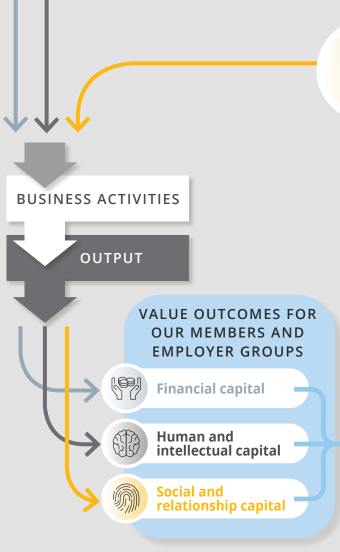
COVID-19 PANDEMIC
- Rapid and equitable access to effective vaccines.
- Safe and effective health technologies and treatments.
- Uninterrupted services through alternative care settings and digital care.
- Active communication and support.
- Impact on healthcare system and economic environment.

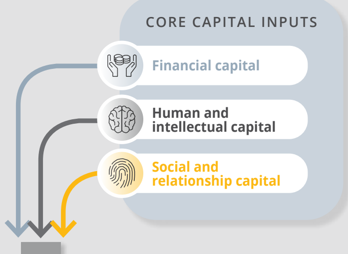
ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS
- Co-creating a stronger healthcare system.
- Equitable access to high-cost health technologies and treatments.
- Ethical leadership, fairness and social responsibility.
- Inadequate governance in the broader business and political environment.
- Best practice governance for innovation, efficiency, excellence and value.

MEMBER NEEDS
- Access to affordable quality care in the face of healthcare inflation.
- Patient-centred, value-based healthcare.
- Participatory care and access to digital healthcare.
- Supporting healthcare through private, secure data assets.
- Managing high utilisation, increasing costs, burden of disease.

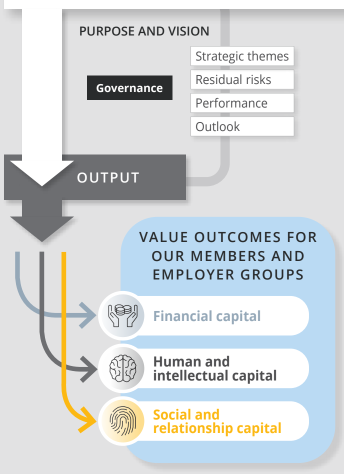
MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY
- Future of private healthcare and supporting universal healthcare.
- Regulatory complexity and policy uncertainty.
- Robust and fair combat of fraud, waste and abuse.

DIFFICULT ECONOMIC CONDITIONS
- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.





BUSINESS ACTIVITIES



OUR PURPOSE

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

OUR VISION

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

The Scheme Office is focused on:

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

Key elements of our business model are discussed in:

Activities supporting excellence

SET STANDARDS FOR EXCELLENCE

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

EXECUTE FOR EXCELLENCE

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

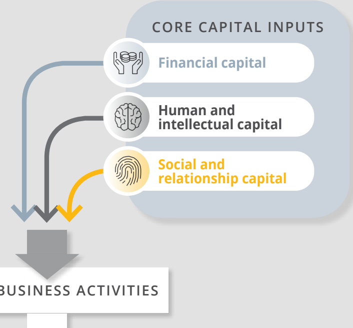
CONTINUOUS LEARNING AND IMPROVEMENT

MONITOR AND REPORT FOR EXCELLENCE

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

EVALUATE AND REFINE FOR EXCELLENCE

- Standards
- Execution requirements



OUTPUT

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

VALUE OUTCOMES FOR OUR MEMBERS AND EMPLOYER GROUPS

Financial capital

- Largest open medical scheme, with 2 758 340 beneficiaries[1] and 57.0%[2] market share.
- Favourable demographics, with an average age of 34.4 and a pensioner ratio of 9.6% (versus 35.5 and 11.4% respectively across all other open medical schemes[3]).
- Financial strength, with R28.2 billion in member funds, a 36.93% solvency level, and an AAA credit rating confirming the Scheme's ability to meet large, unexpected claim variations.
- Scenario-based actuarial modelling of future COVID-19 related costs (including vaccines) and infection rates for DHMS members project that the Scheme's solvency should remain well above the statutory reserve level of 25%.
- DHMS gross administration expenditure is the seventh lowest[4] out of 20 schemes in the open scheme market (2019: seventh lowest).

Other key stakeholder relationships relevant to our financial capital outcomes:

Human and intellectual capital

Board of Trustees

In 2020, the Institute of Directors in South Africa (IoDSA) evaluated our application of the King IV principles, recognised as best governance practice; rating us excellent at a score of 4.8 out of five.

Employees

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

Other key stakeholder relationships relevant to our human and intellectual capital outcomes:

1 *According to the latest available DHMS statutory returns submission from Q4 2020.*

2 *Latest available market share: based on the Council for Medical Schemes Quarterly Report for the period ended 30 September 2020 (www.medicalschemes.co.za/publications/#2009-2010-wpfd-annual-reports).*

3 *Source: CMS Annual Report 2019–2020; values are for 2019 and are calculated as per 1 January 2019.*

4 *As a percentage of gross contribution income.*

VALUE OUTCOMES FOR OUR MEMBERS AND EMPLOYER GROUPS *continued*

Social and relationship capital

Responsive, high-quality value-based healthcare

- Better health outcomes achieved through value-based partnerships with providers, focused on efficiency and quality of care, the ongoing development of managed care programmes, innovation and integration.
- DHMS led the market in responding to COVID-19 with the early release of benefits, extensive communication, and a proactive process for protecting members from infection, wherever possible.
- Benefits available to members related to COVID-19 include access to screening and testing, virtual consultations, isolation facilities, novel therapeutics, home care including oxygen and pulse oximeters for high-risk members, and virtual support for non-COVID positive but at-risk members.
- Provided support to employer groups for high-risk employees, as well as in their COVID-19 response and business continuity planning.
- Contribution relief options of some R372 million were made available to members and SME employer groups.
- Due to the exceptional utilisation patterns caused by the pandemic, and to assist members to deal with economic pressures, the Scheme has been able to defer contribution increases for all members to 1 July 2021, capped to an average maximum of 5.9%. This means that the average increase for the year is 2.95%, lower than the guidance given by the CMS of 3.9%[1].

Value of benefits[2]

- Members receive substantial value in terms of their healthcare benefits when they need to claim[3].
- For an average risk contribution of R1 814 per month, R58.0 billion paid in claims including an average of:
  – R5 155 per beneficiary with a chronic condition (715 955 beneficiaries)
  – R58 285 per admission (506 553 hospital admissions)
  – R101 894 per beneficiary undergoing oncology treatment (39 229 beneficiaries).
- 13.2% of beneficiaries claimed more than their contributions.

Plan choice

- Our full spectrum of 23 plan options offers our members sufficient choice to meet their medical and financial needs.
- 96.44% of members did not change their plan for 2021 (2020: 94.27%), reflecting member satisfaction, stability in benefit design and appropriate pricing.

Affordability

- With the support of the CMS, DHMS was able to allow members with a positive medical savings account balance[4] to cover contributions for up to three months in 2020.
- SME employer groups could defer up to two months of employee contributions, to assist with cash flow. These contributions need to be repaid to the Scheme over a 12-month period after the deferment, with no interest being charged.
- Average contributions for our members in 2021 are 17.3% lower than the next eight largest open medical schemes.

1 *In Circular 52 of 2020.*
2 *Note: All figures for the period October 2019 to September 2020, with the exception of the number of Scheme members with a chronic condition and number of DHMS members undergoing oncology treatment, where the figures are as at September 2020.*
3 *The largest hospital claim made during 2020 would require 184 years of contributions by the member to cover that particular claim, depending on which plan the member is on; put another way, it would take 605 years of contributions based on the average risk contribution of R1 814 per month.*
4 *Refers to the balance in the account at the time, and not to the amount allocated to the member at the start of the calendar year.*

VALUE OUTCOMES FOR OUR MEMBERS AND EMPLOYER GROUPS *continued*

Social and relationship capital *continued*

Value for money

- The Trustees conduct a formal evaluation of the value for money Discovery Health provides to the Scheme every year. The results are expressed as the value added by Discovery Health for each rand paid to it[1].

2019: R2.03	2018: R2.12	2017: R2.02	2016: R2.00	2015: R1.85	2014: R1.73

Digital capabilities and innovation[2]

- The member app gives our members easy access to their health plan information, as well as other convenient functionality to assist them in managing their healthcare needs.
- An average of 2 389 doctors regularly used HealthID in treating our members during 2020, and 2.62 million members have given their doctors consent to access their records on HealthID[3].
- Facilitated the shift to digital care, with 88 730 virtual consultations conducted during 2020.
- Facilitated the shift to alternative care settings including through Connected Care, an ecosystem of benefits, services and digital capabilities to help members manage their health and wellness at home.

Member satisfaction

- Member perception score of 8.74 out of 10 (2019: 8.77).
- Ask Afrika Top Icon Brands 2020/2021
  – Discovery Health Medical Scheme: first place in the Medical Aid category
  – Discovery Health: first place for Private Health Insurance.
- Kantar BrandZ Most Valuable South African Brands 2020
  – Discovery Health Medical Scheme: ranked first in the Medical Aid category.
- The Sunday Times Top Brands retrospective showed DHMS ranking in the Top 3 in the category of Medical Aids – Business Category, over the last 10 years.

Society

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

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

1 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2019, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.03 (2018: R2.12) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year. A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged Deloitte Actuarial Consultants to perform an actuarial peer review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2018 to 2019 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed.*

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

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

Our strategic themes

Our holistic view of value for members considers their health and wellness, quality of care and appropriateness of healthcare services, in balance with the overall cost efficiency and financial sustainability of the Scheme.

Our purpose and our vision guide the development of the Scheme's strategy. Within this framework of aspirations and objectives, the Scheme's strategy remains adaptive and is tailored to the demands of our operating context and the evolving needs of our members and other stakeholders, from which we derive our material matters. Each year, the Trustees and Scheme Office review and agree the material matters, which inform the Scheme's strategic objectives for the coming year.

In line with the nature of our business model, we continually review internal and external factors to identify, mitigate and manage our residual risks and seek opportunities to optimise value outcomes for our members while ensuring the long-term sustainability of the Scheme. Our strategic themes respond to our material matters and delivering on the related objectives mitigate our residual risks.

Two formal strategy planning sessions are held annually: the first with Scheme Office leadership, including external advisory input where relevant; and the second with the Scheme Office and the Trustees, with external advisory input. The latter includes a review of Discovery Health's strategy to support the Scheme's objectives.

High-level objectives are broken down into work streams, with key performance indicators set to measure progress and assess associated outcomes. Work streams are not necessarily tied to a specific benefit year and may be carried over several years or longer; the lifespan of these work streams depends on the complexity and timeframes of their objectives.

Work streams and related objectives are adjusted in response to changing circumstances, with related policies and planning being reviewed and approved by the Trustees as required. Oversight of the work streams is delegated to the relevant Board Committees, according to their terms of reference. The Scheme Office interfaces with these Committees and the Board, and reports regularly on operational oversight and monitoring as well as the mitigation of emerging risks.

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

> "Our purpose and our vision guide the development of the Scheme's strategy.

Performance against our strategic themes in 2020

01 CARING FOR OUR MEMBERS

Continuing healthcare inflation well above CPI requires the development of funding policies to mitigate and manage costs and maintain affordability for our members. The Scheme's strategic priority of driving value-based care, with the member at the centre of care, informs all strategies to expand existing and implement new care programmes, utilising innovative alternative reimbursement models wherever possible.

For 2021, the implementation of a designated service provider network for spinal care and a centre of excellence for colorectal cancer surgery are planned. We will also continue to focus on the management of diabetes, mental health and oncology, among others. We are introducing a programme for care at home, as a substitute for acute hospital care in appropriate circumstances. This development was spurred by our members' need for care outside of traditional settings during COVID-19.

2020 required a deep focus on COVID-19 and the Scheme's response to ensure that members had rapid access to benefits for treatment; in 2021, this will continue with the addition of preventative measures, including vaccines. We will closely monitor healthcare needs given that members deferred screening and treatment during the pandemic, with the risk of more severe disease developing as a result.

Measuring value through health outcomes

DHMS strongly supports the monitoring and measurement of outcomes to improve healthcare for members, as well as to increase competition, support better choices and enable value-based contracting as per the Health Market Inquiry's recommendation.

In this regard, we are working progressively with healthcare providers to collect health outcomes data through our various care programmes as well as via Health ID. We are also engaging with members to understand their self-reported healthcare service experiences and outcomes. We participate in the Health Quality Assessment (HQA) initiative[1], currently using process measures of care as a proxy for outcomes, and support its efforts to engage healthcare providers and other stakeholders to collect and submit standardised clinical data in order to build a robust database, and improve measures over time.

1 HQA (https://www.hqa.co.za/about-us) performs an annual assessment of clinical quality in healthcare offered by medical schemes through the use of healthcare quality indicators.

MATTERIAL MATTER

MEMBER NEEDS

- Access to affordable quality care in the face of healthcare inflation.
- Patient-centred, value-based healthcare.
- Participatory care and access to digital healthcare.
- Supporting healthcare through private, secure data assets.
- Managing high utilisation, increasing costs, burden of disease.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Equitable access to high-cost health technologies and treatments.

MATTERIAL MATTER

DIFFICULT ECONOMIC CONDITIONS

- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

02 MANAGING THE IMPLICATIONS OF COVID-19

Member and employer financial support

With the support of the CMS, DHMS was able to allow members with a positive medical savings account balance[1] to cover contributions for up to three months. SME employer groups were able to defer up to two months of contributions for their employees, to assist with cash flow. These contributions need to be repaid to the Scheme over a 12-month period after the deferment, with no interest being charged.

Minimising contribution increases

Due to the exceptional utilisation patterns caused by the pandemic, and to assist members and employees in these times of economic pressures, the Scheme has been able to implement a 0% increase for all members from 1 January 2021. An increase will need to be implemented from 1 July 2021 but this will be kept to an average maximum of 5.9%. This means that the average increase for the year is 2.95%, lower than the guidance given by the CMS of 3.9%[2].

Regulatory engagement on vaccines

Both DHMS and Discovery Health have been closely involved in discussions regarding the procurement and distribution of vaccines, mostly through the HFA and its representation in Business for South Africa (B4SA). As a result, the Trustees have been kept well informed of the various scenarios and have been satisfied that the Scheme's budget provisions are adequate.

Ensuring Scheme solvency

To support the Scheme's budgeting and forecasting, Discovery Health projected future COVID-19 related costs and the progression of the COVID-19 pandemic using different assumptions for the rate of infection for DHMS members. Three scenarios were used: low, where the virus reproduces relatively slowly in the population; high, where it reproduces relatively quickly and peaks at very high daily infections; and medium, which was in between. These scenarios were used to test the impact on the Scheme's financial position. Under all three scenarios, the Scheme's solvency was projected to remain well above the statutory reserve level of 25%. Looking forward, other scenarios were added to determine the impact of vaccine costs, and the Scheme's solvency was also forecast to remain above 25% in these scenarios.

Management of the ongoing impact of the COVID-19 pandemic underpins much of the work planned for the Scheme this year. The Scheme will continue to be agile in incorporating evidence-based developments in treatment and prevention into member benefits, and proactive in supporting members according to their risk and needs.

Core to this work is close engagement with industry representative bodies, the CMS and the National Department of Health, as well as other stakeholder groups.

The Scheme will also continue to closely monitor the health, financial, economic and social impacts of COVID-19 and will adjust its strategies accordingly.

MATTERIAL MATTER

COVID-19 PANDEMIC

- Rapid and equitable access to effective vaccines.
- Safe and effective health technologies and treatments.
- Uninterrupted services through alternative care settings and digital care.
- Active communication and support.
- Impact on healthcare system and economic environment.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

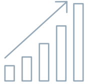
- Co-creating a stronger healthcare system.
- Equitable access to high-cost health technologies and treatments.

MATTERIAL MATTER

DIFFICULT ECONOMIC CONDITIONS

- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

1 *Refers to the balance in the account at the time, and not to the amount allocated to the member at the start of the calendar year.*
2 *In Circular 52 of 2020.*



03 SUSTAINABILITY AND MEMBERSHIP GROWTH

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

These opportunities may include amalgamations with other schemes, engaging with regulators on policy developments that may affect membership, and ensuring that our plans and benefits appeal to a full range of potential members. This is important to counter the impact of anti-selection on the Scheme by young and healthy people who may opt out of medical scheme coverage.

Enhanced focus in 2021 will be given to our investment strategy, especially in light of the market dynamics coming out of COVID-19, together with consideration of responsible investing strategies in alignment with responsible corporate citizenship.

Considering the Scheme's continuity and sustainability, and the far-reaching impact of COVID-19, we will look to migrate a by-necessity work from home environment to a hybrid workplace, in balance with the need to preserve our culture, performance management and development of our team.

MATTERIAL MATTER

COVID-19 PANDEMIC

- Adaptive investment strategy.

MATTERIAL MATTER

MEMBER NEEDS

- Access to affordable quality care in the face of healthcare inflation.
- Patient-centred, value-based healthcare.
- Managing high utilisation, increasing costs, burden of disease.

MATTERIAL MATTER

MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- Regulatory complexity and policy uncertainty.

MATTERIAL MATTER

DIFFICULT ECONOMIC CONDITIONS

- Scheme stability and sustainability.

04 REGULATORY AND POLICY DEVELOPMENTS

We anticipate significant development of the policy and regulatory environment affecting medical schemes and their members. The Scheme continues to monitor these and conducts extensive and detailed work in responding to them, to promote the best outcomes for members. We believe that strong relationships between regulatory authorities and industry stakeholders is key to these developments, to ensure beneficial enhancements for all.

Engagement with the CMS and other relevant regulators and stakeholders in this respect pertain to the second draft of the NHI Bill; Low-Cost Benefit Options (LCBOs) and a framework to govern these in future; the development of a Primary Healthcare package; and the review of Prescribed Minimum Benefits, among others.

The interim report of the Section 59 Investigation Panel found no evidence of intentional, explicit racial bias in any of the processes or methodologies carried out on our behalf by Discovery Health, and confirmed that our fraud, waste and abuse (FWA) processes are necessary and justifiable given the significant risk and implications of losses to medical scheme members.

The Scheme, together with Discovery Health, is committed to working collaboratively with the CMS and the Health Professions Council of South Africa, industry representative bodies, the medical profession and other relevant stakeholders to implement the Panel's recommendations regarding clear standards of procedural fairness, as part of a broader sector-wide initiative to enhance the tools and processes to efficiently and fairly manage Fraud, Waste and Billing Abuse. In this regard, the Scheme is working, through the HFA, on developing an industry framework and code of good practice for FWA activities.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Co-creating a stronger healthcare system.
- Ethical leadership, fairness and social responsibility.
- Inadequate governance in the broader business and political environment.
- Best practice governance for innovation, efficiency, excellence and value.

MATTERIAL MATTER

MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- Future of private healthcare and supporting universal healthcare.
- Regulatory complexity and policy uncertainty.
- Robust and fair combat of fraud, waste and abuse.

05 GOVERNANCE EXCELLENCE

The Trustees closely monitor the work of the Scheme Office, and Discovery Health, to fulfil their accountability to our members. The Scheme's robust governance structures and processes are compliant with the Act, take guidance from the Companies Act where appropriate, and incorporate King IV principles, recognised as global best practice in governance. The Scheme proactively makes submissions and provides responses to various regulatory bodies on issues relating to governance and compliance. The outcomes of our approach to governance are reported in our business model, and in the Performance and Governance and Leadership chapters of this Report.

For 2021, areas of focus for governance are the Special General Meeting (SGM) and joint 2020/2021 AGMs and trustee elections. The pandemic necessitated a postponement of the 2020 AGM and trustee elections, and the continuing restrictions on gatherings mean that in 2021, the Scheme will need to explore technology capabilities and developments to support effective meetings. Measures to protect privacy and security are in place.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Best practice governance for innovation, efficiency, excellence and value.

Discovery Health Medical Scheme registration number 1125

Our residual risks

DHMS is closely attuned to the highly regulated and ever-changing landscape of the local and international healthcare industries, to ensure effective identification and mitigation of risks. This also enables us to identify opportunities to optimise value outcomes for our members.

The Scheme continually scans the internal and external environment to assess risks and opportunities associated with our strategic themes, and the core capitals used and affected by the Scheme in relation to our business model. The Scheme has in place a Board-approved enterprise risk management framework, risk appetite framework and statement by which risks are assessed. Risks are rated according to impact and likelihood on a five-point scale that ranges from low to catastrophic. The process identifies the risks capable of negatively affecting organisational objectives, as well as opportunities made available by effectively managing these risks in ensuring the financial, operational and relational wellbeing of the Scheme.

As noted, the assessment specifically covers the Scheme's dependence on the resources and relationships represented by the various forms of capital, not only those that pertain directly to our core service to our members and business activities, but also more broadly. This ensures that emerging risks, for instance the impact on disease vectors of climate change, are included in the scope of assessment.

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

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

COVID-19

RISK DESCRIPTION

The risk that the COVID-19 pandemic extends well into 2021 and potentially beyond, impacting negatively on the overall national healthcare system, including private healthcare.

MITIGATING ACTIONS

- The Scheme continually monitors COVID-related utilisation and healthcare trends to enable rapid and proactive responses.
- Through industry bodies and other forums, close engagement is held with key stakeholders to agree and implement response and mitigation plans. This includes discussions regarding vaccine funding, procurement, distribution and administration.
- Initiatives and benefits have been introduced to move care, where appropriate, from an in-hospital to a home-based setting which creates additional hospital capacity, while ensuring that our members receive care even in times of constrained hospital capacity.
- For 2021, the Trustees are carefully considering the Scheme's budget and potential expenditure into the next two to three years, given the expected return of utilisation to prior levels and the possibility of more severe cases, as well as ongoing COVID-19 expenses.

MATTERIAL MATTER

COVID-19 PANDEMIC

- Rapid and equitable access to effective vaccines.
- Safe and effective health technologies and treatments.
- Uninterrupted services through alternative care settings and digital care.
- Active communication and support.
- Impact on healthcare system and economic environment.
- Adaptive investment strategy.

MATTERIAL MATTER

MEMBER NEEDS

- Supporting healthcare through private, secure data assets.
- Managing high utilisation, increasing costs, burden of disease.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Co-creating a stronger healthcare system.
- Equitable access to high-cost health technologies and treatments.

MATTERIAL MATTER

DIFFICULT ECONOMIC CONDITIONS

- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

AFFORDABILITY OF CONTRIBUTIONS AND MEDICAL INFLATION

RISK DESCRIPTION

The risk that contributions to the Scheme become unaffordable for members due to the impact of demand-side factors (such as age, gender, chronic status, epidemics and anti-selective behaviour) and/or supply-side factors (such as technology and provider-driven increases in utilisation), as well as FWA, which drive above-inflation increases in healthcare costs. This risk is exacerbated by financial and economic pressures as well as a worsening chronic disease profile in the population. Regulatory changes such as the introduction of LCBOs may exacerbate anti-selective behaviour; however, this also provides an opportunity for the Scheme to extend access to a previously uncovered section of the population.

MITIGATING ACTIONS

- Each year, the Trustees critically assess the benefit plans offered by the Scheme to ensure that the full spectrum of member needs are met, within the bounds of affordability and sustainability.
- Consideration is given to interventions that may lower healthcare costs while ensuring members have access to quality healthcare through value-based contracting, as well as the development of managed care programmes focused on non-communicable diseases and conditions, to support co-ordinated care and better-quality outcomes.
- The Trustees satisfy themselves that value for money is obtained from Discovery Health, along with other providers and suppliers, and that the Scheme's budget and expenditure is closely monitored and managed.
- Risk management interventions are implemented by Discovery Health on behalf of DHMS. These include close management of hospital admissions, sophisticated fraud prevention and recovery services, alternative reimbursement mechanisms and clinical funding policy design and implementation.
- In keeping with the social solidarity principles on which the Scheme operates, active marketing and distribution strategies are developed and implemented to attract and retain members who enable effective cross-subsidisation.
- Engagement with regulators to address concerns and propose appropriate guardrails in regulatory amendments, help to protect the sustainability of the Scheme.

MATTERIAL MATTER

MEMBER NEEDS

- Access to affordable quality care in the face of healthcare inflation.
- Patient-centred, value-based healthcare.
- Participatory care and access to digital healthcare.
- Managing high utilisation, increasing costs, burden of disease.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Co-creating a stronger healthcare system.
- Equitable access to high-cost health technologies and treatments.
- Ethical leadership, fairness and social responsibility.
- Best practice governance for innovation, efficiency, excellence and value.

MATTERIAL MATTER

MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- Future of private healthcare and supporting universal healthcare.
- Regulatory complexity and policy uncertainty.
- Robust and fair combat of fraud, waste and abuse.

MATTERIAL MATTER

DIFFICULT ECONOMIC CONDITIONS

- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

POLICY, REGULATORY AND COMPLIANCE

RISK DESCRIPTION

Changes in the regulatory environment may have an adverse impact on the operations, strategy and sustainability of the Scheme. This includes the challenge of navigating a potentially contradictory or incomplete regulatory environment. The reforms underway could influence changes to the structure and operating requirements of the industry. The risk includes being assessed as not or only partially compliant with laws, regulations, rules and self-regulated Scheme standards and codes of conduct, including those related to our values and ethics. This may impact the Scheme's ability to operate effectively and efficiently, and may damage our reputation.

MITIGATING ACTIONS

- Regular, detailed and proactive engagement with relevant regulators at all stages of the regulatory change process, enabling a two-way flow of information and views, and greater certainty on changes the Scheme must make. This enables the Scheme to develop and implement compliance strategies that are both comprehensive and pre-emptive in anticipation of regulatory changes.
- Proposed amendments are subject to close assessment, including detailed research and analysis regarding potential impacts on the Scheme, our members and other key stakeholders, the healthcare industry, and the regulatory framework as a whole in order to provide comprehensive submissions. Where appropriate, collaborative submissions are made with industry partners and/or representatives.
- The Scheme's views and positions are developed considering input from independent advisers and Discovery Health's extensive policy and regulatory capabilities.
- Participation at public and industry forums, both individually and through industry associations, building of consensus with stakeholders on effective and enabling regulatory and legislative frameworks, detailed review of publications requiring commentary and the submission of considered and well-supported responses to support positive change for the industry.
- Operating in a highly regulated environment requires extensive controls to ensure ongoing compliance with complex legislated obligations. The Scheme is acutely focused on ensuring compliance in all areas and has appropriate operational, oversight and assurance processes in place.
- Regulatory change is monitored closely, and plans are made well ahead of implementation dates to ensure that requirements are incorporated ahead of time.
- Existing processes are reviewed to ensure continued compliance and responsiveness to external changes, with independent assessments commissioned as necessary.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Co-creating a stronger healthcare system.
- Equitable access to high-cost health technologies and treatments.
- Ethical leadership, fairness and social responsibility.
- Inadequate governance in the broader business and political environment.
- Best practice governance for innovation, efficiency, excellence and value.

MATTERIAL MATTER

MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- Future of private healthcare and supporting universal healthcare.
- Regulatory complexity and policy uncertainty.

MATTERIAL MATTER

DIFFICULT ECONOMIC CONDITIONS

- Scheme stability and sustainability.

TECHNOLOGY AND INFORMATION

RISK DESCRIPTION

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

MITIGATING ACTIONS

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

MATTERIAL MATTER

COVID-19 PANDEMIC

- Safe and effective health technologies and treatments.
- Uninterrupted services through alternative care settings and digital care.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Equitable access to high-cost health technologies and treatments.
- Best practice governance for innovation, efficiency, excellence and value.

MATTERIAL MATTER

MEMBER NEEDS

- Participatory care and access to digital healthcare.
- Supporting healthcare through private, secure data assets.

STAKEHOLDER MANAGEMENT

RISK DESCRIPTION

The risk of ineffective stakeholder engagement and management, resulting in harm to the Scheme's ability to perform optimally, and its reputation in the eyes of members and other stakeholders. This may ultimately impact the Scheme's sustainability. Equally, effective stakeholder engagement enables the development of improved understanding, information, achieving consensus where necessary and the development of a stronger and more robust private healthcare industry.

MITIGATING ACTIONS

- The Scheme engages proactively and frequently with all stakeholder groups to understand their needs, engender better understanding of the Scheme and promote alignment with its objectives.
- The Trustees embrace the Treating Customers Fairly (TCF) principles and framework, and receive regular reports on the performance of Discovery Health on key TCF indicators, as well as other stakeholder engagements conducted on behalf of the Scheme.
- The Scheme conducts ongoing environmental scanning to identify possible risks related to our key stakeholders, which may affect business continuity, and develops or amends specific engagement strategies to deal effectively with these.
- The Scheme proactively shares evidence-based information with stakeholders to support their healthcare needs, access to healthcare, awareness of quality outcomes, regulatory changes, and the non-profit status of the Scheme.

MATTERIAL MATTER

MEMBER NEEDS

- Patient-centred, value-based healthcare.

MATTERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Co-creating a stronger healthcare system.
- Equitable access to high-cost health technologies and treatments.
- Ethical leadership, fairness and social responsibility.
- Inadequate governance in the broader business and political environment.
- Best practice governance for innovation, efficiency, excellence and value.

MATTERIAL MATTER

MACRO AND MICRO POLICY AND REGULATORY UNCERTAINTY

- Future of private healthcare and supporting universal healthcare.
- Regulatory complexity and policy uncertainty.

MATTERIAL MATTER

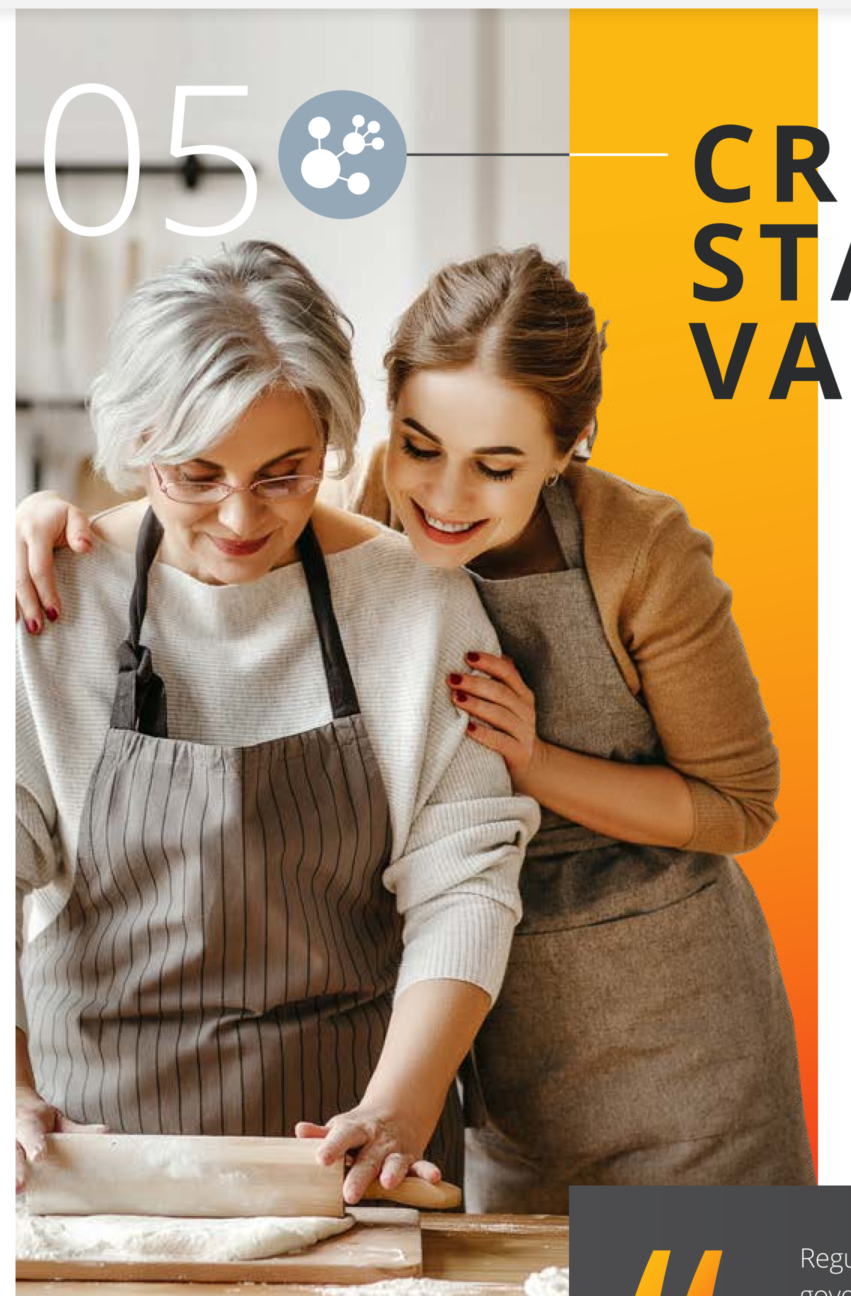
DIFFICULT ECONOMIC CONDITIONS

- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

05

CREATING STAKEHOLDER VALUE

Our approach to stakeholder management is strongly rooted in our values-driven culture and our commitment to being an engaged and thoughtful corporate citizen that cares deeply for the wellbeing of our members, our industry and our society.



Our ethics, values and culture

We operate according to the highest ethical standards, with relevant policies that are binding on the Trustees and employees of the Scheme.

Policies set the standard of behaviour expected of our Board of Trustees (the Board or the Trustees) and employees, in areas such as legal compliance, protecting personal information, human rights, employee rights and sound business practices. These policies are available to all Trustees and employees, and are referenced in employment contracts.

Regular assessments are conducted into the effectiveness of the Scheme's governing body; these include considering whether the Scheme's ethics are upheld and identifying any areas of concern. The Scheme Office has an ongoing focus on ethics, supported by an experienced executive whose portfolio includes legal and ethics matters and who is also a certified ethics officer[1].

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

In 2020, an ethics risk and opportunity assessment of the Scheme's procurement function was carried out, with satisfactory results. In 2021, further assessments will be carried out and any culture, policy and process gaps identified will be addressed appropriately.

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

> "Regular assessments of the effectiveness of the Scheme's governing body include whether the Scheme's ethics are upheld.

MORAL DUTIES AND ETHICAL VALUES

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

THESE ARE ARTICULATED IN OUR GOVERNANCE FRAMEWORK:

Moral duties

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

Ethical values for governance, management and operations

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

OUR VALUES GUIDE OUR BEHAVIOURS AND INTERACTIONS

INTEGRITY

We will do the right thing. We will take personal accountability for our actions and, in our actions and decisions, hold true to our promise that we care.

MUTUAL RESPECT

We will be courteous and treat others as we would want to be treated ourselves. We will listen to what people say, and ask for and value other people's inputs.

ADAPTABILITY AND AGILITY

We will be sensitive to the external environment and to the needs of others, while remaining responsive to changing needs and adapting to the pace of change.

TEAMWORK, SUPPORT AND CARE

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

PURSUIT OF EXCELLENCE

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

RESILIENCE

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

SOCIAL RESPONSIBILITY

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

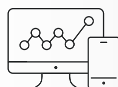
Responsible Corporate Citizenship

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

In line with the requirements of King IV, the Stakeholder Relations and Ethics Committee is mandated to oversee the Scheme's social responsibility. To help it fulfil its mandate, the Committee employs a corporate citizenship framework adapted from The Ethics Institute, which incorporates King IV requirements[1,2,3]. The Committee receives regular reports, recommendations and presentations on areas covered by the framework, enabling it to monitor progress and provide input on the Scheme's social responsibility activities.

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

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



Economy

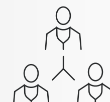
- *Economic transformation*
- *Fraud and corruption detection and response*
- Broad-based black economic empowerment
- *Responsible and transparent tax practices*

Workplace

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

Natural environment

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



Social environment

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

1 Crane, Matten & Spence (2008). Corporate social responsibility: Readings and cases in global context. London: Routledge.
2 Groenewald & Dondé (2017). Ethics and compliance handbook. Pretoria: The Ethics Institute.
3 Areas specified in King IV are shown in italics.

Treating Customers Fairly

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

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

The desired outcomes of TCF:

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

To assess its TCF performance, Discovery Health monitors:

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

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

Engaging with our **stakeholders**

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

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

The inclusion of a trust rating is in line with the Vested® outsourcing model, which is formally applied in our contractual arrangement with Discovery Health and also informs our interaction with our other stakeholders. The results of the assessment are reported to the Committee and inform its priorities, as well as the formulation and management of engagement plans. The Committee monitors the effectiveness of these plans and attends closely to the resolution of specific incidents and stakeholder concerns.

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

Discovery Health has extensive stakeholder engagement capacity and experience. Specialised teams respond either to requests and queries received, or proactively according to the Scheme's initiatives and industry activity. Material items are presented to executive-level forums on a weekly basis, or escalated to the appropriate executives, including the CEO.

SOME ACTIVITIES CONDUCTED ON BEHALF OF THE SCHEME INCLUDE:

- Responding to member queries via call centres, chat platforms, the member app and website.
- Proactively contacting identified member groups regarding healthcare concerns or opportunities.
- Developing and implementing innovative managed care programmes, together with healthcare providers and societies, to increase quality of care, decrease fragmentation and control costs for our members and the Scheme.
- Supporting the Scheme's regulatory and policy engagement through gathering information and working with stakeholders.
- Providing training and support to financial advisers on the Scheme's products.

OUR MEMBERS

We exist for our members, who entrust us with their healthcare funding needs and with facilitating their access to beneficial programmes and treatments. Keeping this top-of-mind, the Scheme aims to manage affordability of contributions in a challenging economic context with high healthcare inflation, exacerbated by the impact of COVID-19. This is critical to ensuring our members have continued access to the highest possible quality of care. Building and maintaining strong relationships with our other stakeholders is fundamental to our ability to achieve these objectives.

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

Through Discovery Health, the Scheme is engaged in many quality of care initiatives. These are closely monitored to strive to ensure that our members have access to the safest, most effective and efficient healthcare available in South Africa, at the lowest possible cost. We also empower our members with information that is relevant to their needs, when they need it.

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

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

Information is also made available on an ad hoc basis in response to specific healthcare concerns. In 2020, substantial information on COVID-19, related support available and screening and testing procedures was made available on the website. This is updated as information as well as treatment and vaccination options become available.

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

MEASURING MEMBER SATISFACTION

The Scheme maintained a high average member perception score in 2020: 8.74 out of 10 (2019: 8.77). We track members' perceptions of service received at multiple points and locations, including after-claims processes and the call centre. Follow-up surveys are also frequently conducted with members after their interactions with us.

During the course of 2020, the Scheme made virtual doctor consultations available to members to keep them safe, and protect our healthcare workers, during the pandemic.

Read about the experience of two of our members on the links below.

Our members *continued*

DHMS has many innovative programmes and initiatives to support members in their healthcare journey. In 2021, the Scheme approved the implementation of some new care initiatives for implementation in 2021, such as a designated service provider network for spinal surgery, and a centre of excellence for colorectal cancer surgery:

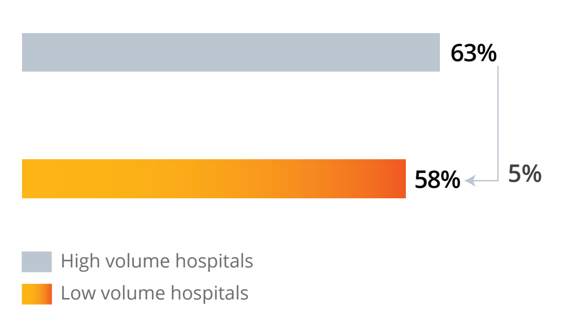
IMPROVED CLINICAL OUTCOMES FOR COLORECTAL SURGERY

Colorectal cancer is the third most prevalent cancer and affects over 3 200 of our members every year.

The treatment regime for colorectal cancer may often include surgical intervention, the success of which has a significant impact on the survival rate of colorectal cancer patients. The Scheme funds more than 900 colorectal cancer surgeries each year. There are a number of hospitals where surgeons routinely perform colorectal surgery, with statistical evidence of lower mortality rates and improved survival rates in these high-volume hospitals.

Comparison of outcomes in hospitals with high volumes of colorectal surgery to hospitals with low volumes:

5-year survival rate after surgery (2010 – 2018)



Introducing centres of excellence for colorectal cancer surgery

DHMS is introducing a network of centres of excellence for colorectal cancer surgery in 2021. The network provides members with several benefits:

- Hospitals where surgeons routinely perform colorectal surgery with improved clinical outcomes.
- Participating hospitals, surgeons, anaesthetists and physicians contracted to the network based on clinical outcomes, to ensure quality of care for our members.
- Full cover for surgery in the network, which applies to all DHMS plans.
- Doctors benefit from bidirectional information sharing through a Colorectal Cancer record, which will create the first Colorectal Cancer Registry for South Africa.

INTRODUCING THE SPINAL CARE PROGRAMME AND SPINAL SURGERY NETWORK

Back pain is one of the most common reasons why people miss work, visit the doctor, or stop exercising. Locally and internationally, evidence points to early conservative treatment as the most effective for back pain. This reduces the need for invasive treatments such as injections or surgery. Where surgery forms part of an effective regime of conservative treatment, outcomes are significantly better when compared to spinal surgery that does not form part of a broader, holistic treatment plan.

In 2021, the Scheme will introduce a Spinal Care Programme and Spinal Surgery Network to improve the outcomes of back treatment for our members.

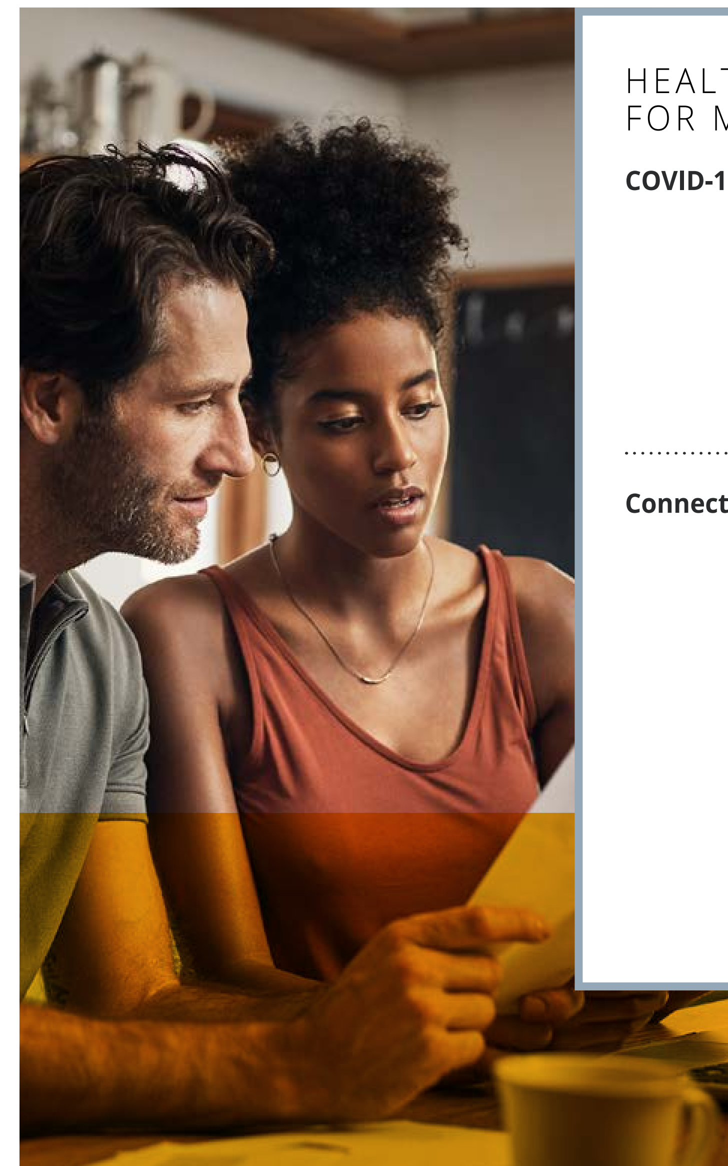
Spinal care programme

The Spinal Care Programme is a co-ordinated out-of-hospital conservative treatment programme for back pain. Access to the benefit requires appropriate referral and enrolment and includes access to:

- A network of physiotherapists who have been trained in the management of back pain, supported by a panel of specialist surgeons
- Face-to-face and virtual consultations, where appropriate, with an appropriately registered allied healthcare professional.

Spinal Surgery Network

The Spinal Surgery Network provides members with full cover for approved spinal surgery admissions. The Network consists of hospitals, surgeons, anaesthetists and allied healthcare professionals who are contracted to the Network based on clinical outcomes.



HEALTHCARE BENEFITS, INFORMATION AND DISEASE MANAGEMENT FOR MEMBERS

COVID-19

Connected Care

Diabetes Care

Mental health

Oncology

Member App

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

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

The app can be downloaded here, and a video about how the app can assist members is available here.

EMPLOYER GROUPS

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

In 2020, the South African Government imposed interventions to contain the initial spread of COVID-19, and 'flatten the curve' of the outbreak. During these unprecedented times, the focus on social solidarity has been enhanced, with strong value being placed on the corporate social responsibility and identity of institutions in providing a safe and supportive environment for their workforce.

PROVIDING EMPLOYER GROUPS WITH AN INTEGRATED HEALTH AND WELLNESS SOLUTION

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

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

As employees returned to work after the highest levels of lockdown, we launched COVID-19 business support services to assist employers with the safe return of their workforce.

COVID-19 has also created a need among employers for support in managing their COVID-19 risk, as their employees return to work. The Scheme, through Discovery Health, launched a range of initiatives in response to this need, as well as other support measures.

In 2020, employer offerings included:

- A comprehensive set of COVID-19 support services to assist employers in formulating and executing an effective response to COVID-19, including daily screening, call centre triage, case management and contact tracing for all employees who are members of DHMS.
- Financial support during the pandemic for employees and qualifying SME employers to maintain medical scheme membership through contribution deferment and alternative payment strategies.
- Corporate wellness days, adapted to encourage health and wellness interaction by employer group members in a safe environment.
- Focused service and engagement strategies, tailored to suit workforce servicing needs, were developed with employer groups.
- In a national rollout, the Scheme's product and benefit enhancements for 2021 were presented to key decision-makers of employer groups; this was followed by employee training sessions.

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES

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

The COVID-19 pandemic has impacted healthcare providers in significant ways. Healthcare professionals are on the frontline of the battle against this devastating virus, placing themselves at high risk of infection and being witness to the traumatic consequences for their patients and their loved ones. Generally, they have also experienced substantial income loss as many patients have avoided consultations and deferred elective medical or surgical procedures in fear of exposing themselves to COVID-19. The combined effect of these has taken a heavy toll on their physical and mental health.

The Scheme has been in a position to offer much needed support to healthcare providers. This has been done through Discovery Health's Strategic Contracting and Health Professions Unit, intensive engagements with the Scheme's healthcare delivery provider partners, including the major hospital groups, and representative bodies of independent and corporate healthcare providers such as pharmacies, pathology groups, radiologists and professional associations.

The support took different forms, for example, in recognition of high virus exposure risk, the Scheme funded enhanced risk benefits for COVID-19 pathology tests and the seasonal influenza vaccine for all healthcare professionals who are members of the Scheme. The Scheme also offers a benefit at 100% of the tariff rate for healthcare professionals requiring accommodation in hotel isolation facilities.

We also adjusted reimbursement structures and increased tariffs for personal protective equipment (PPE), and facilitated higher utilisation of remote screening and other clinical consultations through increased tariffs and enhanced virtual platforms.

In recognition of the risk of negative health outcomes associated with deferred healthcare, the Scheme implemented the innovative benefit for virtual house calls, where the doctor was able to schedule virtual consultations with members identified as high-risk due to co-morbidities. These interventions drove unprecedented utilisation of telemedicine and virtual consultations across all disciplines.

The support was not limited to independent healthcare professionals, as corporate providers such as radiologists were also supported through innovative risk sharing alternative reimbursement mechanisms (ARMs), in an effort to smooth out the utilisation experience. Other ARMs, designed to ensure enhanced continuity of care for members with COVID-19, and ease of billing for healthcare professionals, included the implementation of GP and specialist COVID-19 episode fee structures.

While COVID-19 dominated 2020, the Scheme did not slow its strategy to engage and collaborate with healthcare providers to develop and incrementally implement value-based care (VBC) models. Building on previous VBC initiatives, and their successful implementation, the Scheme approved the implementation of new VBC initiatives for implementation in 2021. These included the designated service provider network for spinal care, and a centre of excellence for colorectal cancer surgery.

The focus on mitigating the growth and impact of chronic diseases such as diabetes remains. Following on from extensive engagements with the relevant professional societies and member advocacy groups, the Scheme has launched a benefit to cover innovative continuous glucose monitoring for members with Type 1 Diabetes who fulfil entry criteria. The funding of these innovations supports healthcare professionals in utilising advanced and innovative, albeit costly, technologies in the appropriate patient populations.

Other focus areas where close collaboration with providers has resulted in the Scheme implementing ARMs or designated service provider networks to improve quality of care include chronic disease management especially for diabetes, mental health and oncology – leading causes of morbidity for members, and cost drivers for the Scheme. In this regard, we adopt a population management approach to chronic conditions, with enhanced benefits for appropriate patient groups and alternative funding for contracted providers.

Healthcare providers and professional societies *continued*

LOOKING FORWARD TO 2021

We continue to collaborate with and support the profession, to mitigate the impact that the ongoing pandemic is having on our providers. This extends to building a shared value healthcare ecosystem that uses digital tools, in line with global trends and best practice. This ecosystem is one in which patients, doctors and the funder can unite to sustainably improve healthcare outcomes.

To further support healthcare professionals in managing their patients remotely, with confidence growing in the quality of care afforded through remote care, 2021 will see more advanced digital healthcare technology being implemented and funded by the Scheme. This has been enabled through the innovative Discovery Health Connected Care platform which effectively integrates Scheme benefits, healthcare services and digital capabilities. Using the Connected Care app, doctors will be able to diagnose, and monitor their patients (Scheme members) remotely. The introduction and funding of the Tytocare digital device (which transmits clinical parameters including clinical grade pictures of the throat, ear, heart sounds etc.) will give providers increased confidence in managing patients' acute and chronic conditions remotely. This should improve the adoption of telemedicine consultations by both healthcare professionals and members.

In 2021, qualifying Discovery Health Medical Scheme members can be enrolled in Discovery Health's Connected Care programme for acute care at home as a substitute for acute hospital care.

Care delivery within the programme will be facilitated by a dedicated nurse-based care team under the supervision of the treating doctor, providing 24-hour clinical support and remote monitoring using smart health devices. DHMS benefits will ensure enhanced funding to care in-hospital.

HEALTHCARE BENEFITS, INFORMATION AND DISEASE MANAGEMENT INFORMATION FOR PROVIDERS

COVID-19

Diabetes Care

Mental health

Connected Care

Oncology

FINANCIAL ADVISERS (BROKERS)

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

The Health Market Inquiry (HMI) final report concluded that "brokers play an important role within the current complex benefit option environment" and recommended that their assistance to members continue, albeit with additional transparency[1].

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

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

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

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

Perception surveys were conducted to establish how satisfied financial advisers are with Discovery Health. The overall perception score by brokers of Discovery Health for the year was 9.06 out of 10, slightly up from 8.92 for 2019.

ENGAGEMENTS IN 2020

The annual update on the Scheme's product and benefit enhancements for the coming year was provided in a national rollout to over 200 business consultants and agents. It was also presented and broadcast to more than 8 200 financial advisers from the annual product launch event. Following the product update, approximately 19 virtual sessions were held with business consultants and financial advisers across the country. In addition, all brokers had access to year-end training videos informing brokers and their clients of updates and benefit changes for 2021.

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

A COVID-19 information hub and three industry leading thought-leadership webinars were hosted during the year, providing brokers with access to the latest clinical insights related to the pandemic, and the associated benefits and tools available to employers and members of the Scheme.

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

> "The Scheme focuses on ensuring that our health plan information is written in an easily understood and accessible manner, for the benefit of both members and advisers.

DISCOVERY HEALTH (PTY) LTD

Discovery Health is a leader in healthcare administration and managed care, with a strong reputation for excellent service and innovation. Providing services to over 3.5 million medical scheme members, they provide administration and managed care services to DHMS, as well as 18 other restricted schemes. Our relationship with Discovery Health has enabled the Scheme to become the largest open medical scheme in South Africa.

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

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

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

Engagement between the organisations is frequent and focuses on:

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

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

OUR EMPLOYEES

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

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

The Scheme employs a small team who must be agile in responding to industry developments and challenges to ensure the Scheme's effective operation and sustainability, and whose work and remuneration must be aligned to the Scheme's vision, purpose and objectives. All employees are nurtured and developed to ensure that they are engaged and fulfilled and therefore able to consistently deliver their best efforts. Training and development opportunities are regularly identified and a development plan is in place for all employees, who attend training, conferences and industry events relevant to their work and their potential within the Scheme.

Periodic assessments of the Scheme's value proposition to employees support interventions to promote staff satisfaction and retention, and regular performance discussions help employees to maintain focus on their role objectives and career development.

During 2020, the Scheme focused strongly on protecting employees during the COVID-19 pandemic, and supporting their wellbeing. All employees moved to work-at-home and regular team engagements were conducted, including seminars on how to take care of themselves and their families during the pandemic. A culture survey was also conducted, including wellbeing elements, as was a survey about the workplace environment. The results of both of these will be incorporated into a hybrid workplace strategy, as well as to protect employees and their families and to inform improvements to the Scheme's employee value proposition.

REGULATORY BODIES

The Scheme and Discovery Health are required to adhere to strict legislation, with the Scheme primarily governed by the Medical Schemes Act (the Act). We work with our regulatory bodies and relevant stakeholders, advocating for effective regulatory reform to drive positive change in the healthcare industry; this includes contributing towards health policymaking and amendments to legislation.

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

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

COUNCIL FOR MEDICAL SCHEMES (CMS)

The CMS regulates all medical schemes in South Africa, and its role includes:

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

The Scheme engages actively with the CMS on matters of policy, application and interpretation of rules, benefit design, Scheme finances and resolution of disputes with members.

In 2020, the CMS engaged closely with and supported the industry in its response to the pandemic, including establishing Prescribed Minimum Benefits for treatment to ensure members had access to much-needed healthcare. The CMS also published 73 circulars and the Scheme submitted responses to these where required, as well as to other ad hoc and formal enquiries from the CMS. The CMS publishes regular reports covering activity across the private healthcare funding industry.

THE NATIONAL DEPARTMENT OF HEALTH

The Scheme interacts with the National Department of Health whenever needed. In late 2020 and into 2021, many industry engagements have been held. In these the Scheme has been represented by the Health Funders Association, on the national approach to vaccination procurement, prioritisation, funding and rollout.

The Scheme supports the objectives of universal health coverage as well as the need for the healthcare industry to respond to the needs of its patients, within our social, economic and demographic context. In the interests of our members, we will continue to engage with the Ministry on these and we look forward to presenting to the Portfolio Committee for Health on our joint submission, with Discovery Health, on the revised NHI Bill.

> "The Scheme supports the objectives of universal health coverage as well as the need for the healthcare sector to respond to the needs of its patients, within our social, economic and demographic context.

06

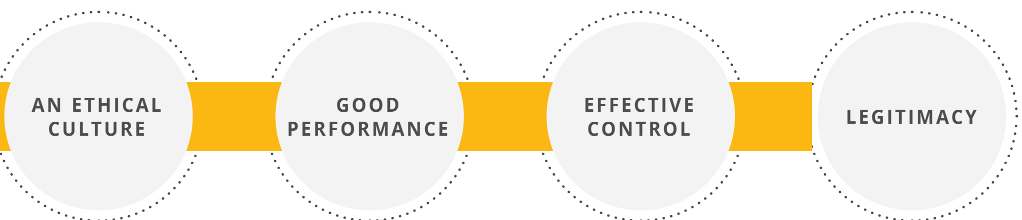
GOVERNANCE AND LEADERSHIP

> The Trustees embrace the principles of King IV in achieving optimal governance outcomes for the Scheme and within the Scheme environment.

How we are governed

All medical schemes in South Africa are governed by the Medical Schemes Act (the Act). The Scheme Rules are developed in accordance with the Act and approved annually by the Council for Medical Schemes (CMS).

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



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

The Board of **Trustees**

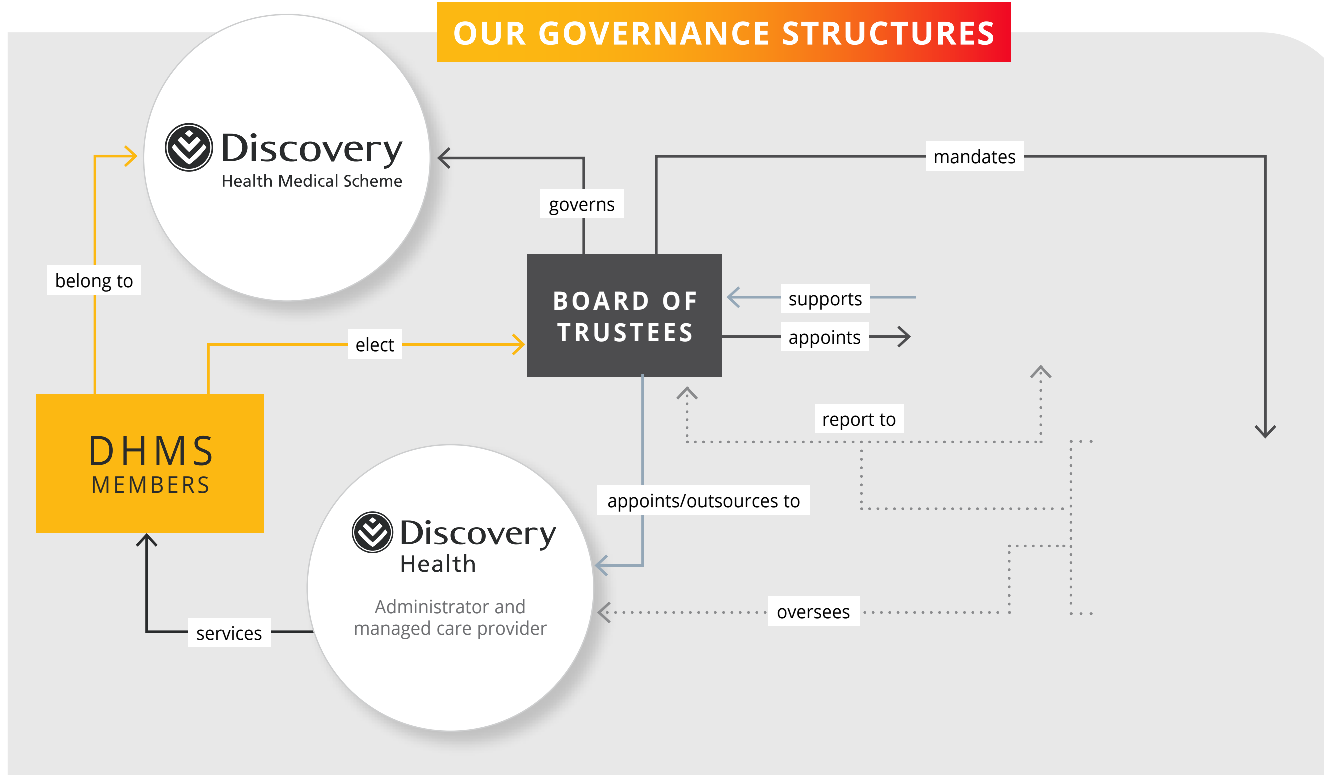
DHMS is governed by an independent Board of Trustees, responsible for overseeing the business of the Scheme. The Trustees hold decision-making power and are ultimately responsible for overseeing the Scheme's material matters, developing and implementing the Scheme's strategy and responsibly managing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

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

According to the Scheme Rules, the Scheme's affairs must be managed according to these Rules by a Board of fit and proper members; having the requisite character, integrity, skill, competence, financial soundness and ability to exercise a fiduciary duty.

The Board comprises independent, highly skilled professionals with a diverse range of specialisms, experience and professional background, bringing multiple perspectives to bear in discussion and debate, and ensuring robust oversight and strategic decision-making. Our Trustees' expertise extends across various fields including legal, actuarial, accounting, economics, governance, medical, financial, financial reporting, investment and human resources.

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



Composition and functioning

The affairs of the Scheme are managed by a Board of a minimum of five and a maximum of eight persons. At any given time, at least half of the Trustees must be elected by members. The balance of the Trustees may be elected by members of the Scheme or appointed by the Trustees, provided that the number of these Trustees shall, at any given time, not exceed three[1].

The Scheme has no influence over the re-election of these Trustees or of Board composition with respect to member-elected Trustees. Due to its limited succession planning ability in this regard, the Board may appoint additional Trustees to fill knowledge, experience and skills gaps where required, and may re-appoint such Trustees (subject to the requirement that a Trustee may only serve two consecutive terms of not more than three years).

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

1 *An amendment to the Scheme Rules to allow for the appointment of a maximum of three Trustees has been approved by the CMS. This Rule was amended to provide more flexibility in obtaining essential skills needed on the Board.*

THE ROLE OF THE TRUSTEES

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

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

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

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

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

TRUSTEE REMUNERATION

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

BOARD EVALUATIONS

The Board is assessed at least every two years, either by external independent parties, or through self-appraisals. The last Board evaluation was conducted by the Institute of Directors in South Africa (IoDSA) in 2020 via self-evaluation questionnaires and virtual consultations with each Trustee, resulting in an overall evaluation score of 4.8 out of 5 (rated as excellent by the IoDSA). As part of the evaluation, the IoDSA reviewed responses against King IV corporate governance best practice and used this to develop a plan and recommended actions for the Board; these are in the process of being implemented. The next evaluation will be conducted in 2022.

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

TRUSTEE TERMS

TRUSTEE	Designation	Appointed/Elected	Start of Term	End of Term
David King	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Dhesan Moodley	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Joan Adams SC[1]	Trustee	Elected	22 Jun 17	21 Jun 20
Johan Human[2]	Independent Co-opted Member	Appointed	05 Sep 16	13 Aug 17
	Trustee	Appointed	14 Aug 17	13 Aug 20
	Trustee	Appointed	14 Aug 20	14 Aug 23
John Butler SC[2]	Independent Co-opted Member	Appointed	05 Sep 16	13 Jun 17
	Trustee	Appointed	14 Jun 17	13 Jun 20
	Trustee	Appointed	14 Jun 20	14 June 23
Neil Morrison	Trustee – Chair of the Board	Elected	23 Jun 16	22 Jun 19
	Trustee – Chair of the Board	Elected	20 Jun 19	22 Jun 22
Susette Brynard[1]	Trustee	Elected	22 Jun 17	21 Jun 20

1 The 2020 AGM and the Trustee elections due to be held at it were postponed due to COVID-19.
2 Re-appointed at Board of Trustees meeting held on 12 June 2020.

ATTENDANCE IN 2020

BOARD MEETINGS attendance in 2020		30 Jan[A]	19 Feb	20 Feb	20 Mar[A]	27 Mar[A]	08 Apr	14 May[A]	12 Jun	27 Aug	03 Nov[A]	19 Nov	02 Dec[A]
Trustees	Mr Neil Morrison (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Dave King	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
	Dr Dhesan Moodley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Adv Joan Adams ¤	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
	Mr Johan Human ◊	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr John Butler ~	✓	✓	✓	✓	✓	✓	✓	✓	x	–	✓	✓
	Dr Susette Brynard ¤	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
Chairperson: Audit Committee	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
Independent Members	Dr Alewyn Burger # * ∞	–	✓	–	–	–	–	✓	–	–	–	–	–
	Mr Ndumiso Luthuli #	–	✓	–	–	–	–	–	–	–	–	–	–
	Prof Selma Smith #	–	✓	–	–	–	–	–	–	–	–	–	–
	Mrs Susan Ludolph ∞	–	–	–	–	–	–	✓	–	–	–	–	–

A Ad hoc meetings: Ad hoc Committee meetings occur outside the usual and scheduled recurring meetings and are called to deal with specific topics or discussions. Trustees who are adequately experienced with sufficient skills and knowledge to address these issues are appointed to serve in such Committees, with clear mandates given to these committees.

These meetings may be shorter than scheduled Board or Committee meetings. Trustees and Committee Members are remunerated according to the duration of such meetings.

- *A meeting was convened on 30 January 2020 to discuss the administration re-accreditation of Discovery Health.*
- *COVID-19 update meetings were convened on 20 and 27 March 2020.*
- *A joint Board, Audit and Product Committee meeting was convened on 14 May 2020 to discuss and approve COVID-19 benefits.*
- *A Board task team was convened on 03 November 2020 to discuss the 2021 Non Healthcare Expenses budget.*
- *A meeting was convened on 02 December 2020 to discuss Circular 77 of 2019: Administration Agreements.*

¤ *Term ended on 21 June 2020. The AGM and Trustee elections have been postponed due to COVID-19, and the CMS gave approval for these Trustees to continue in office pending the Scheme's ability to hold elections.*

◊ *Term ended on 13 August 2020. Re-appointed as a Trustee effective 14 August 2020.*

~ *Term ended on 13 June 2020. Re-appointed as a Trustee effective 14 June 2020.*

Attended the Board of Trustees strategy session on 19 February 2020.

* *Appointed as an Independent Audit and Risk Committee Member effective 01 January 2020.*

∞ *Requested to attend the joint Board, Audit and Product Committee meeting held on 14 May 2020.*

– *Not required to attend.*

x *Apology tendered.*

Our Trustees[1]

MR NEIL MORRISON (64)

BSc (Hons) Physics; MA (Economics)

Chairperson

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

Mr Morrison was elected as a Trustee in 2016. He currently serves on the Remuneration and Investment Committees having previously served on the Stakeholder Relations and Ethics Committee. He was elected Chairperson of the Board on 14 August 2017.

MS JOAN ADAMS SC (57)

B.IURIS LLB; (FP) SA[2]

Ms Adams SC has been an advocate for 31 years. She was previously a Senior State Advocate and Senior Family Advocate. She served for five years on two presidentially elected Commissions of Inquiry addressing fraud and corruption. She was appointed Senior Counsel in early 2018. She is an accredited forensic practitioner[3] and a member of the Gauteng Society of Advocates. Ms Adams SC has considerable experience in medical law and ethics, has chaired numerous professional conduct inquiries, and presented various ethics seminars including the Vista Academy (Vista Clinic) and the Nutrition Network of the Noakes Foundation. She is currently in the process of completing the Certified Director qualification at the IoDSA.

She was elected as a Trustee in 2017 and serves on the Clinical Governance, Risk, and Stakeholder Relations and Ethics Committees.

DR SUSETTE BRYNARD (64)

BSc (Sciences); PhD (Education)

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

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

MR JOHN BUTLER SC (54)

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

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

Mr Butler SC was appointed as a Trustee on 14 June 2017. He chairs the Stakeholder Relations and Ethics Committee, and serves on the Audit and Remuneration Committees.

1 All ages are as at 31 December 2020.
2 Forensic Practitioner, South Africa.
3 Institute for Commercial Forensic Practitioners, South Africa.

MR JOHAN HUMAN (50)

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

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

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

MR DAVID KING (57)

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

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

Mr King was elected as a Trustee in 2016 and currently chairs the Remuneration and Risk Committees and serves on the Stakeholder Relations and Ethics Committee.

DR DHESAN MOODLEY (58)

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

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

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

1 *Fellow of the Institute of Actuaries UK.*
2 *Fellow of the Actuarial Society of South Africa.*

Board **Committees**

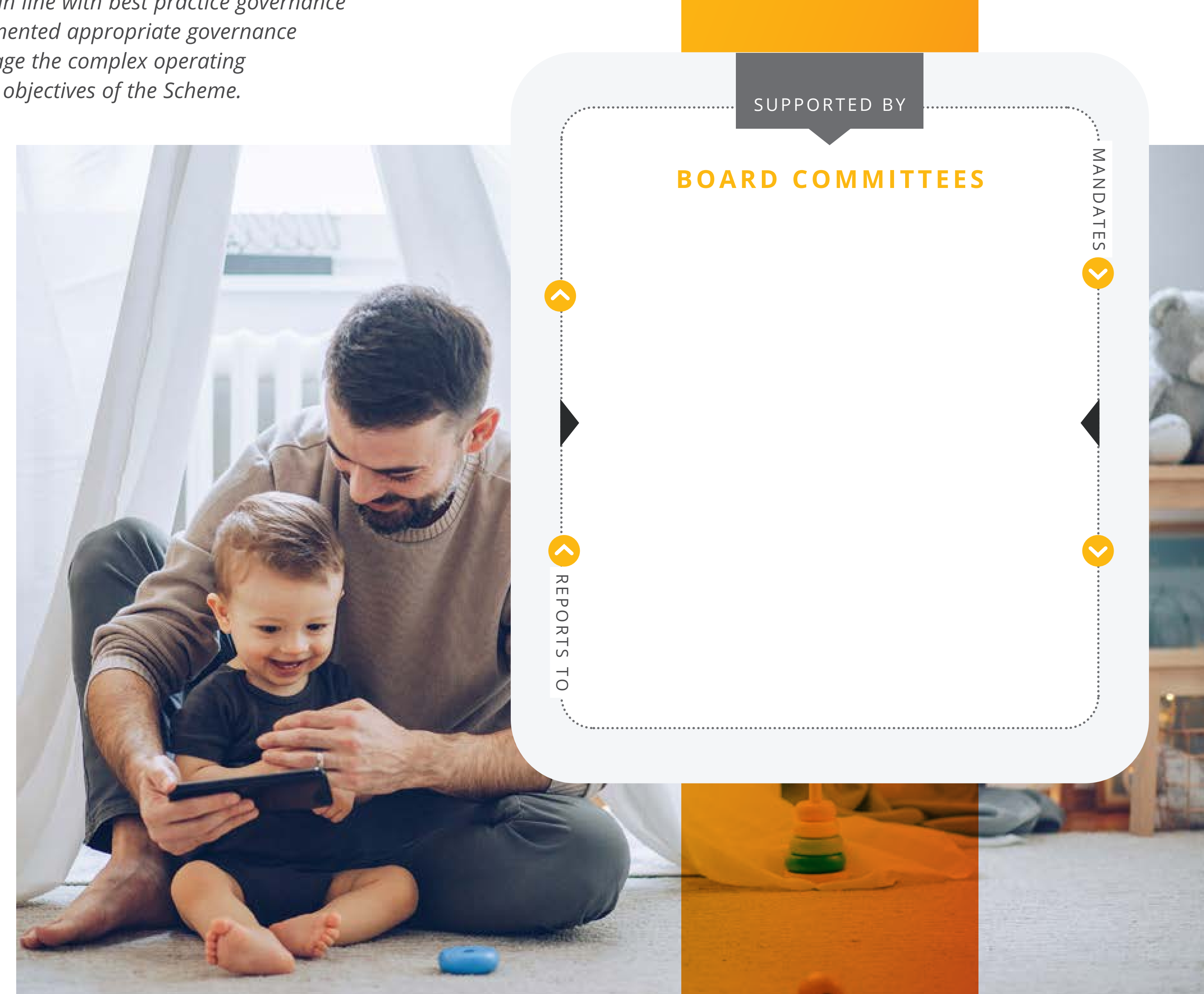
In compliance with the Act, and in line with best practice governance principles, the Board has implemented appropriate governance structures to navigate and manage the complex operating environment, risks and strategic objectives of the Scheme.

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

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

Board Committee evaluations

Board Committees are assessed at regular intervals, either by external independent parties, or through self-appraisals. The last Board Committee evaluation was conducted by the IoDSA in 2018 with highly satisfactory results reported in the 2018 Integrated Report. The next evaluation will be conducted in 2021.



Our Committees' mandates, activities, attendance and future focus

AUDIT COMMITTEE

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

The responsibilities of the Committee include:

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

Combined assurance

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

First Line – Scheme management

Second Line – Group Risk Management, Compliance and Forensics

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

The combined assurance assessment showed that adequate assurance was provided and received in respect of all significant risks for the 2020 benefit year. The Trustees are comfortable with the level and type of assurance the Scheme obtains.

Activities during 2020

The Committee continued to support the Trustees in fulfilling their governance and oversight responsibilities during the year. It is satisfied that its activities, reporting and recommendations to the Board during 2020 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2020

At the end of 2020, the Committee comprised two Trustees and three Independent Committee Members, one of whom chaired the Committee.

During 2020, the Committee met four times, and also attended ad-hoc Board meetings to engage on the financial sustainability implications of COVID-19 on the Scheme. The external and internal auditors met regularly with the Committee without the administrator and managed care provider and Scheme management present. The external auditor, internal auditor, Principal Officer, Chief Financial Officer, Chief Operations Officer, Head of Governance and Compliance, and heads of the outsourced administration functions attend all Committee meetings by invitation to provide information and insight into their areas of responsibility, and have unrestricted access to the Chairperson of the Audit Committee. The Committee may consult any expert or specialist to assist in performing its duties. To this end, the independent actuarial function is regularly invited to Committee meetings to provide information and comfort in accordance with the applicable agreements in place.

AUDIT COMMITTEE attendance in 2020		26 Mar	13 Aug	20 Aug	15 Oct
Independent Member/ Chairperson	Mr Eric Mackeown	✓	✓	✓	✓
Committee Members	Mr Johan Human (Trustee) #	✓	✓	✓	✓
	Mr John Butler (Trustee) ▫	✓	✓	✓	✓
	Ms Susan Ludolph (Independent Member)	✓	✓	✓	✓
	Dr Alewyn Burger (Independent Member) ◊	✓	✓	✓	✓

 # Term ended on 13 August 2020. Re-appointed as a Trustee effective 14 August 2020.
▫ Term ended on 13 June 2020. Re-appointed as a Trustee effective 14 June 2020.
◊ Appointed as an Independent Audit and Risk Committee Member effective 01 January 2020.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. This will include careful consideration of how the Scheme's required solvency levels should be balanced against providing future COVID-19-related benefits, managing higher utilisation and keeping contributions affordable.

Our committees' mandates, activities, attendance and future focus *continued*

CLINICAL GOVERNANCE COMMITTEE

While there is no statutory requirement for this Committee, it has been established in terms of Scheme Rule 19.3, which gives power to the Board to appoint and delegate authority to a subcommittee consisting of such Board members and other experts as it may deem necessary. In this instance, the Committee was established to ensure compliance with the Act, and to align with best practice governance principles. The Committee comprises members with the requisite skills to consider the clinical complexities in healthcare funding.

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

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

The Committee also engages with Health Quality Assessment (HQA), an independent industry body that performs and produces an annual assessment and report of clinical quality in the medical schemes industry. The Scheme is represented in the HQA Board of Directors and its Clinical Advisory Committee by the Scheme's Chief Medical Officer, and also indirectly through Discovery Health representatives. Through this representation, the Scheme is directly involved in the strategic evolution of HQA as an independent organisation for the measurement and reporting of outcomes measures, as recommended by the Health Market Inquiry (HMI).

Activities during 2020

In accordance with its annual work plan, the Committee held four meetings over the course of 2020, during which the Committee considered and provided input on, and monitored implementation of, the Strategic (Utilization) Risk Management (SRM) strategic plan for the year. To do this, the Committee considered SRM reports and evaluated the implementation and impact of key strategic initiatives on key stakeholders and the broader healthcare system. Key initiatives included the Oncology medicines Designated Service Provider (DSP), the Day Surgery Network, and the array of value-based care (VBC) initiatives implemented by the Scheme in recent years.

This year, the Committee was particularly focused on monitoring the evolution of the COVID-19 pandemic, specifically with respect to its impact on South Africa, and the Scheme's response which included various initiatives ensuring the Scheme was afforded relevant and enhanced COVID-19 benefits as well as other support mechanisms to mitigate adverse impacts of the pandemic on Scheme members, employer groups, healthcare professionals and healthcare providers like hospital groups.

As per its terms of reference, in support of the Product Committee, the Clinical Governance Committee also considered proposed benefits for implementation in 2021, and evaluated these through a clinical lens.

The Committee is satisfied that its activities, recommendations and reporting to the Board of Trustees during 2020, have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2020

At the end of 2020, the Committee comprised two Trustees (one of whom chaired the Committee), two Independent Members and the Chief Medical Officer of the Scheme. Regular attendees of Committee meetings include experts from Discovery Health's clinical and risk management teams. The Committee also hosted external speakers such as representatives from contracted hospital groups and the HQA on specific topics of interest to the Committee.

CLINICAL GOVERNANCE COMMITTEE attendance in 2020		02 Mar	04 Jun	03 Sep	29 Oct
Trustee/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓
Committee Members	Adv Joan Adams (Trustee)	✓	✓	✓	✓
	Dr Nonkululeko Mlaba (Independent Member)	✓	✓	✓	✓
	Prof Selma Smith (Independent Member)	✓	✓	✓	✓
	Dr Unati Mahlati (Chief Medical Officer) %	✓	✓	✓	✓

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

Future focus areas

The Committee continues to focus on the Scheme's strategy of partnering with healthcare providers to progressively scale up VBC, with the objective of improving members' health outcomes, while ensuring the sustainability of providers and the healthcare system broadly. In this regard, the Committee monitors and evaluates the impact of benefits, funding policies, and risk management initiatives on members, healthcare professionals and other health care providers. Key focus areas in 2021 will be informed by the Scheme's burden of disease and cost drivers and include benefit enhancements and VBC programmes for chronic conditions that impact the Scheme's disease burden and cost drivers; these include diabetes mellitus, mental health, oncology, and spinal surgery, among others.

Informed by the experience of COVID-19, the Committee will focus on exploring innovations in health care delivery models and on monitoring the various settings of care initiatives, such as the home-based Connected Care benefits being implemented in 2021.

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

Our committees' mandates, activities, attendance and future focus *continued*

DISPUTE COMMITTEE

The independent Dispute Committee hears and adjudicates on all formally lodged member and forensic-related provider disputes in a transparent and equitable manner.

The Committee's purpose is to make fair and consistent decisions, carefully considering the provisions of the Act, all applicable laws and the Scheme Rules, which are binding on the Committee. The Committee is not empowered to make discretionary rulings or those contravening applicable legislation and the latest registered Scheme Rules. In the event of a member being dissatisfied with a ruling made by the Committee, they are able to lodge a complaint with the CMS in terms of Section 47 of the Act.

The responsibilities of the Committee include:

- Receiving submissions from members or practitioners involved in the dispute, as well as the Scheme's representatives.
- Convening dispute hearings in person, virtually, telephonically or in writing. Since the advent of the national state of disaster and lockdown restrictions , all hearings have been convened virtually;
- Ensuring that it has sufficient information regarding disputes to adjudicate cases objectively;
- Adjudicating disputes and drafting rulings with due regard for all facts presented at hearings and in line with relevant legislation and the Scheme Rules; and
- Ensuring that the process at hearings and in adjudicating disputes is managed as efficiently as possible and without undue delay.

Activities during 2020

In 2020, 757 disputes were lodged in terms of Rule 27, with 692 or 91% of disputes being settled or withdrawn prior to a hearing. Only 43 cases proceeded to a hearing before the Dispute Committee.

As the Committee's work covers the full spectrum of stakeholder concerns, its activities are overseen by the Stakeholder Relations and Ethics Committee, on behalf of the Board. The Committee is satisfied that its activities during 2020 have fulfilled its responsibilities in accordance with its operating framework.

Composition and meetings in 2020

All Dispute Committee panellists have either legal or medical expertise. Each panel consists of three members drawn from the greater Committee according to availability, and must include at least one legal and one medical expert. A practising attorney is always the Chairperson of each hearing. Dispute Hearings are scheduled as and when required, and individual panels can be constituted several times a week if needed. Committee Members are independent and not employed by the Scheme but are remunerated for their time and input in objectively hearing and adjudicating cases, regardless of the outcome of the hearings. During 2020, as before, all hearings were properly constituted. Due to the frequency of hearings and variation of panellists, an attendance register is not shown.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. Access to the Committee is not only available to members, but also to healthcare practitioners in respect of forensic (fraud, waste and abuse-related) disputes; the Committee heard its first healthcare practitioners' matters in early 2021.

Our committees' mandates, activities, attendance and future focus *continued*

INVESTMENT COMMITTEE

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

The responsibilities of the Committee include:

- Recommending an Investment Policy for the Scheme to the Trustees, with due regard to the requirement that the assets invested should maximise returns while maintaining solvency;
- Monitoring the effectiveness and implementation of the Investment Policy;
- Making recommendations to the Trustees regarding strategic and long-term asset allocation and approving plans for implementation;
- Approving any short-term asset allocation and plans for implementation;
- Reviewing investment strategies, capital and equity market assumptions, performance of the investment portfolio and of asset managers against established benchmarks, and reporting to the Trustees quarterly on the performance of the portfolio;
- Monitoring the performance of each asset class with a view to maximising the total return, while considering the risk appetite of the Scheme;
- Reporting to the Trustees annually on overall investment performance;
- Making recommendations to the Trustees on the appointment of asset consultants and asset managers, including fees payable and the terms of appointment;
- Assisting the Trustees to decide whether to withdraw funds from portfolios to support daily operations;
- Supervising the safekeeping and handling of the Scheme's investments;
- Monitoring all reported investment activities in line with the Scheme's Investment Policy and statutory requirements, and where there is deviation from the Investment Policy, investigating the reasons for this and recommending corrective action to the Trustees; and
- Assisting the Trustees in preparing their annual report on investment performance and compliance.

Activities during 2020

- Considered the Scheme's asset allocation across various asset classes, taking into account the prevailing economic outlook, and oversaw the implementation of the asset allocation plan.
- Considered the ongoing impact of the COVID-19 pandemic on the Scheme generally, and specifically considered the Scheme's investment strategy with respect to changes in the Scheme's cashflow patterns.
- Reviewed the investment strategies and performance of asset managers relative to their benchmarks.
- Completed a process optimising asset allocation across various equity portfolio management styles resulting in changes to the splits across the management styles as well as the appointment of All Weather Capital as a new manager.
- Reviewed and amended the equity benchmark in light of the concentration risk that arises from Naspers and Prosus.
- Terminated inflation-linked bond mandates and transitioned these assets into new flexible fixed-income mandates.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included onsite visits by the Scheme. Recommended an updated Investment Policy document to the Board for approval.
- Reviewed the effectiveness of services provided by the investment consultant.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2020 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2020

At the end of 2020, the Committee consisted of three Trustees and one Independent Member. The Committee receives investment advice and quarterly reports from the Scheme's investment consultants, Riscura, who attend all Committee meetings. Asset managers are invited to attend meetings on a rotational basis to report on their strategy and performance.

INVESTMENT COMMITTEE attendance in 2020		13 Feb	22 Apr[A]	07 May	06 Aug	08 Oct
Trustee/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓	✓
Committee Members	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓	✓
	Ms Philile Maphumulo (Independent Member) #	✓	–	–	–	–

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

- *A meeting was convened on 22 April 2020 to discuss the equity hedging strategy in light of COVID-19.*

 # Resigned as Independent Committee Member effective 29 February 2020.

– Not required to attend.

Future focus areas

During 2021, the Committee will review the Scheme's asset allocation across the various asset classes to account for changes in market conditions and the Scheme's risk appetite. This will include continuing to optimise asset allocation across the various equity portfolio management styles.

Our committees' mandates, activities, attendance and future focus *continued*

NOMINATION COMMITTEE

The Committee oversees the nomination and vetting process to elect suitably fit and proper persons as Trustees. In terms of the Scheme Rules, the Trustees may appoint an independent third-party service provider to assist the Nomination Committee in carrying out its functions. For the 2020 election, the Trustees approved the appointment of PricewaterhouseCoopers' (PwC's) Forensic Services division as the independent third-party service provider to assist the Nomination Committee.

Activities during 2020

The following activities were initiated by the Committee for the 2020 Trustee elections. This process will continue into 2021, with Deloitte & Touche as an independent third-party service provider to assist the Nomination Committee to:

- Oversee the procedural aspects of the nominations process, including approving communications to members;
- Ensure that the Independent Electoral Body applies a vetting process ensuring that candidates standing for election are fit and proper. During the process, each nominee is subject to stringent vetting criteria; and
- Review and discuss the draft candidate list compiled by the Independent Electoral Body (IEB), and provide the final list of candidates for election to the Trustees.

The Committee reported to the Board on its activities for the 2020 election and fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2020

The Board, at their meeting on 8 April 2020, approved the re-appointment of the Nomination Committee Members for the purposes of the 2020 nominations and elections processes. The Committee comprises three Members who are independent of the Board and Board Committees. Committee meetings are attended by the IEB and its representatives.

NOMINATIONS COMMITTEE attendance in 2020		27 Jan	14 Feb	25 Feb	06 Mar	25 Mar	01 Oct
Independent Member/ Chairperson	Mr Peter Goss	✓	✓	✓	–	✓	✓
Committee Members	Mr Roy Shough (Independent Member)	✓	✓	✓	✓	✓	✓
	Mr Tom Wixley (Independent Member)	✓	✓	✓	✓	✓	✓

– *Not required to attend. On 06 March 2020, the Nomination Committee met to observe the IEB's nominations closure procedures. Not all members of the Committee were required to be present.*

Future focus areas

Trustee elections were not held 2020 due to the COVID-19 restrictions relating to public gatherings. The necessary approvals were sought and received from the CMS and the 2020 Trustee elections will be held in 2021. The Nomination Committee will oversee this process from a governance perspective in terms of its mandate. The IEB has appointed Deloitte & Touche to apply nomination and vetting processes, ensuring that candidates who stand for election are fit and proper.

PRODUCT COMMITTEE

While there is no statutory requirement for this Committee, it was established in terms of Scheme Rule 19.3, as the Trustees consider it necessary for ensuring compliance with the legislative and regulatory requirements of the Act, as well as compliance with best practice governance principles pertaining to benefit and product development. The Committee comprises members with the requisite skills including actuarial and medical expertise. At the end of 2020, the Committee comprised three Trustees, one of whom is the Chairperson of the Clinical Governance Committee which facilitates the required overlap between the two Committees. The Principal Officer is also a member of this Committee.

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

Activities during 2020

The Committee held three Product Committee meetings during 2020, and also participated and executed its functions in many more Board meetings urgently convened to consider new COVID-19 benefits for launch outside of the regular Product Committee and Board approval schedule; expedited benefit launches were needed to facilitate an agile response to the fast-paced evolution of the South African COVID-19 epidemic. In accordance with the Committee's annual work plan, the Committee considered matters pertaining to the Scheme's operating position and surplus, impact of current benefits and proposed 2021 product and benefit enhancements, relative to the Scheme's market position, all in the context of prevailing and proposed policy and regulatory matters, including monitoring developments related to NHI, and the potential

Our committees' mandates, activities, attendance and future focus *continued*

impact of the proposed Low-Cost Benefit Options framework development and other relevant developments.

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

Composition and meetings in 2020

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

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

PRODUCT COMMITTEE attendance in 2020		17 Mar	23 Jul	20 Aug
Trustee/ Chairperson	Mr Johan Human	✓	✓	✓
Committee Members	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Dr Susette Brynard (Trustee)	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	✓	✓	✓
Attendees	Adv Joan Adams (CGC) *	–	✓	–
	Dr Nonkululeko Mlaba (CGC) *	–	✓	–
	Prof Selma Smith (CGC) *	–	✓	–

% Scheme executive. All other Committee Members are non-executive. Ms Mbewu was Acting Principal Officer until she was appointed Principal Officer, effective 01 July 2020.

** Attended in their capacity as members of the Clinical Governance Committee.*

– Not required to attend.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate to ensure the Scheme remains the leading open medical scheme in the industry. This is done through continuous product and benefit innovations and enhancements while also ensuring the Scheme is sustainable and compliant with the regulated reserves, and able to meet the needs of members in the case of significant unforeseen events, as was the case with COVID-19.

REMUNERATION COMMITTEE

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

The responsibilities of the Committee include:

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

Activities during 2020

- Recommended Trustee and Independent Committee Member remuneration to the Board for approval and advised the Board on regulatory aspects of remuneration implementation, with due regard to the fact that the Scheme's AGM was not held.
- Considered and recommended the Trustee and Independent Committee Member Remuneration Policy to the Board for approval and advised the Board on regulatory aspects of policy implementation, with due regard to the fact that the Scheme's AGM was not held.
- Considered and recommended employee remuneration to the Trustees for approval.
- Considered and recommended Scheme human resources policies to the Board for approval.
- Considered and approved training and development requirements for Scheme employees.
- Considered plans to address the impact of COVID-19 on Scheme employees.
- Assessed and provided input into the Scheme's culture and values alignment plans.

The Committee is satisfied its activities, recommendations and reporting to the Board during 2020 have fulfilled its responsibilities in accordance with its terms of reference.

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

Our committees' mandates, activities, attendance and future focus *continued*

Composition and meetings in 2020

At the end of 2020, the Committee comprised four Trustees and an Independent Committee Member. The Principal Officer attends Committee meetings by invitation.

REMUNERATION COMMITTEE attendance in 2020		21 May	05 Nov
Trustee/ Chairperson	Mr Dave King	✓	✓
Committee Members	Mr John Butler (Trustee)	✓	✓
	Mr Ndumiso Luthuli (Independent Member)	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓
	Dr Susette Brynard (Trustee)	✓	✓

Future focus areas

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

- Exercising oversight of the revised performance management approach with the intention of full implementation in 2021;
- Continuing to engage with the Principal Officer and Board on the Scheme's Remuneration Policy and ensuring the appropriateness of remuneration and reward arrangements and/or systems; and
- Reviewing the Scheme's remuneration practices, where appropriate, and ensuring these comply with changing legislative and regulatory requirements, including those relating to King IV.

RISK COMMITTEE

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

The purpose of the Risk Committee is to exercise ongoing oversight of risk management, and the Committee's responsibilities include:

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

Compliance management

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

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

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

Risk management

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

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

Our committees' mandates, activities, attendance and future focus *continued*

Activities during 2020

- Participated in the annual risk assessment, which included representatives of the Committee, the Scheme Office, and the administrator and managed care provider.
- Regularly reviewed risk management reports and key risk indicators, and performed the review of the risk management framework and risk appetite recommended to the Trustees for approval.
- Regularly reviewed compliance reports and monitored exposure and actions taken to mitigate compliance risks.
- Received reports to assist in managing the Scheme's IT governance obligations. This included a focus on cybersecurity and business continuity.
- Considered specific risks related to data sharing across the industry to ensure that Scheme and member data are protected.
- Approved the Scheme's fraud risk management strategy.
- Reviewed and monitored reports on the service levels delivered by Discovery Health.
- Assessed the value added to the Scheme by Discovery Health.
- Reviewed the Scheme's non-healthcare expenses against budget.
- Reviewed and recommended to the Board for approval, the new accredited administration and other administration services agreements to be entered into by the Scheme and Discovery Health, arising from the implementation of CMS Circular 77 of 2019.
- Reviewed the Committee's terms of reference.

The Committee is satisfied its activities recommendations and reporting to the Board during 2020 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2020

At the end of 2019, the Committee comprised two Independent Members, two members of the Scheme Office, and two Trustees, one of whom chaired the Committee. The external auditors, PwC, as well as the Discovery Group Risk Management function and Discovery Group Compliance function attend every Committee meeting. Representatives from Discovery Health also attend to provide detailed operational insight.

RISK COMMITTEE attendance in 2020		12 Mar	28 Jul[A]	13 Aug	15 Oct	26 Nov[A]
Trustee/ Chairperson	Mr Dave King (Trustee)	✓	✓	✓	✓	✓
Committee Members	Dr Alewyn Burger (Independent Member) [∞]	✓	✓	✓	✓	✓
	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓	✓
	Adv Joan Adams (Trustee)	✓	✓	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) [#%]	✓	✓	✓	✓	✓
	Mr Selwyn Kahlberg (Chief Risk Officer) [%]	✓	✓	✓	✓	✓

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

- *The meeting on 8 July 2020 was for the Scheme's annual risk register review, to which Committee Members were invited.*
- *A meeting was convened on 26 November 2020 to discuss Circular 77 of 2019: Administration Agreements.*

∞ Appointed as an Independent Audit and Risk Committee Member effective 01 January 2020.

 # Ms Mbewu was Acting Principal Officer until she was appointed Principal Officer, effective 01 July 2020.

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

Future focus areas

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

Our committees' mandates, activities, attendance and future focus *continued*

STAKEHOLDER RELATIONS AND ETHICS COMMITTEE

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

Ethics and society:

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

Stakeholder relations:

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

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

Activities during 2020

- Considered the impact of COVID-19 and how best to support the Scheme's members and other stakeholders, and reviewed the impact of the Scheme's and other organisations' interventions to understand the widespread national effects of the pandemic from a stakeholder perspective.
- Reviewed reports relating to the Committee's social and ethics mandate, including overall stakeholder engagement and risk, social media engagement, disputes and complaints, the Scheme's workplace, Treating Customers Fairly (TCF) and high-risk cases.
- Reviewed stakeholder responses to year-end benefit changes along with stakeholder engagement plans, where required.
- Considered the consequences to members and the Scheme of postponing the Scheme's AGM and Trustee nominations and elections due to the COVID-19 pandemic.
- Considered information regarding the activities of the Dispute, Relationship Management and Research Governance Committees, and ratified appointments to the Dispute Committee.
- Discussed impending regulatory changes which may affect the Scheme's members, other stakeholders, and the operations of the Scheme.
- Reviewed the establishment of new industry bodies and patient advocacy groups and considered the Scheme's relationship to these.
- Considered the progress of the implementation of some of the recommendations of the HMI and how these would affect members, as well as activity regarding the NHI Bill.
- In early 2021, closely considered the interim report of the Section 59 Investigation Panel and its implications for the Scheme and our stakeholders.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2020 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2020

At the end of 2020, the Committee comprised five Trustees, one of whom chaired the Committee, and the Principal Officer. The Committee requires that one of its members is a medical professional.

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

STAKEHOLDER RELATIONS AND ETHICS COMMITTEE attendance in 2020		27 Feb	21 May	05 Nov
Trustee/ Chairperson	Mr John Butler	✓	✓	✓
Committee Members	Mr Dave King (Trustee)	✓	✓	✓
	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Adv Joan Adams (Trustee)	✓	✓	✓
	Mr Neil Morrison (Trustee) ∞	✓	✓	–
	Dr Susette Brynard (Trustee)	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) % #	✓	✓	✓
Attendees	Mr Johan Human (Trustee) *	–	✓	–

∞ *Resigned as Committee Member effective 30 April 2020. Mr Morrison attended the meeting of 21 May 2020 on the invitation of the Chairperson, and was not remunerated for attendance.*
% *Scheme Executive. All other Committee Members are non-executive.*
# *Ms Mbewu was Acting Principal Officer until she was appointed Principal Officer, effective 01 July 2020.*
* *Mr Human attended the meeting of 21 May 2020 on the invitation of the Chairperson, and was not remunerated for attendance.*
– *Not required to attend.*

Future focus areas

In addition to its usual focus areas, the Committee will be closely monitoring COVID-19, its effects on stakeholders and society and any regulatory and other developments emerging from the country's response to the pandemic.

Our committees' mandates, activities, attendance and future focus *continued*

ACCREDITATION COMMITTEE

The Accreditation Committee is an ad-hoc committee established on 30 January 2020 by the Trustees to deliberate on matters raised by the CMS with regards to the accreditation of Discovery Health (Pty) Ltd, and provide feedback to the Trustees. The Committee was established in terms of Rule 19.3 of the Scheme Rules, which gives power to the Board:

"To appoint and delegate authority to a subcommittee consisting of such Board Members and other experts as it may deem necessary. This Committee will be responsible to provide feedback to the Board. The Board remains responsible and accountable for the fulfilment of its functions despite the appointment of any subcommittee."

Activities during 2020

The Committee met once to consider aspects of the accreditation standards required, and provided feedback to the Trustees accordingly. Subsequently, the Committee received and evaluated periodic progress updates on the Discovery Health accreditation project through email correspondence. All related feedback has also been reported directly by Discovery Health to the Trustees.

Composition and meetings in 2020

The Committee comprises four Trustees and was convened once during 2020.

ACCREDITATION COMMITTEE attendance in 2020		20 Feb
Trustee/Chairperson	Dhesan Moodley	✓
Committee Members	Adv Joan Adams	✓
	Mr Johan Human	✓
	Mr John Butler	✓

Future focus areas

This Committee will be dissolved when concerns and queries raised by the CMS have been concluded.

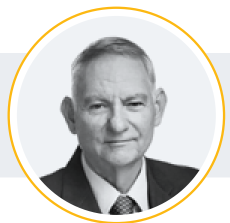
Independent Member terms[1]

INDEPENDENT BOARD COMMITTEE MEMBER	Designation	Appointed/ Elected	Start of Term	End of Term
Eric Mackeown	Chair of the Audit Committee, Independent Risk and Investment Committee Member	Appointed	01 Sep 19	31 Aug 22
Alewyn Burger	Independent Audit and Risk Committees Member	Appointed	01 Jan 20	31 Dec 22
Ndumiso Luthuli	Independent Remuneration Committee Member	Appointed	18 Apr 18	17 Apr 21
Nonkululeko Mlaba	Independent Clinical Governance Committee Member	Appointed	28 Aug 18	27 Aug 21
Selma Smith	Independent Clinical Governance Committee Member	Appointed	01 Jan 16	31 Dec 18
		Re-appointed	01 Jan 19	31 Dec 21
Susan Ludolph	Independent Audit and Risk Committees Member	Appointed	19 Jan 16	19 Jan 19
		Re-appointed	20 Jan 19	19 Jan 22
Peter Goss	Chair of the Nomination Committee	Appointed	22 Oct 15	22 Jun 17
		Re-appointed	28 Aug 18	30 Sep 21[2]
Tom Wixley	Nomination Committee Member	Appointed	22 Oct 15	22 Jun 17
		Re-appointed	28 Aug 18	30 Sep 21[2]
Roy Shough	Nomination Committee Member	Appointed	22 Oct 15	22 Jun 17
		Re-appointed	28 Aug 18	30 Sep 21[2]

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

2 Amended from the date 26 June 2020 reported in the 2019 Integrated Report. The change is due to COVID-19 restrictions on public gatherings which prevented Trustee elections being held as planned; these have since been postponed to 2021. As the Board constitutes the Nomination Committee only when required for Trustee elections, these Committee Member terms are not for a fixed three-year period.

Independent Board Committee Members[1]



DR ALEWYN BURGER (69)

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

Member of the Audit and Risk Committees

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

MR ERIC MACKEOWN (63)

CA(SA)

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

More than 40 years' experience in the Accounting and Auditing profession. Was lead audit partner for numerous major multinational and JSE-listed companies. Thorough and deep understanding of the health and medical aid industries.

DR PETER GOSS (53)

Professor of Practice (Governance, Fraud Risk, Forensic Auditing): University of Johannesburg; PhD (Criminal Justice), College of Law, UNISA

Chairperson of the Nomination Committee

Established corporate governance adviser and forensic auditor with a career spanning over 30 years. Author of three books on Corporate Governance, Fraud and Corruption Risk Governance, and the Forensic Investigation Process.

MRS SUE LUDOLPH (57)

CA(SA)

Member of the Audit Committee

Technical expert in IFRS and financial and integrated reporting, including standard setting for accounting in South Africa. Established and implemented the strategy and work plan for South Africa's first top 100 CFO Forum to guide, influence and lead on issues affecting CFOs and business. Independent non-executive director of Fortress REIT from December 2018, a member of their Audit and Risk Committees and appointed Chairperson of the Risk Committee from December 2019. Judge for the PwC Building Public Trust Awards from 2014 to 2018.

MR NDUMISO LUTHULI (45)

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

Member of the Remuneration Committee

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

DR NONKULULEKO MLABA (49)

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

Member of the Clinical Governance Committee

Seasoned healthcare professional with a medical degree and postgraduate public health and health economics qualifications, working as a specialist radiation oncologist at Charlotte Maxeke Academic Hospital. Deep understanding of managed healthcare, healthcare regulation and clinical research.

MR ROY SHOUGH (70)

CA(SA); HDip BDP

Member of the Nomination Committee

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

DR SELMA SMITH (59)

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

Member of the Clinical Governance Committee

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

MR TOM WIXLEY (80)

BCom; CA(SA)

Member of the Nomination Committee

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

1 Note: all ages as at 31 December 2020.
2 Bachelor of Civil Law.
3 Masters in Family Medicine.
4 Fellow of the College of Family Physicians of South Africa.

Our approach to **remuneration**

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

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

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

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

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

The purpose of the Remuneration Policy is to:

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

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

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

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

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

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

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

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

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

Managing the Scheme Office

As one of their fiduciary duties, the Trustees appoint and delegate accountability for the day-to-day management of the Scheme to the Principal Officer, who is the chief executive and accounting officer of the Scheme.

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

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

Guided by the Act, its Regulations, the Scheme Rules along with other applicable laws, codes and standards, the Board's delegation of authority to the Principal Officer is supported by an executive management team in executing the strategic objectives of the Scheme. The team works in collaboration with Discovery Health, which provides it with administration and managed care services, to implement strategy.

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

Remuneration and human resources planning

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

The Scheme must attract and retain high-calibre staff to manage and oversee its complex operations. In 2020, the Scheme Office consisted of twelve staff members, including a team of six executives who report to the Principal Officer and are supported by the Scheme Secretariat and administration departments. This lean employee complement makes succession planning challenging and, as a result, the operational model applied by the Scheme Office requires significant overlap in executive team capabilities. In turn, this must be supported by a mature knowledge management and retention strategy to mitigate this risk, including a notice period sufficient to allow for transition and recruitment of scarce skills.

Staff movements during 2020/21

In April 2021, Ms Joy Malete joined us as our new Chief Financial Officer (CFO). Ms Malete is a qualified CA (SA) with over nine years cumulative working experience and over six years post articles experience, five of which were in management positions.

Scheme Secretariat

The Scheme has an appropriately qualified and experienced secretariat function within its operational structure that provides the Board with support regarding their duties, responsibilities and powers. In addition, the secretariat function ensures that all rules and legislation applicable to the Scheme are adhered to by the Board and its Committees during meetings, and that Board decisions are implemented. The Scheme Secretariat is also responsible and accountable for all governance-related records and documentation for the Scheme.

Delegation of authority

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

PRINCIPAL OFFICER

Ms Charlotte Mbewu[1]

BCom (Hons) Accounting; CA (SA)

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

Accounting (Chief Executive) Officer of the Scheme.

1 HEAD: LEGAL AND ETHICS (HLE)

Mr Howard Snoyman

LLB; MSc. Med (Bioethics and Health Law); Dip Sports Management; Adv Dip Sports Management; Certified Deal Architect[3]; Certified Ethics Officer ; Certified Fraud Examiner (in progress); MicroMasters (Healthcare Administration) (in progress).

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

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

2 HEAD: COMPLIANCE AND GOVERNANCE (HCG)

Mrs Lusani Nelufule-Mugivhi

LLB; Postgraduate Diploma in Compliance Management

Board member of the Corporate Counsel Association of South Africa.

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

6 CHIEF FINANCIAL OFFICER (CFO)

Mrs Joy Malete[7]

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

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

3 CHIEF MEDICAL OFFICER (CMO)

Dr Unati Mahlati

MBChB; FCPHM[4]; MMed; MBA (in progress)

Board member of HQA[5].

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

4 CHIEF OPERATIONS OFFICER (COO)

Mr Selwyn Kahlberg

BSc (Hons) Actuarial; CFA; FASSA; FIA

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

5 HEAD: SPECIAL PROJECTS AND STAKEHOLDER RELATIONS (HSPSR)

Ms Michelle Culverwell

BA (Hons); MBA in Executive Management

Member of the HFA[6] Technical Advisory Committee.

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

1 *Previously the CFO, Ms Mbewu was appointed Acting Principal Officer from 1 December 2019 after the resignation of the previous Principal Officer. On 1 July 2020, after a rigorous recruitment process followed by the Board of Trustees, she was appointed Principal Officer. She acted as CFO until 11 April 2021.*
2 *iFHP: International Federation of Health Plans.*
3 *The Vested® Certified Deal Architect (CDA) programme, offered by the University of Tennessee, certifies individuals as experts in the field of collaborative contracting and negotiations.*
4. *Fellow of the College of Public Health Medicine of South Africa.*
5. *HQA: Health Quality Assessment.*
6. *HFA: Health Funders Association.*
7 *Ms Malete was appointed CFO from 12 April 2021.*

Regulatory and industry matters dealt with in 2020

FRAUD, WASTE AND ABUSE

In recognition of the severe impact of fraud, waste and abuse (FWA) on medical schemes and their members, the CMS held its inaugural annual FWA Summit in early 2019. DHMS attended and, together with other industry stakeholders, signed an industry charter pledging to combat FWA. An industry code of good practice for managing incidents of FWA is in development, and the HFA has submitted its code for consideration for incorporation into the industry-wide approach.

During 2019, the CMS convened an inquiry into the scope and use of Section 59 of the Act which confers on medical schemes powers to recover funds unduly paid to either members or healthcare practitioners. Various healthcare professionals, facilities, medical schemes and medical scheme administrators testified at the inquiry, as did Discovery Health and DHMS. The Scheme and Discovery Health were able to explain in detail the processes and principles of its activities to combat FWA, and to demonstrate that these are legal and ethical, together with making written submissions in support of the testimony.

The publication of the investigation report was delayed during 2020; however an interim report was published for stakeholder comments in early 2021 and Discovery Health made a submission to the Panel on 5 April 2021 in this regard. The Scheme and Discovery Health support the objectives of the Panel and are committed to the development and implementation of an industry framework and code of good practice to ensure clear standards of procedural fairness.

COVID-19

Throughout 2020 and into 2021, the pandemic has driven significant industry activity. This has been characterised by high levels of co-operation, with proactive steps taken to support all South African citizens, including Scheme members and other stakeholders. In recognition of the economic impact of the pandemic, particularly during and after the hard lockdown, the Trustees approved the submission of exemption applications in respect of certain provisions of the Act and Scheme Rules, enabling the Scheme to provide much needed economic relief to members. Qualifying members were afforded the opportunity to utilise their positive medical savings account balances to pay for monthly Scheme contributions, and concessions were granted to qualifying small and medium enterprise employer groups. Several COVID-19 benefits were launched to facilitate members' access to diagnostic testing and treatment and care, with some exceeding the Prescribed Minimum Benefits (PMBs). Through HFA, engagements have taken place with the CMS and the Department of Health to ensure rapid adoption of updated PMB guidelines for funding COVID-19 care through risk benefits. DHMS has also been highly supportive of the country's initiatives to timeously procure and distribute effective COVID-19 vaccines to all South Africans, to protect the population and restore the economy. The Scheme continues to contribute to these efforts through HFA representation.

> "Several COVID-19 benefits were launched to facilitate members' access to diagnostic testing and treatment and care.

CMS MATTERS

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

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

Scheme Rule 14.7 dealing with the rejection of claims from providers where these place the Scheme at risk, was submitted to the CMS in 2012 and was registered. Subsequent iterations of the Rule were the subject of debate with the CMS and were not registered. The matter was taken on appeal in terms of Section 49 of the Act and was set down for hearing on 13 July 2018. Just prior to the appeal hearing, the CMS conceded that the Rule was in effect still registered and, by agreement, the hearing was no longer necessary.

The effect of this concession is that the Rule, as it stood when last registered in 2012, remains legally registered and enforceable. At the time of writing, iterations of the Rule from 2014, up to and including 2020, remain unstamped (unregistered) by the CMS, however this does not affect the validity of the 2012 registration (also stamped and thus re-registered in 2013).

The explanatory notes to Annexure A of the Regulations to the Act acknowledge that, due to constantly changing medical practice and health technology, PMBs must be reviewed every two years taking cognisance of the impact, effectiveness and appropriateness of the PMB package. The PMB Review project, convened by the CMS with industry stakeholders including medical schemes and administrators represented in the Advisory and Costing Committees, is ongoing since 2017. Thus far a draft Primary Health Care Package has been published, and is currently being costed.

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

The CMS subsequently held a number of stakeholder engagements and has established two advisory committees incorporating stakeholders from both the insurance and medical scheme industries to develop a roadmap for the products. In Circular 56 of 2020, the CMS extended the exemption period to 31 March 2022. As of early 2021, the work of these committees to assist the CMS to establish the best way forward, while protecting the many lives currently covered by these products, is in progress. DHMS will engage with this important work through the HFA wherever appropriate, and supports the development of an LCBO framework. LCBOs will expand necessary access for low-income and uninsured households, ensuring access to quality and appropriate care while expanding and improving the risk pools of medical schemes and also reducing pressure on public sector resources and infrastructure.

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

COMPETITION COMMISSION'S HEALTH MARKET INQUIRY (HMI) INTO THE PRIVATE HEALTHCARE INDUSTRY

On 30 September 2019, the final report of the inquiry by the Competition Commission into the private health industry to determine whether there are aspects of the market which distort, restrict or prevent competition was published. The Scheme supports the implementation of the HMI's recommendations wherever these contribute to improved functioning within the industry, to the benefit of all South Africans. In September 2020, the Competition Commission indicated that it had begun discussions with the CMS and the Department of Health about establishing a multi-stakeholder working committee for the development of a multi-lateral tariff negotiating framework and voluntary outcomes monitoring and reporting functionality[1]. The HMI also confirmed that administrators are within their rights to negotiate collectively for the restricted schemes they administer in addition to a single open scheme, as there is no mutual competition between such schemes.

> The Scheme supports the implementation of the HMI's recommendations wherever these contribute to improved functioning within the sector, to the benefit of all South Africans.

1 *Initially, this will be hosted by the Health Quality Assessment (HQA).*

DISCOVERY HEALTH ACCREDITATION

All administrators and managed care providers in the industry must renew their CMS accreditation every two years. In December 2019, the CMS informed the Scheme that administration accreditation was granted to Discovery Health to perform administration services for a further two-year period, extending this to 31 December 2021. The accreditation was subject to conditions which Discovery Health was required to fulfil. The Trustees and Principal Officer closely monitored the fulfilment of these conditions in line with their governance responsibilities and fiduciary duties. In 2020, Discovery Health submitted evidence of compliance to the CMS and awaits further feedback.

NATIONAL HEALTH INSURANCE (NHI) AND THE DRAFT MEDICAL SCHEMES AMENDMENT BILL

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

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

The Parliamentary Committee on Health (PCH) conducted extensive stakeholder engagements and has received over 100 000 submissions, which are under review as of early 2021. DHMS and Discovery Health have requested to present to the PCH on their submission and await scheduling of this matter.

07 OUR PERFORMANCE

Scheme performance **for the 2020 financial year**

The Scheme's limited sources of financial capital (derived only from member contributions and returns from investing member funds) requires a careful balancing of the resources required to meet our strategic objectives, and the financial sustainability and solvency requirements of the Council for Medical Schemes (CMS).

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

Overview

For the year ended 31 December 2020, DHMS delivered a positive net healthcare result of R7 451 million (2019: R136 million). This sharp year-on-year increase in surplus is attributable to members deferring healthcare during the COVID-19 pandemic. The Scheme expects a reversal of this during the next two years, as pent-up healthcare needs – likely exacerbated by worsened states of health due to postponing care – result in steep increases in utilisation.

Despite volatile and uncertain investment markets, the Scheme generated a healthy investment income of R1 690 million (2019: R1 698 million), contributing to the net surplus of R9 006 million (2019: R1 563 million) for the year.

This solid financial performance increased members' funds to R28.2 billion (2019: R19.2 billion) with a solvency level of 36.9% (2019: 27.5%), exceeding the regulatory requirement of 25%. Receiving a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co (GCR), the Scheme has achieved the highest possible rating for a medical scheme in South Africa for the 21st consecutive year, confirming the Scheme's financial strength and ability to pay claims. Despite challenging and unusual market conditions, it is the Trustees' view that DHMS ended 2020 in a strong financial position, and remains well-positioned to continue to meet members' needs despite expected increases in utilisation.

INVESTMENT INCOME
R1 690 million
(2019: R1 698 million)

NET SURPLUS
R9 006 million
(2019: R1 563 million)

MEMBERS' FUNDS
R28.2 billion
(2019: R19.2 billion)

SOLVENCY LEVEL
36.9%
(2019: 27.5%)

CREDIT RATING
AAA
The Scheme has achieved the highest possible rating for a medical scheme in South Africa for the **21ST CONSECUTIVE YEAR**

1 At 31 December 2020.

Key performance information

Ensuring the Scheme's sustainability

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

GROWTH AND SUSTAINABILITY

MEMBERSHIP GROWTH

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

AVERAGE NET MEMBERSHIP DECLINE[1]
1.57%
(2019: 0.06% growth)

AVERAGE BENEFICIARY DECLINE[1]
1.77%
(2019: 0.39% decline)

AVERAGE AGE AT YEAR-END[2]
35.86
(2019: 35.33)

10.98%
PENSIONER RATIO[3]
(2019: 10.35%)

5.19%
ANNUALISED LAPSE RATE
(2019: 5.41%)

MEMBERSHIP SIZE

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

1 330 513
PRINCIPAL MEMBERS
at 31 December 2020
(2019: 1 351 720)

2 758 340
BENEFICIARIES
at 31 December 2020
(2019: 2 808 106)

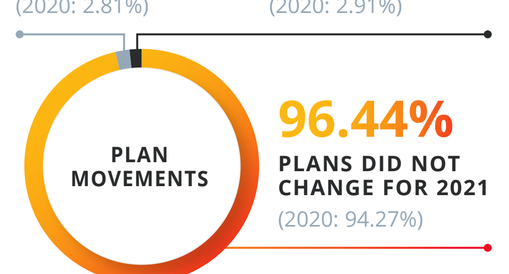
57.0%
SHARE OF OPEN SCHEME MARKET[4]
(2018: 56.7%)

PLAN MOVEMENTS

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

1.96%
PLANS WERE UPGRADED
(2020: 2.81%)

1.60%
PLANS WERE DOWNGRADED
(2020: 2.91%)



96.44%
PLANS DID NOT CHANGE FOR 2021
(2020: 94.27%)

RELATIVE CONTRIBUTION LEVELS

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

AVERAGE CONTRIBUTIONS FOR 2021
17.3%
lower than the next eight largest open schemes[5]
(2020: 16.7%)

1 *Membership growth across medical schemes is currently affected by affordability and a challenging economic climate, including job losses.*
2 *An increase of less than one year per annum is favourable as it indicates that young people are joining the Scheme.*
3 *Based on beneficiaries' dates of birth.*
4 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2020 (www.medicalschemes.co.za/publications/#2009-2010-wpfd-annual-reports).*
5 *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a single member and for a family unit comprising one principal member, one adult dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. The data is sourced from published contributions for 2021 and uses a maximum average contribution increase of 2.95% for DHMS in 2021 (0% for the first six months of 2021, and a maximum of 5.9% for the second six months).*

FINANCIAL STRENGTH AND MANAGEMENT

ABSOLUTE RESERVES

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

ACCUMULATED FUNDS EXPRESSED AS A PERCENTAGE OF GROSS ANNUAL CONTRIBUTIONS

36.9%

(2019: 27.5%)

exceeding the statutory solvency requirement of 25%

AAA

INDEPENDENT CREDIT RATING FOR CLAIMS PAYING ABILITY[1]

(2020: AAA)

PRICING SUFFICIENCY

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

NET SURPLUS FOR THE YEAR OF[2]

R9 006 million

(2019: R1 563 million)

PRUDENT INVESTMENT MANAGEMENT

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

5.77%

GROSS RETURN ON INVESTMENTS

(2019: 7.02%)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE

FOR EVERY R1.00 SPENT BY DHMS ON ADMINISTRATION AND MANAGED CARE FEES IN 2019[3], OUR MEMBERS RECEIVED

R2.03

(2018: R2.12)

in value from the activities of Discovery Health. This is equivalent to nominal added value of R7.09 billion in 2019 (2018: R7.34 billion)

ADMINISTRATION FEES

7.23%

of gross contributions

(2019: 7.38%)

MANAGED CARE FEES

2.54%

of gross contributions

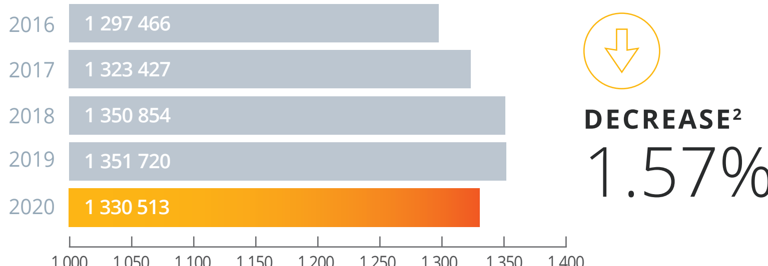
(2019: 2.53%)

1 *Rating affirmed in April 2021, and refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*
2 *Claims experience in 2020 was substantially reduced due to deferred healthcare seeking during the COVID-19 pandemic.*
3 *As the assessment uses industry information, results are only available for the preceding year.*

Historical performance indicators

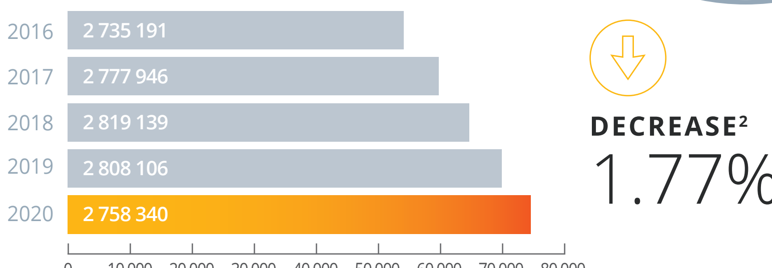
Consistent with the stagnant South African economy and the impact of COVID-19, the medical scheme industry is experiencing a slight decline[1]. Despite this environment, the Scheme's number of principal members and total lives under management remain stable, and members' funds are sufficient to assure members that the Scheme is able to take care of them.

SCHEME PRINCIPAL MEMBERS



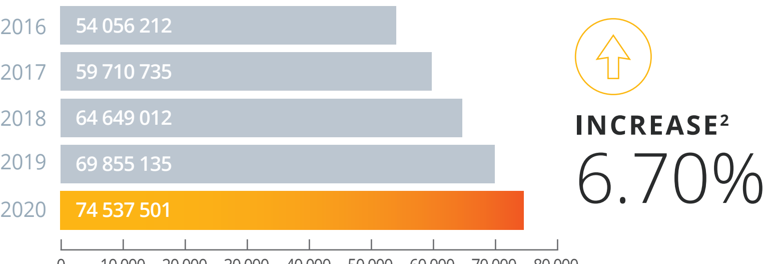
DECREASE[2]
1.57%

SCHEME LIVES



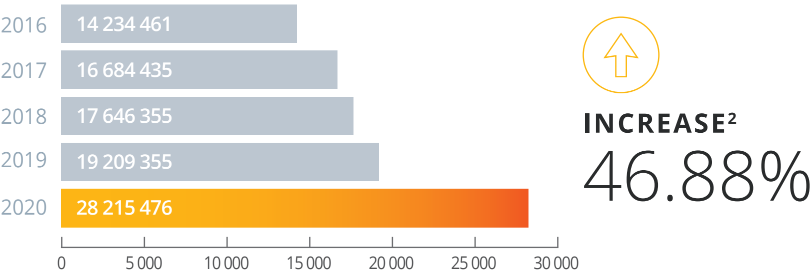
DECREASE[2]
1.77%

GROSS CONTRIBUTIONS (R'000)



INCREASE[2]
6.70%

MEMBERS' FUNDS (R'000)



INCREASE[2]
46.88%

1 *According to the Q3 2020 CMS report, at the end of September 2020, a total of 8 901 342 beneficiaries were covered, down from 8 953 000 at the end of 2019.*
2 *Year-on-year change (2019 – 2020).*

DHMS plans and beneficiary distribution

17
BENEFIT OPTIONS
(2019: 17)

6
NETWORK EFFICIENCY DISCOUNT OPTIONS*
(2019: 6)

Saver Series:
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta* Saver
- Essential Delta* Saver

KeyCare Series:
- KeyCare Plus
- KeyCare Core
- KeyCare Access

Core Series:
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

Comprehensive Series:
- Classic Comprehensive
- Classic Comprehensive Zero MSA
- Essential Comprehensive
- Classic Delta* Comprehensive
- Essential Delta* Comprehensive

Priority Series:
- Classic Priority
- Essential Priority

Smart Series:
- Classic Smart
- Essential Smart

Executive Series:
- Executive

MEMBER DISPUTES AND CMS COMPLAINTS

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

The number of CMS complaints made by DHMS members reduced by 26% to 401 in 2020 (2019: 604), a fraction of the 47 675 525 claims made by Scheme members in 2020 (2019: 51 206 844). The ratio of internal disputes to CMS complaints has continued to improve from 39% in 2015, to 51.7% in 2016, 97% in 2017, 119% in 2018, 130% in 2019, and 134% in 2020.

The internal disputes mechanism continues to prove effective in resolving the majority of cases amicably, with a high rate of withdrawals and settlements achieved without the member requiring a hearing. In 2020, 757 disputes were lodged in terms of Rule 27[1], with 692 or 91% of disputes being settled or withdrawn prior to a hearing. Only 43 cases proceeded to a hearing before the Dispute Committee.

During 2020, the Disputes Committee process was made available to healthcare providers wishing to escalate a disagreement with the Scheme, and the first hearings of this nature were held in early 2021.

GROSS CONTRIBUTION INCOME

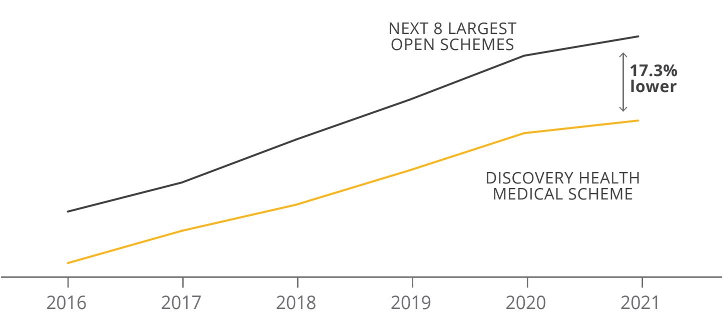
Maintaining the balance between competitive contributions and providing affordable quality healthcare to our members, while also retaining regulatory reserve requirements remains a challenge.

The Scheme remained highly competitive with average contributions for 2021 being 17.3% lower[2] on a plan-for-plan basis (2020: 16.7%) than the next eight largest open schemes; this is predominantly due to our ability to contain the impact of healthcare inflation. With a maximum average contribution increase of 2.95% for DHMS members compared to 4.93% across the next eight largest open schemes, our members experienced lower contribution increases than the weighted average across the next eight largest open schemes.

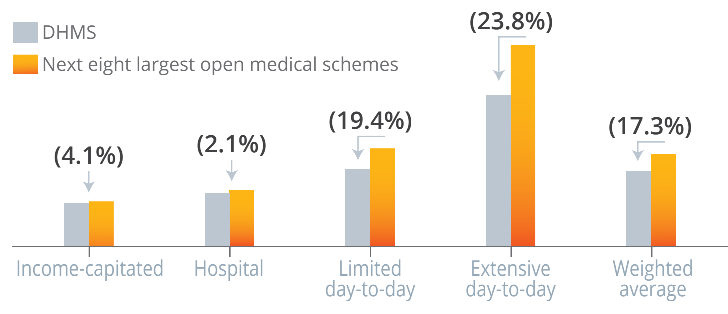
As a consequence of the COVID-19 pandemic, the Scheme experienced a sharp reduction in utilisation, with deferral of healthcare resulting in 76.5%[3] of contributions being used to fund claims for members' direct benefit. The remainder of the funds are used to build reserves and support and benefit members in areas such as innovation, managed care, administration, financial advisers and the daily operations of the Scheme.

Driven by contribution increases required to match healthcare inflation, gross contribution income rose 6.7% to R74.5 billion (2019: R69.9 billion). The most significant net membership growth was recorded in mid- to low-tier options, where the Smart series recorded net membership growth of 16 512 (2019: 17028). At a net principal membership decline of 14 452 (2019: 11628), the Comprehensive series of plans experienced the largest reduction.

DHMS contributions are 17.3% lower than the next eight largest open medical schemes in 2021



DHMS is more affordable across all plan categories in 2021



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

2 To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a single member and for a family unit comprising one principal member, one adult dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. The data is sourced from published contributions for 2021 and uses a maximum average contribution increase of 2.95% for Discovery Health Medical Scheme in 2021 (0% for the first six months of 2021, and a maximum of 5.9% for the second six months).

3 Reduced from 87.3% in 2019 due to the deferral of healthcare by members and a reduction in claims experience.

NET CLAIMS INCURRED

Net claims incurred decreased by 7.63% to R44.8 billion (2019: R48.5 billion), a lower rate of increase than the previous year attributable to the impact of COVID-19 on healthcare-seeking behaviour. The Scheme expects a concomitant increase in claims between 2021 and 2022, likely with a more severe disease case mix, as pent-up healthcare needs drive increased utilisation.

The gross claims ratio[1] reduced to 76.5 % (2019: 87.3 %) through a combination of reduced claims because of COVID-19 and robust risk management interventions implemented by the Scheme's administrator and managed care provider, Discovery Health.

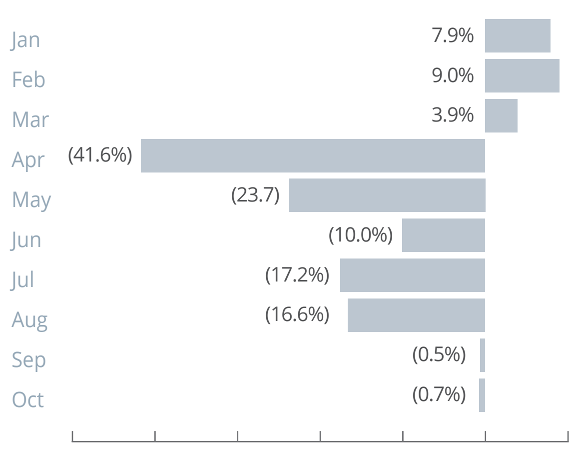
Healthcare inflation continues to be a concern for medical schemes, with inflation consistently above consumer price index (CPI) inflation. The primary driver of healthcare inflation is the extent of healthcare services utilisation due to demand- and supply-side effects. Higher supply-side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare. Increases in demand-side utilisation, on the other hand, pertain to deterioration in the demographic profile of beneficiaries.

COVID-19 has had a material impact on the entire healthcare system during 2020, dampening the expected influence of demand- and supply-side effects due to:

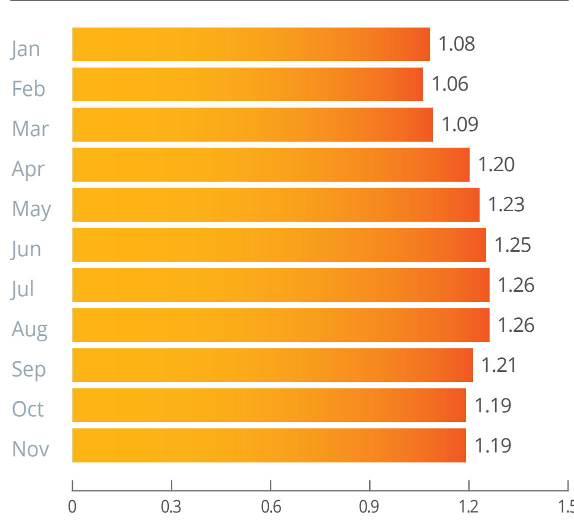
- The extensive government regulations issued under the Disaster Management Act which limited freedom of movement.
- Reduced capacity within hospitals to treat non-COVID-19 and non-emergency cases due to the high number of hospital beds used for treating COVID-19 cases.
- Members reducing infection risks by deferring, or choosing to forgo treatment that would ordinarily have taken place in hospitals or at a provider's practice.
- The higher degree of severity in hospital admissions (increased by 11.6% compared to 2019), despite a lower total number of hospital admissions.
- Additional costs incurred for Personal Protective Equipment (PPE) used by healthcare practitioners when treating patients.

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).*

Unprecedented claim patterns in 2020
Risk cost per life per month (PLPM), year-on-year change

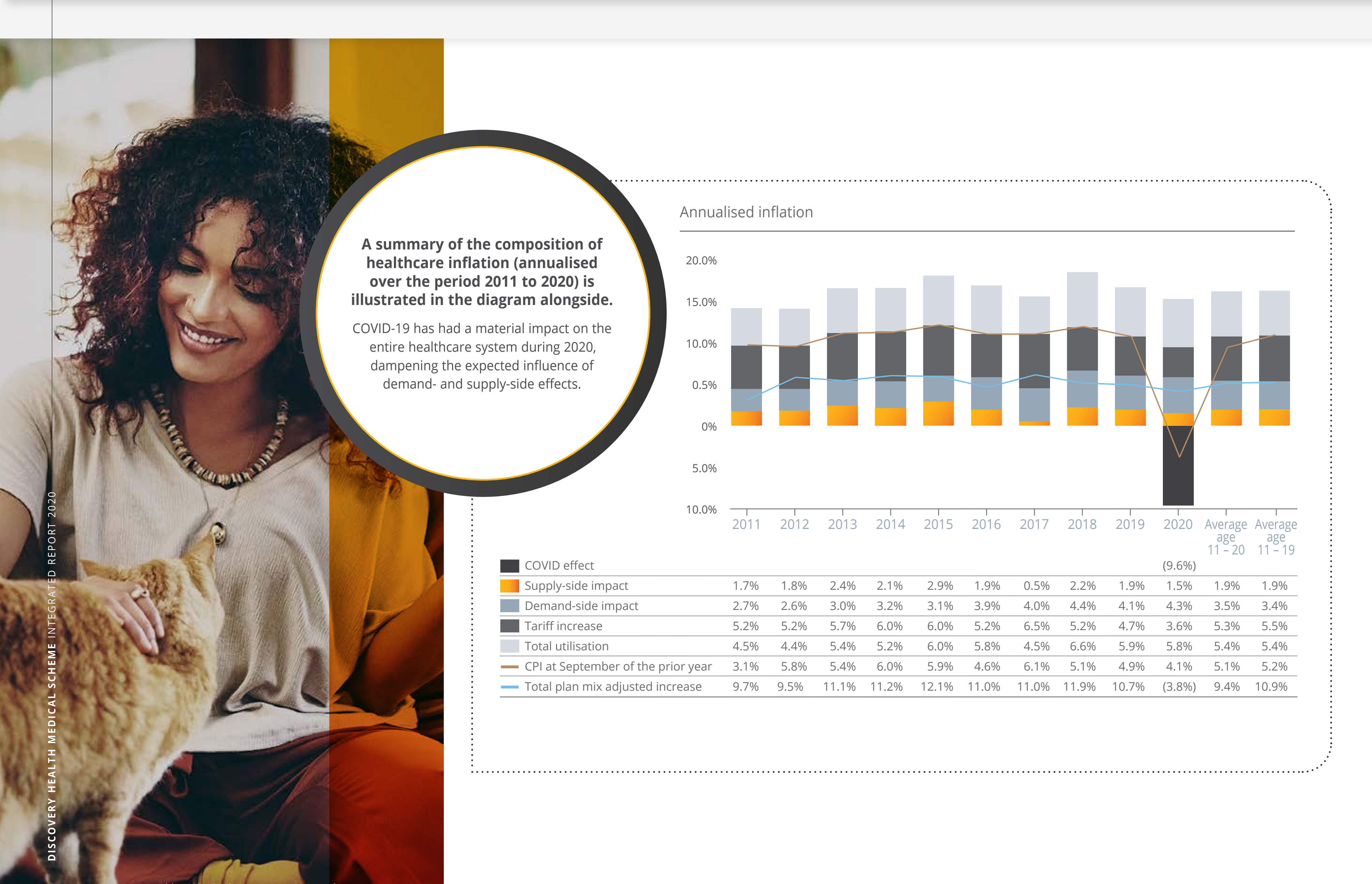


Higher severity admissions in 2020



9.4%
LOWER COST PLPM, PAID FROM RISK (YEAR-TO-DATE OCTOBER 2020)

11.6%
MORE SEVERE ADMISSIONS



A summary of the composition of healthcare inflation (annualised over the period 2011 to 2020) is illustrated in the diagram alongside.

COVID-19 has had a material impact on the entire healthcare system during 2020, dampening the expected influence of demand- and supply-side effects.

Annualised inflation

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Average age 11 – 20	Average age 11 – 19
COVID effect										(9.6%)		
Supply-side impact	1.7%	1.8%	2.4%	2.1%	2.9%	1.9%	0.5%	2.2%	1.9%	1.5%	1.9%	1.9%
Demand-side impact	2.7%	2.6%	3.0%	3.2%	3.1%	3.9%	4.0%	4.4%	4.1%	4.3%	3.5%	3.4%
Tariff increase	5.2%	5.2%	5.7%	6.0%	6.0%	5.2%	6.5%	5.2%	4.7%	3.6%	5.3%	5.5%
Total utilisation	4.5%	4.4%	5.4%	5.2%	6.0%	5.8%	4.5%	6.6%	5.9%	5.8%	5.4%	5.4%
CPI at September of the prior year	3.1%	5.8%	5.4%	6.0%	5.9%	4.6%	6.1%	5.1%	4.9%	4.1%	5.1%	5.2%
Total plan mix adjusted increase	9.7%	9.5%	11.1%	11.2%	12.1%	11.0%	11.0%	11.9%	10.7%	(3.8%)	9.4%	10.9%

GROSS ADMINISTRATION EXPENDITURE

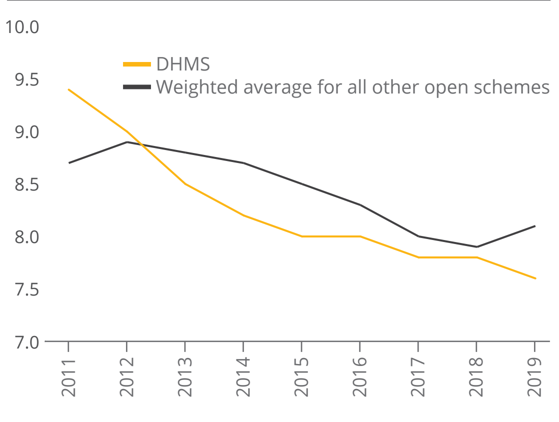
Gross administration expenditure comprises administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's administrator, Discovery Health. During 2020, gross administration fees increased by 4.5% to R5.4 billion (2019: R5.2 billion), driven by an increase in the average administration fee per member of 5.25% to R336.84 (2019: 320.05), primarily reflecting the impact of an annual CPI-linked increase.

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

The Scheme's analysis of the CMS Annual Report 2019 – 2020 shows that, at 7.6% for 2019, 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 8.1% excluding the Scheme. This means that the Scheme's gross administration expenditure is the seventh lowest out of 20 open medical schemes in the market.

The Scheme's members benefit through continuously reducing administration expenditure that is among the lowest in the industry.

Administration expenditure among the lowest in the industry



Administration expenditure as % of gross contribution income (2011 – 2019)
Source: CMS Annual Report 2019 – 2020.

ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 6.64% to R1.88 billion (2019: R1.77 billion) is predominantly attributable to the increase of 7.40% from R109.59 to R117.70, in accredited average managed care costs per member per month.

This reflects the annual CPI-linked increase and the full-year impact of an expansion in services provided by Discovery Health during 2019 as well as further expended services during the year, including diabetes management services and COVID-19 management services. Managed care costs as a percentage of gross contribution income remained the same with the 2020 ratio at 2.53%.

An analysis of the CMS Annual Report 2019 – 2020 demonstrates that the Scheme's managed care cost as a proportion of gross contribution income was 2.5%, compared to the weighted average of 3.0% (which excludes the Scheme).

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

In 2019, claims cost savings of R213.84 (2018: R199.73) per average beneficiary per month were realised through claims review processes, protocols implemented, price negotiations and drug utilisation reviews[1]. This equates to a saving of R3.05 (2017: R2.68) for every Rand paid in managed care costs, an exceptional return on investment of 305%.

1 *Source: The Value-Added Assessment report presented to the Board of Trustees; figures are only available for the preceding year.*

INVESTMENT RESULTS

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

The Scheme earned a gross investment return of 5.77% for 2020 (2019: 7.02%). The Scheme's diversified investment strategy resulted in outperformance of its strategic benchmark.

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 292.

At 31 December 2020, the Scheme's solvency level of 36.93% (2019: 27.5%) of gross annual contributions was R8.9 billion (2019: R1.8 billion), exceeding the statutory solvency requirement.

R'000	2020	2019
Total Members Funds	**28 215 476**	19 209 355
Less: cumulative unrealised net gain on re-measurement of investments	**-686 683**	-
Total net assets (Regulation 29)	**27 528 792**	19 209 355
Gross annual contributions	**74 537 501**	69 855 135
Solvency ratio	**36.93%**	27.50%
Average accumulated funds per member at year-end	**20 690**	14 211

SCHEME'S SOLVENCY LEVEL

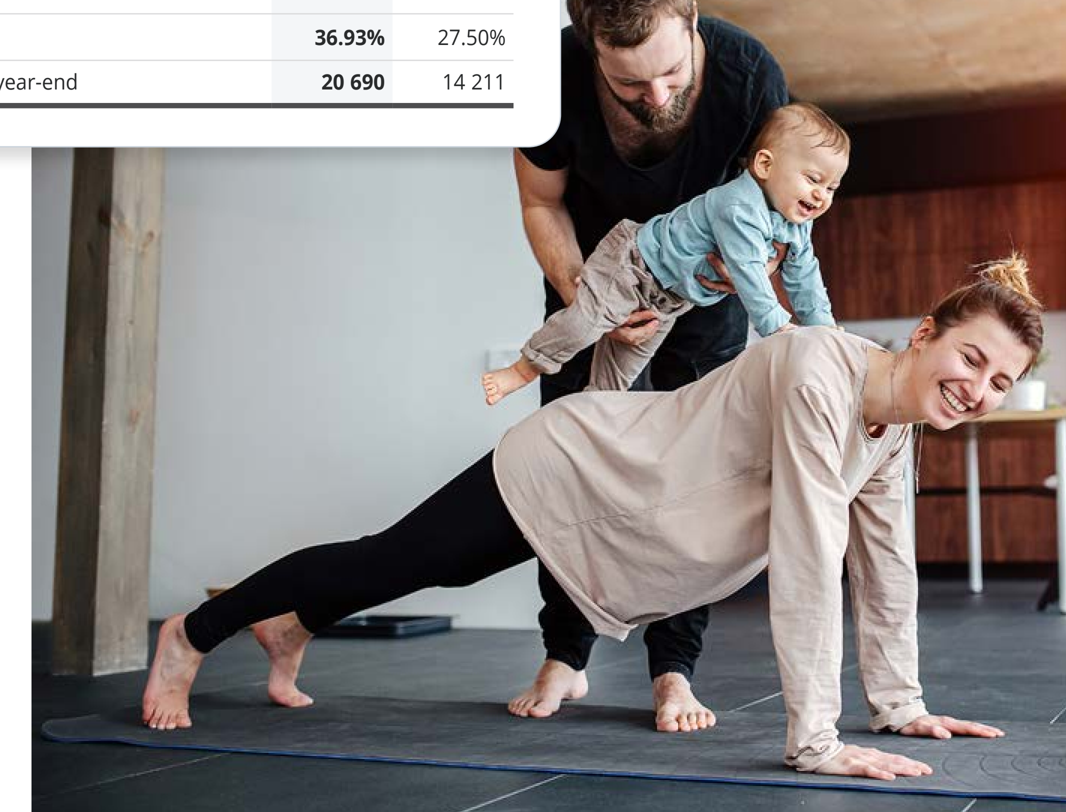
36.93%

(2019: 27.5%)

PRUDENT FINANCIAL MANAGEMENT

The Scheme has a duty to timeously collect all contributions due. The table below indicates the high level of contribution collection management achieved during the year, with average outstanding collection days at 11.95 for 2020 (11.11 in 2019). At year-end, only a very small proportion of contributions had not yet been collected.

Year ended	2020	2019
Gross contributions	**74 537 501**	69 855 135
Total outstanding - excluding December contributions	**52 343**	23 653
% Outstanding	**0.07**	0.03



RESERVE ACCOUNTS

OUTSTANDING CLAIMS

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2020

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

During 2020, the Scheme did not comply with the following Sections and Regulations of the Act:

SUSTAINABILITY OF BENEFIT PLANS

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

For the year ended 2020 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/surplus (R'000)
Executive	(103 856)	(95 203)
KeyCare Plus	(213 255)	74 378

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

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

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

ANNUAL GENERAL MEETING NOT HELD

In terms of Scheme Rule 25.1.1, the Scheme must convene an annual general meeting on or before 30 June each year. As a result of COVID-19 restrictions on gatherings, the Scheme applied for an exemption to deviate from this rule under Section 32 of the Act to postpone the 2020 AGM. The CMS granted the exemption in line with Section 8 (h) of the Act on 14 May 2020.

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2020 *continued*

INVESTMENTS IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide. CMS has granted DHMS exemption for a period of three years effective from 1 December 2019.

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

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

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS an exemption for a period of three years effective from 1 December 2019.

CONTRIBUTIONS RECEIVED AFTER DUE DATE

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

BROKER FEES PAID

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

In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.01% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the administrator has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

PRESCRIBED MINIMUM BENEFITS

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

CLAIMS PAID IN EXCESS OF 30 DAYS

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

During the year, there were instances where claims were not paid within 30 days. These represent less than 1% of total claims paid for the year. There is a defined process to identify claims that have not been paid within 30 days to ensure that the claims are paid expeditiously.

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2020 *continued*

DISCLOSURE OF PERSONAL INFORMATION

Regulation 15J (2) (b) requires the Scheme to ensure that there are provisions for ensuring confidentiality of clinical and proprietary information, including the diagnosis and treatment pertaining to any beneficiary. POPIA Condition 7 requires that personal information should be kept secure against the risk of loss, unauthorised access, interference, modification, destruction or disclosure.

During the year under review, a dashboard meant for one employer was mistakenly sent to another employer contact. The dashboard contained information on COVID-19 risk assessments and contact tracing for 19 employees. The data included personal identification information. The data was only sent to a specific person who confirmed deletion of the information. The information was not shared for criminal or malicious intent.

CONTRIBUTION NOT BILLED FOR NEW DEPENDANTS

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. Contributions must be received within a prescribed time when becoming due. The failure in not including dependants in the billing process constitutes non-compliance with the Act.

136 memberships were added through the online platform (new business system) and contributions since 2015 were not billed, resulting in a gross financial loss for the Scheme of R633 318, the majority of which has been written off.

The underwriting system has been enhanced to recognise active and historical additions, to ensure there are no duplicates. The data issues created by the addition of dependants through the online platform has been corrected, to ensure the system does not create historical records that cause data discrepancies.

COMMISSION PAID TO BROKERS WITH EXPIRED CMS ACCREDITATION

Section 65 (3) states that no broker shall be compensated for providing broker services unless the CMS has granted accreditation to such broker.

There was a total of 151 brokers over a two-year period where commission was paid to brokers whose accreditation had expired. The total value of these payments was R1.5 million. Commission paid to brokers with expired accreditation has been reversed and a process is underway to recover these amounts.

Enhancements to the commission system have been made to ensure this is not repeated.

COVID-19 INITIATIVES

The Scheme introduced specific initiatives to support stakeholders in managing the adverse impact of COVID-19. For the Scheme to offer these initiatives, exemptions from the following provisions of the Act were obtained from the CMS.

Payment of contributions from positive Personal Medical Savings Account balances

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. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R165 474 000 affecting 15 202 policies. The CMS granted DHMS a three-month exemption on 9 April 2020 effective from 1 April 2020. An extension was granted on 4 November 2020 up to 31 December 2020.

SME employer contribution concessions

Also relating to Section 26 (7) and Section 35 (8) (a) of the Act, financial relief to SMEs through contribution concessions amounted to R206 872 000 affecting 532 SMEs. The concession balance at 31 December 2020 was R86 172 000. Four SMEs with a balance of R71 000 defaulted on their repayments. The CMS granted DHMS a three-month exemption on 9 April 2020 effective from 1 April 2020.

Payment of commissions to brokers prior to receipt of contributions

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. The CMS granted DHMS a three-month exemption on 11 June 2020 effective from 1 April 2020.

OPERATIONAL STATISTICS PER BENEFIT PLAN

for the year ended 31 December 2020

2020	EXECUTIVE	CLASSIC				ESSENTIAL				COASTAL		KEYCARE			CLASSIC SMART COMP	SMART		
		COMP	CORE	SAVER	PRIORITY	COMP	SAVER	CORE	PRIORITY	SAVER	CORE	PLUS	CORE	START		CLASSIC	ESSENTIAL	TOTAL
Number of members at the end of the accounting period	8 237	111 632	48 210	308 970	78 484	12 738	141 708	49 036	5 203	172 053	76 359	208 859	15 950	6 151	467	47 602	38 854	**1 330 513**
Number of beneficiaries at the end of the accounting period	17 057	239 654	104 414	680 184	174 025	23 272	302 754	107 039	10 653	386 250	172 129	365 712	26 389	8 007	958	94 353	45 490	**2 758 340**
Average number of members for the accounting period	8 523	115 662	48 088	312 996	80 299	13 136	140 056	46 523	5 272	174 589	76 506	209 314	14 803	5 999	482	45 855	35 136	**1 333 237**
Average number of beneficiaries for the accounting period	17 769	249 252	104 137	686 963	177 914	24 101	297 985	101 650	10 771	391 360	172 318	366 263	24 422	7 776	1 000	90 658	40 654	**2 764 994**
Average risk contributions per member per month (R')	9 308.46	7 460.05	4 212.66	3 976.25	5 001.79	6 353.44	3 263.98	3 334.08	4 541.26	3 603.93	3 562.39	2 170.62	1 781.75	1 333.03	7 854.32	3 077.32	1 639.59	**3 827.95**
Average risk contributions per beneficiary per month (R')	4 464.68	3 461,73	1 945.31	1 811.67	2 257.50	3 462.90	1 534.10	1 525.93	2 222.50	1 607.74	1 581.64	1 240.47	1 080.01	1 028.34	3 781.86	1 556.52	1 417.02	**1 845.78**
Average net claims incurred per member per month (R')	9 713.36	6 365.06	2 817.39	2 733.99	3 655.11	4 985.35	1 922.66	2 093.59	2 661.56	2 608.98	2 636.55	1 875.14	1 127.20	637.11	2 606.71	1 869.42	785.08	**2 801.20**
Average net claims incurred per beneficiary per month (R')	4 658.88	2 953.62	1 301.01	1 245.67	1 649.69	2 717.23	903.67	958.19	1 302.57	1 163.89	1 170.58	1 071.61	683.26	491.49	1 255.13	945.56	678.51	**1 350.69**
Average administration costs per member per month (R')	366.87	366.87	366.87	366.87	366.87	366.87	366.87	366.87	366.87	366.87	366.87	198.81	106.70	198.81	366.87	366.87	366.87	**336.84**
Average administration costs per beneficiary per month (R')	175.96	170.24	169.41	167.15	165.58	199.96	172.43	167.91	179.55	163.66	162.88	113.62	64.68	153.37	176.65	185.56	317.07	**162.42**
Average managed care: Management services per member per month (R')	116.67	116.67	116.67	116.67	116.67	116.67	116.68	116.68	116.67	116.67	116.67	116.53	116.54	116.54	116.67	116.68	116.69	**116.65**
Average managed care: Management services per beneficiary per month (R')	55.96	54.14	53.88	53.16	52.66	63.59	54.84	53.40	57.10	52.05	51.80	66.60	70.64	89.90	56.18	59.02	100.85	**56.25**
Average family size	2.07	2.15	2.17	2.20	2.22	1.83	2.14	2.18	2.05	2.24	2.25	1.75	1.65	1.30	2.05	1.98	1.17	**2.07**
Loss ratio (%)	105.67%	86.96%	69.68%	71.71%	75.43%	80.37%	62.49%	66.31%	61.20%	75.64%	77.30%	91.00%	69.80%	56.19%	36.08%	64.52%	55.01%	**76.18%**
Total non-healthcare expenses as a percentage of risk contributions (%)	5.19%	6.51%	11.16%	12.18%	9.71%	7.67%	14.49%	13.95%	10.66%	13.29%	13.14%	12.69%	9.69%	18.95%	6.13%	15.02%	26.31%	**11.52%**
Average non-healthcare expenses per member per month	482.87	485.46	470.02	484.26	485.80	487.22	473.07	464.98	484.02	479.02	468.06	275.35	172.57	252.59	481.65	462.31	431.34	**441.05**
Average non-healthcare expenses per beneficiary per month	231.60	225.27	217.05	220.64	219.26	265.56	222.35	212.81	236.88	213.69	207.81	157.36	104.60	194.86	231.92	233.84	372.79	**212.67**
Average age of beneficiaries (years)	46.74	43.94	41.27	35.01	40.41	50.17	32.33	38.35	39.60	36.07	39.98	30.68	35.68	34.94	42.84	31.76	34.92	**35.86**
Pensioner ratio (beneficiaries over 65 years)	27.22%	21.51%	17.60%	9.44%	15.76%	33.82%	6.81%	13.36%	15.43%	10.02%	15.12%	7.85%	13.10%	8.74%	18.50%	4.97%	4.55%	**10.98%**
Average relevant healthcare expenses per member per month	9 836.17	6 487.21	2 935.17	2 851.39	3 773.07	5 106.09	2039.65	2 210.82	2 779.20	2 726.14	2 753.66	1 975.21	1 243.74	749.07	2 833.51	1 985.36	901.90	**2 916.25**
Average relevant healthcare expenses per beneficiary per month	4 717.78	3 010.30	1 355.40	1 299.16	1 702.93	2 783.04	958.65	1 011.84	1 360.14	1 216.15	1 222.58	1 128.81	753.90	577.86	1 364.34	1 004.20	779.47	**1 406.17**
Net surplus/(deficit) per benefit plan	(95 203)	786 843	529 535	2 712 146	793 731	132 447	1 402 896	431 492	86 019	1 005 732	413 710	74 377.83	85 515	31 894	26 841	408 686	179 457	**9 006 120**

OPERATIONAL STATISTICS PER BENEFIT PLAN *continued*

for the year ended 31 December 2020

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

PERSONAL MEDICAL SAVINGS ACCOUNTS

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

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

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

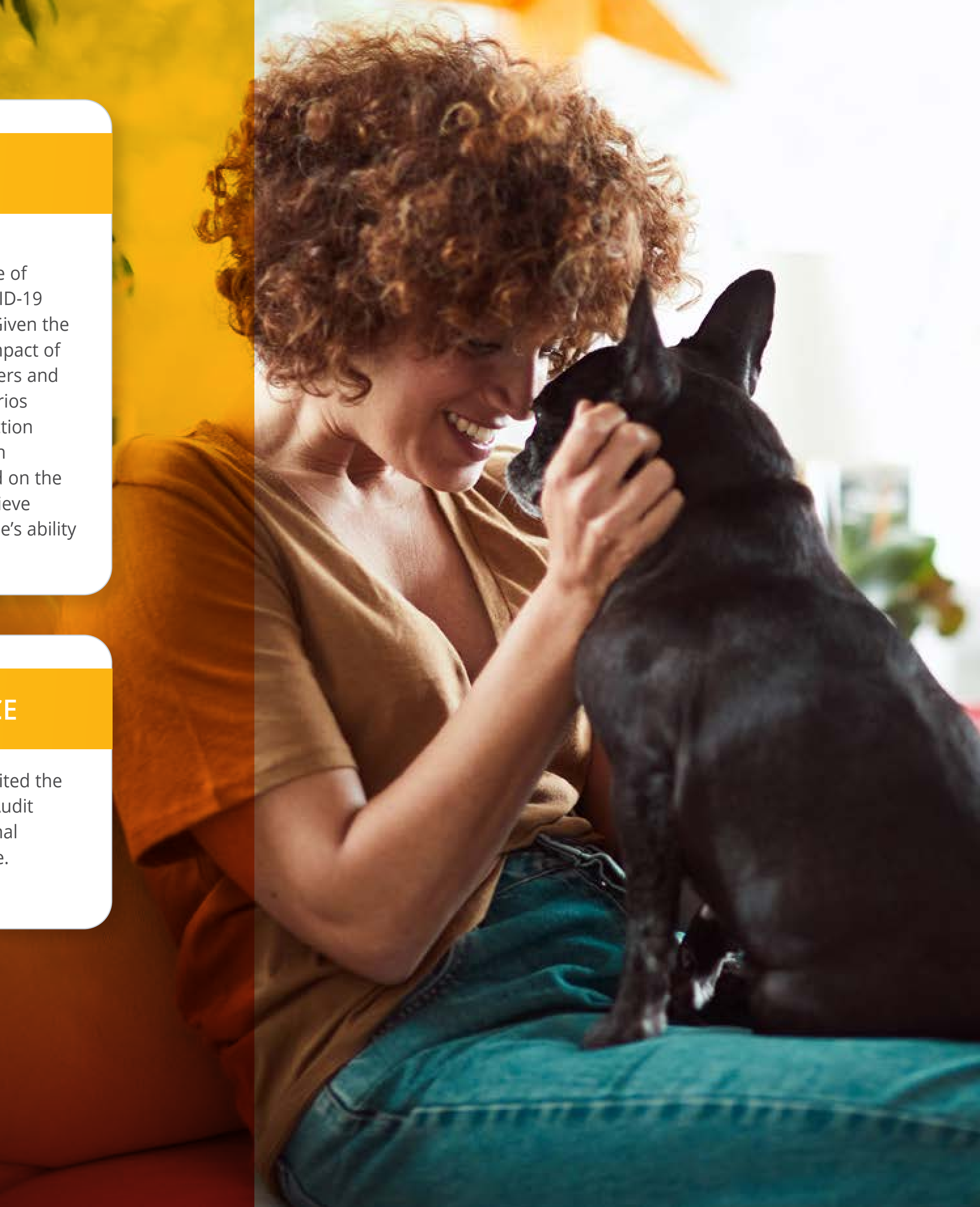
The Scheme's liability to members in respect of PMSAs is reflected as a current liability in the Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act.

GOING CONCERN

On 15 March 2020, the President of South Africa declared a National State of Disaster as a result of the global COVID-19 pandemic, which continues to date. Given the uncertainties about the continuing impact of COVID-19 on the Scheme, our members and the healthcare system, various scenarios including high, medium and low infection rates and vaccination costs have been modelled to assess the impact. Based on the most likely scenario, the Trustees believe there will be no impact on the Scheme's ability to pay claims as they arise.

AUDITOR INDEPENDENCE

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



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

We outsource administration and managed care services to Discovery Health. The Trustees are confident that Discovery Health is the best administrator and managed care provider in the industry, based on the measures applied to evaluating their services to the Scheme and our members.

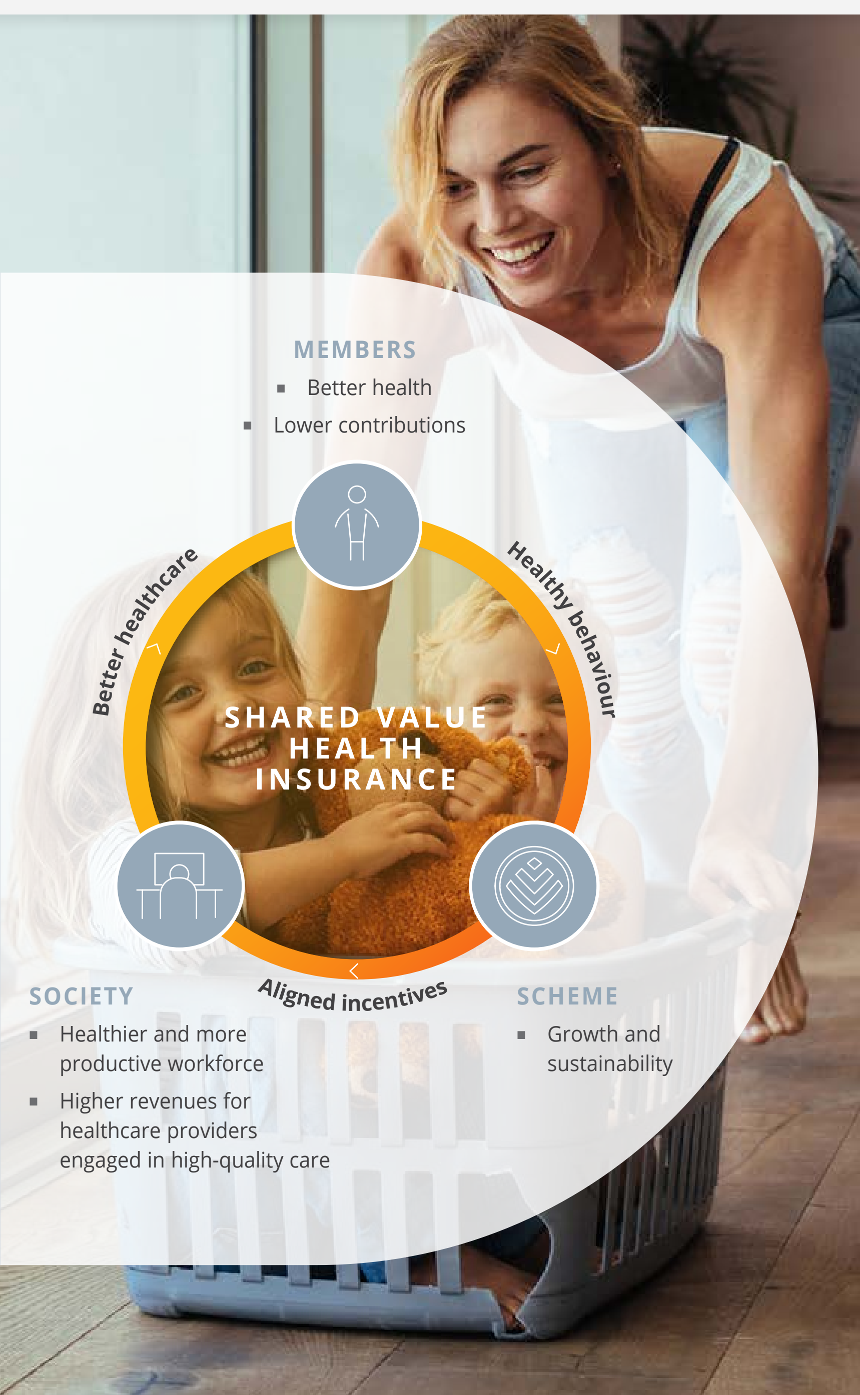
In accordance with the Act and the Scheme Rules, the Trustees appoint an accredited administrator and managed care provider to deliver approved services to the Scheme and our members. We elect to use a single provider as the Trustees believe that an integrated model (as opposed to one using multiple service providers) delivers best value for money and optimal efficiency.

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

With respect to the Scheme's relationship with Discovery Health, the Vested® model operationalises the Scheme's governance and oversight role and embeds its independence. It also allows us to leverage Discovery Health's expertise, systems, innovation and value-added services in the best interests of the Scheme and our members. The relationship is overseen by our operational Relationship Management and Innovation Committees, which are mandated to monitor, review and improve the relationship and the innovation that the Vested model promotes.

Discovery Health's business model: shared value health insurance

Discovery Health shares the Scheme's commitment to deliver an integrated value-driven healthcare system, centred on meeting the needs of our members and providing access to the best quality care at the best value for money. Discovery Health's pioneering shared value health insurance model incentivises people to be healthier, and utilises initiatives to slow down the progression of disease, reducing claims costs. It also incentivises healthcare professionals through value-based contracting, with an emphasis on quality of care. This model supports the Scheme's sustainability, with shared value healthcare ultimately leading to a better healthcare system.



Discovery Health supports members, health practitioners and South Africa throughout COVID-19 pandemic

During 2020, Discovery Health supported DHMS by launching several initiatives to support members through COVID-19. DHMS has led the market with the early release of benefits, extensive communication, and a proactive process for protecting members from infection, wherever possible.

This included providing support to employer groups for high-risk employees, as well as in their COVID-19 response and business continuity planning. Contribution relief options of some R372 million were also made available to members and SMEs, between 17 April and 31 December 2020.

The success of Discovery Health's initiative to provide care-at-home and assist high-risk members to monitor their health via pulse oximeter devices, achieved a 56% reduction in mortality in this member group. The benefit and its results are currently being documented and will be peer-reviewed for clinical publication.

Value for money for members

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

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged Deloitte Actuarial Consultants to perform an actuarial peer review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2018 to 2019 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed. The results are expressed as the value added by Discovery Health for each rand paid to it[1]:

R2.03
2019

R2.12
2018

R2.02
2017

R2.00
2016

R1.85
2015

R1.73
2014

The assessment takes account of value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members, additional services offered, and innovation.

1 Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2019, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.03 (2018: R2.12) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.

Discovery Health's initiatives for our members

Discovery Health's innovative and integrated approach provides state-of-the art medical scheme risk management and service delivery, which extends their services to DHMS well beyond traditional administration and managed care services. Their ongoing investments in digital capabilities, along with their strategic focus on improving value through efficiency and quality of care initiatives, promote better healthcare outcomes. This is supported by their focus on comprehensive care, health support and the latest medical technologies and treatments.

Enabled by Discovery Health's integrated digital health platforms such as HealthID and Dr Connect, and more recently the Connected Care app, the Scheme will implement Connected Care benefits in 2021. Connected Care facilitates remote management of patients by their providers across the continuum of care, including acute and chronic disease outpatient management, and management of patients who would otherwise be admitted to hospital facilities. These are essential capabilities in the context of COVID-19.

In early 2021, the Scheme also introduced benefits for the Tytocare medical device – a digital diagnostic tool that transmits high-quality pictures and sounds – to enhance the efficacy of video-consultations by simulating an in-person clinical examination. This innovation, together with e-scripting and medicine courier services, will enable seamless, efficient and convenient access to high-quality care in members' homes.

DIGITAL INITIATIVES

Member App

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

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

The app can be downloaded here, and a video about how the app can assist members is available here.

Discovery HealthID

Discovery Health's client journeys[1] demonstrate its capabilities and the impact of the pandemic

At 31 December 2020, Discovery Health administered approximately 3.55 million beneficiaries, including 2.76 million for DHMS. As such, Discovery Health services and interacts with millions of individuals during the course of any given year. The comprehensive and world-class service offerings, programmes and platforms Discovery Health provides gives DHMS assurance that our members always have access to the best services and information available to suit their health and care needs.

Discovery Health's interactions in 2020 compared to the prior year (below) indicate some stark contrasts with typical experience, and are indicative of the significant shifts in member behaviour during the pandemic.

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

In 2020…

A new membership activated every
29 seconds

29 710 calls
received per day

R7.8 billion
billed in contributions per month

267 000 claims
received per day

R35.9 million
paid in claims per hour

74 560
HIV programme members

71 550
oncology programme members

417 900
website users each month

21%
of calls Interactive Voice Response assisted

5 180
current HealthID users

569 250
digital membership cards downloaded

Average member accesses website
2 times per month

Average member makes
20 claims per year

27% members
with a chronic condition

COVID-19 IMPACT

2 200
HOSPITAL ADMISSIONS APPROVED PER DAY
down 800 per day from 2019

5 900
WELLNESS SCREENINGS PER YEAR
down 145 100 from 2019

472 600
MOBILE USERS
up 46 200 from 2019

1 million
SOCIAL MEDIA FOLLOWERS
up 569 000 from 2019[2]

2 *The change in social media use and followers is attributable to the publication of COVID-19-related information on social media by Discovery Health and DHMS, increasing comfort with the use of technology platforms for interactions, and increased numbers of people working from home, among other factors.*

FINANCIALS

Statement of responsibility by the Board of Trustees

FOR THE YEAR ENDED 31 DECEMBER 2020

The Board of Trustees is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the annual Financial Statements of Discovery Health Medical Scheme (the Scheme).

The Financial Statements comprise the Statement of Financial Position at 31 December 2020, and the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and the Statement of Cash Flows for the year then ended, and Notes to the Financial Statements, including a summary of significant accounting policies. The annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act, No 131 of 1998, as amended, (the Act) and include amounts based on judgements and reasonable estimates.

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

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

Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention and the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and, in particular, the presentation of the Financial Statements. To the best of their knowledge and belief, based on the above, the Trustees are satisfied that no material breakdown in the operation of the systems of internal control and procedures has occurred during the year under review.

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2021. In considering this budget, the Trustees considered the impact of COVID-19 vaccine related expenses on the Scheme.

The Scheme's strong financial position and reserve levels allow the Scheme to absorb the potential negative impact of COVID-19, with a potential negligible impact the Scheme's 2021 solvency level and based on the expected claims experience through 2021 is not envisaged to impact the Scheme's ability to pay claims as they arise. The Trustees also concluded that there was no need to adjust the 2020 Financial Statements.

On the basis of this review and in light of the current financial position and available cash resources, the Trustees have no reason to believe that the Scheme will not be a going concern for the foreseeable future. The going concern basis has therefore been adopted in preparing the Financial Statements and these Financial Statements support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Financial Statements and their unmodified report is presented on pages 89 – 91. The Financial Statements, which are presented on pages 92 – 160, were approved by the Board of Trustees on 14 April 2021 and are signed on its behalf by:

NEIL MORRISON
Chairperson

JOHAN HUMAN
Trustee

CHARLOTTE MBEWU
Principal Officer

REPORT OF THE AUDIT COMMITTEE

FOR THE YEAR ENDED 31 DECEMBER 2020

We are pleased to present our report for the financial year ended 31 December 2020. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit Committee terms of reference and assessment

The Committee's role and responsibilities include statutory duties as per the Act and further responsibilities assigned to it by the Board. The Committee has adopted formal terms of reference that have been approved by the Board of Trustees and are reviewed at least annually. The Committee executed its duties and conducted its affairs in accordance with its terms of reference and applicable laws and regulations in force during the financial year, and has discharged the responsibilities contained therein.

Members of the Committee collectively keep up to date with key developments affecting their required skill set.

The Committee is assessed at least every two years either by external independent parties, or through self-appraisals. The next evaluation will be conducted in 2021.

Audit Committee Members, meeting attendance and assessment

The membership and attendance of the Members of the Committee has been set out on page 50.

EXTERNAL AUDITOR APPOINTMENT AND INDEPENDENCE

The Committee considered the matters set out in Section 36 of the Act and nominated PricewaterhouseCoopers Inc. for appointment as external auditor of the Scheme. Linda Pieterse was approved by the Council for Medical Schemes (CMS) as the statutory auditor of the Scheme for the financial period 1 January 2020 to 31 December 2020 in accordance with section 36 (2) of the Act on 23 September 2020.

The Committee has satisfied itself that the External Auditor is independent of the Scheme as set out in Section 36 (3) of the Act. Requisite assurance was sought and provided by the Auditor that internal governance processes within the audit firm support and demonstrate its independence.

The Committee ensured that the appointment of the Auditor complied with the Act and Scheme Rules relating to the appointment of auditors. Pursuant to the issuance of Circular 45 of 2020: Authorisation of Auditors and IFRS advisors, the CMS, having noted the impact that mosts schemes had not held their 2020 annual general meetings (AGMs), agreed that the application form and Trustee Resolution suffices for this process. This will be ratified at the 2021 AGM for completeness.

The Committee, following consultation with the Scheme's Executive Officers, approved the engagement letter, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2020. The Committee approved the actual audit fees for the year ended 2019.

There is a formal policy in respect of the provision of non-audit services by the external auditors of the Scheme and a formal procedure governs the process whereby the auditor is appointed to provide any non-audit services. The Chairperson of the Committee approves the nature and extent of any non-audit services that the external auditor provides in terms of the agreed pre-approval policy and a schedule of approved non-audit services is reviewed annually by the Committee. Fees in respect of audit and non-audit services are reflected in Note 16 to the Financial Statements.

During the year, the Committee met with the external auditors without management being present. The Committee Chairperson also met separately with the external auditors.

INTERNAL AUDITORS (IA)

The Committee is responsible for ensuring that the IA function is independent and has the necessary resources, standing and authority to enable it to discharge its duties. Furthermore, the Committee oversees co-operation between IA and the external auditors, and serves as a link between the Board of Trustees and these functions.

The Committee considered and approved the IA charter.

The IA annual audit plan was approved by the Committee. The results of the work carried out by IA in terms of the audit plan were reviewed and the effect of any action plans to mitigate risks of any matters reported were considered by the Committee.

IA has responsibility for reviewing and providing assurance on the adequacy of the internal control environment across all of the Scheme's operations. The Chief Audit Executive (CAE) is responsible for reporting the findings of the internal audit work, against the agreed IA plan to the Committee on a regular basis.

The CAE has direct access to the Committee, primarily through its Chairperson.

The Committee has assessed and was satisfied with the performance of the CAE and the IA function.

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

FINANCIAL STATEMENTS AND ACCOUNTING POLICIES

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

INTERNAL FINANCIAL CONTROLS

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, among other things, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board of Trustees. This included a formal documented review by the IA function of the design, implementation and effectiveness of the administrator's system of internal financial controls pertaining to the Scheme.

REPORT OF THE AUDIT COMMITTEE *continued*

Based on the results of this review, it is the view of the Committee that Reasonable Assurance* can be placed on the internal controls and risk management and that High Assurance** can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Financial Statements.

* *Reasonable Assurance – The existing control framework provides reasonable assurance that material risks are identified and managed effectively.*

** *High Assurance – The existing control framework provides a high level of assurance that the annual Financial Statements are fairly presented.*

EVALUATION OF THE EXPERTISE AND EXPERIENCE OF THE CHIEF FINANCIAL OFFICER AND FINANCE FUNCTION

The Committee is satisfied with the expertise and experience of the Scheme's Chief Financial Officer. The Committee further reviewed and satisfied itself of the appropriateness of the expertise, resources and experience of the administrator's finance function pertaining to the Scheme.

WHISTLE BLOWING

The Committee receives and deals with any concerns or complaints, whether from within or outside the Scheme, relating to the accounting practices and IA of the Scheme, the content or auditing of the Scheme's Financial Statements, the internal financial controls of the Scheme and related matters. The administrator's forensic department assists the Committee in discharging this responsibility. No such concerns or complaints were received during the year.

ETHICS AND COMPLIANCE

The Committee is responsible for reviewing any major breach of relevant legal and regulatory obligations. The Committee is satisfied that there has been no material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 33 to the Financial Statements. Certain Members of the Audit Committee also serve as Members of the Risk Committee.

RISK MANAGEMENT

The Committee monitors the risk management processes and systems of internal control of the Scheme through review of reports from and discussions with the Scheme's internal and external auditors and the risk management function.

The Audit Committee is responsible for ensuring that appropriate systems are in place for the monitoring of risk and compliance with laws, regulations and codes of conduct that may affect the integrity of the Financial Statements.

The Committee is satisfied that the system and the process of risk management is effective.

GOING CONCERN

The Committee has reviewed the going concern basis for the preparation of the Scheme's Financial Statements taking into account the operational and financial position as at 31 December 2020 as well as the Scheme's budget for the year ended 31 December 2021.

Total members' funds exceeded R28.2 billion with a solvency level of 36.93% at 31 December 2020. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) at 31 December 2020 to cover monthly claims expenditure 7.49 times.

On the basis of this review and taking note of the current net surplus of R9 billion, the Committee considers that:

1. The Scheme's assets currently exceed its liabilities; and
2. The Scheme will be able, in the ordinary course of the Scheme's business, to settle its liabilities as they arise for the foreseeable future.

The Committee agreed that based on the assessment conducted, the Board of Trustees could be advised that there is no reason to believe that the Scheme will not be a going concern in the foreseeable future.

Eric Mackeown

MR E MACKEOWN
Chairperson: Audit Committee

14 April 2021

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF DISCOVERY HEALTH MEDICAL SCHEME

Report on the Financial Statements

OPINION

We have audited the Financial Statements of Discovery Health Medical Scheme (the Scheme), set out on pages 92 to 160, which comprise the Statement of Financial Position at 31 December 2020, and the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and the Statement of Cash Flows for the year then ended, and notes to the Financial Statements, including a summary of significant accounting policies.

In our opinion, these Financial Statements present fairly, in all material respects, the financial position of the Scheme at 31 December 2020, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

BASIS FOR OPINION

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

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

INDEPENDENCE

We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountants' International Code of Ethics for Professional Accountants (including International Independence Standards).

KEY AUDIT MATTERS

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

Key audit matter	How our audit addressed the key audit matter
Outstanding Claims Provision – The outstanding claims provision of R1 769 008 000 at year-end as described in Note 6 to the Financial Statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end. The outstanding claims provision is calculated by the Scheme's actuaries which is reviewed by management and the Audit Committee and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to project the year-end provision. This model applies a combination of the Basic Chain Ladder (BCL) and Cost Per Event (CPE) methods. The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern can cause a material change to the amount of the provision.	We obtained an understanding from the Scheme's actuaries regarding the process to calculate the outstanding claims provision. The actuarial methods applied by the Scheme are generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the year ended 31 December 2020. The actual claims data includes the impact of COVID-19 and therefore the impact was taken into account in the claims patterns in the outstanding claims provision. For a sample of actual claims received by the Scheme in the 31 December 2020 financial year, we tested the accuracy of the service and process dates. No material inconsistencies were noted. We substantively tested a sample of claims against the relevant Scheme Rules and assessed completeness of the claims data. The claims data that were included in the Scheme's actuarial model was agreed to the above actual claims data with no material inconsistencies noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. Based on our assessment, the estimation process was considered reasonable. Our internal actuarial experts independently calculated the Scheme's outstanding claims provision, taking into account the claims data as tested above. We compared our results with that of the Scheme and found the amounts to approximate each other. We obtained the actual claims run-off report up to 31 March 2021 from the Scheme's management. For a sample of claims from the report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates and we identified no material inconsistencies.

INDEPENDENT AUDITOR'S REPORT *continued*

OTHER INFORMATION

The Scheme's Trustees are responsible for the other information. The other information comprises the information included in the document titled "Discovery Health Medical Scheme Integrated Report 2020". The other information does not include the Financial Statements and our auditor's report thereon.

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

In connection with our audit of the Financial Statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the Financial Statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

RESPONSIBILITIES OF THE SCHEME'S TRUSTEES FOR THE FINANCIAL STATEMENTS

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

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

AUDITOR'S RESPONSIBILITIES FOR THE AUDIT OF THE FINANCIAL STATEMENTS

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

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

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

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

From the matters communicated with the Scheme's Trustees, we determine those matters that were of most significance in the audit of the Financial Statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report, unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on other legal and regulatory requirements

NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT OF SOUTH AFRICA

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, as amended, that have come to our attention during the course of our audit:

1. Section 29 (1) (o) and Regulation 8 of the Medical Schemes Act of South Africa:
   During the financial year, there were instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits.

INDEPENDENT AUDITOR'S REPORT *continued*

2. Regulation 28 (2), 28 (5), 28 (8) and Section 65 (3) of the Medical Schemes Act of South Africa:
   There were instances where some brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount, more than one broker per member was paid and brokers with expired Council for Medical Scheme accreditation were paid.

These material non-compliance findings are disclosed in Note 32 of the Financial Statements.

AUDIT TENURE

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Discovery Health Medical Scheme for 20 years.

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

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.
Director: L. Pieterse
Registered Auditor
Waterfall

23 April 2021

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2020

R'000	Notes	2020	2019
ASSETS			
Non-current assets		**16 270 481**	18 426
Property and equipment	1	**11 144**	12 630
Long-term employee benefit plan asset	25	**6 427**	5 796
Financial assets at fair value through profit or loss	3	**16 252 910**	–
Current assets		**22 004 691**	27 818 342
Financial assets at fair value through profit or loss	3	**15 177 582**	23 191 456
Derivative financial instruments	7	**193 030**	75 179
Trade and other receivables	4	**2 625 411**	2 560 425
Cash and cash equivalents	5	**4 008 668**	1 991 282
Total assets		**38 275 172**	27 836 768
FUNDS AND LIABILITIES			
Members' funds		**28 215 475**	19 209 355
Accumulated funds		**28 215 475**	19 209 355
LIABILITIES			
Non-current liabilities		**9 394**	9 933
Leases	2	**9 394**	9 933
Current liabilities		**10 050 303**	8 617 480
Leases	2	**1 832**	1 713
Derivative financial instruments	7	**34 723**	14 689
Outstanding claims provision	6	**1 769 008**	1 526 497
Personal Medical Savings Account liabilities	8	**6 675 945**	5 522 613
Trade and other payables	9	**1 568 795**	1 551 968
Total funds and liabilities		**38 275 172**	27 836 768

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2020

R'000	Notes	2020	2019 Restated
Risk contribution income	10	**61 242 728**	57 222 228
Relevant healthcare expenditure		**(46 656 654)**	(50 199 101)
Net claims incurred	11	**(44 815 954)**	(48 515 757)
Risk claims incurred	11	**(44 957 497)**	(48 672 460)
Third-party claim recoveries	11	**141 543**	156 703
Accredited managed healthcare services (no risk transfer)	12	**(1 883 081)**	(1 765 827)
Net income on risk transfer arrangements	13	**42 381**	82 483
Risk transfer arrangement fees paid		**(260 068)**	(299 464)
Recoveries from risk transfer arrangements		**302 449**	381 947
Gross healthcare result		**14 586 074**	7 023 127
Broker service fees	14	**(1 489 823)**	(1 444 563)
Expenses for administration	25	**(5 389 056)**	(5 156 926)
Other operating expenses	15	**(177 363)**	(179 943)
Net impairment losses on healthcare receivables	17	**(79 096)**	(106 108)
Net healthcare result		**7 450 736**	135 587
Other income		**1 920 700**	1 757 601
Investment income	21	**1 690 370**	1 697 827
Net gains on financial assets	22	**212 981**	44 250
Sundry income	23	**17 349**	15 524
Other expenditure		**(365 316)**	(330 188)
Asset management fees		**(78 608)**	(76 610)
Other expenses	23	**(2 372)**	(5 938)
Finance costs	24	**(1 429)**	(1 373)
Interest paid on savings accounts	24	**(282 907)**	(246 267)
Total comprehensive income for the year		**9 006 120**	1 563 000

STATEMENT OF CHANGES IN FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2020

R'000	Notes	2020 **Accumulated funds**	2019 Accumulated funds
Balance at beginning of the year		**19 209 355**	17 646 355
Total comprehensive income for the year		**9 006 120**	1 563 000
Total member funds at the end of the year		**28 215 475**	19 209 355

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2020

R'000	Notes	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows generated from operations before working capital changes	27	7 470 530	181 892
Working capital changes:			
Increase in trade and other receivables	27	(144 082)	(308 631)
Increase in outstanding claims provision		242 511	27 270
Increase in Personal Medical Savings Account liabilities		1 153 332	481 781
Increase/(decrease) in trade and other payables	27	16 825	(3 068 085)
Cash generated/(utilised) by operations		**8 739 116**	**(2 685 773)**
Payments for financial assets	3	(11 887 221)	(4 783 355)
Proceeds from sale of financial assets	27	3 763 349	2 238 283
Increase in long-term employee plan asset		(3 472)	(3 271)
Cash transferred from other medical schemes		–	–
Interest received	21	1 534 060	1 513 838
Dividend income	21	156 310	183 989
Interest paid	24	(283 043)	(246 309)
Net cash inflow/(outflow) from operating activities		**2 019 099**	**(3 782 598)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for property and equipment	27	–	–
Net cash outflow from investing activities		**–**	**–**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payment of lease liabilities	2	(1 713)	(1 601)
Net cash outflow from financing activities		(1 713)	(1 601)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		2 017 386	(3 784 199)
Cash and cash equivalents at beginning of the year		1 991 282	5 775 481
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**4 008 668**	**1 991 282**

ACCOUNTING POLICIES

FOR THE YEAR ENDED 31 DECEMBER 2020

General information

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

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

Basis of preparation

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

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

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

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

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

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

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

During 2020 the Council for Medical Schemes (CMS) published Circular 46 of 2020: *General concerns noted during the analysis of the 2019 Annual Financial Statements (AFS) and Annual Statutory Returns (ASR)*. The CMS noted that there were instances where medical schemes did not comply with the full requirements in respect of the *Prescribed format for the Statement of Comprehensive Income* and noted that should a medical scheme not have any items of other comprehensive income, the net surplus or deficit should be replaced by "Total comprehensive income".

The Statement of Comprehensive Income (SOCI) has been aligned to the prescribed format as set out in Circular 46 of 2020, with the most notable changes being the disclosure of "Net impairment losses on healthcare receivables" and "Interest paid on savings accounts" on the face of the SOCI. Net impairment losses were previously included as part of "Other operating expenses" with interest paid on savings accounts included under "Finance costs".

This change in accounting policy will be applied in preparing the Financial Statements for the year ended 31 December 2020. The change is applied retrospectively, with the comparative period presented as if this accounting policy had always been applied.

Table 2 sets out the change in disclosure of the SOCI.

ACCOUNTING POLICIES *continued*

TABLE 2: COMPARISON OF STATEMENT OF COMPREHENSIVE INCOME

	2019 Restated R'000		2019 Previously presented R'000
Risk contribution income	**57 222 228**	**Risk contribution income**	**57 222 228**
Relevant healthcare expenditure	**(50 199 101)**	**Relevant healthcare expenditure**	**(50 199 101)**
Net claims incurred	(48 515 757)	Net claims incurred	(48 515 757)
Risk claims incurred	(48 672 460)	Claims incurred	(48 672 460)
Third-party claim recoveries	156 703	Third-party claim recoveries	156 703
Accredited managed healthcare services (no risk transfer)	(1 765 827)	Accredited managed healthcare services (no risk transfer)	(1 765 827)
Net income on risk transfer arrangements	82 483	Net profit on risk transfer arrangements	82 483
Risk transfer arrangement fees paid	(299 464)	Risk transfer arrangement fees	(299 464)
Recoveries from risk transfer arrangements	381 947	Recoveries from risk transfer arrangements	381 947
Gross healthcare result	**7 023 127**	**Gross healthcare result**	**7 023 127**
Broker service fees	(1 444 563)	Broker service fees	(1 444 563)
Expenses for administration	(5 156 926)	Expenses for administration	(5 156 926)
Other operating expenses	(179 943)	Other operating expenses	(286 051)
Net impairment losses on healthcare receivables	(106 108)		
Net healthcare result	**135 587**	**Net healthcare result**	**135 587**
Other income	**1 757 601**	**Other income**	**1 757 601**
Investment income	1 697 827	Investment income	1 697 827
Net gains/(losses) on financial assets	44 250	Net gains/(losses) on financial assets	44 250
Sundry income	15 524	Sundry income	15 524
Other expenditure	**(330 188)**	**Other expenditure**	**(330 188)**
Asset management fees	(76 610)	Asset management fees	(76 610)
Other expenses	(5 938)	Other expenses	(5 938)
Finance costs	(1 373)	Finance costs	(247 640)
Interest paid on savings accounts	(246 267)		
		Net surplus for the year	1 563 000
		Other comprehensive income	–
Total comprehensive income for the year	**1 563 000**	**Total comprehensive income for the year**	**1 563 000**

Implementation of new standards

New standards, amendments and interpretations effective and relevant to the Scheme

STANDARD	SCOPE	EFFECTIVE DATE
IAS 1: *Presentation of Financial Statements*	Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS Standards. The amendments did not have a significant impact on the Scheme.	1 January 2020
IAS 8: *Accounting Policies, Changes in Accounting Estimates and Errors*	Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS Standards. The amendments did not have a significant impact on the Scheme.	1 January 2020

New standards, amendments and interpretations not yet effective and relevant to the Scheme:

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact on the Scheme's assets, liabilities and results but may result in additional disclosure in the Financial Statements.

STANDARD	SCOPE	EFFECTIVE DATE
Amendments to IFRS 9 'Financial Instruments', IAS 39 'Financial Instruments: Recognition and Measurement', IFRS 7 'Financial Instruments: Disclosures', IFRS 4 'Insurance Contracts' and IFRS 16 'Leases' – interest rate benchmark (IBOR) reform (Phase 2)	The Phase 2 amendments address issues that arise from the implementation of the reform of an interest rate benchmark, including the replacement of one benchmark with an alternative one.	1 January 2021
Amendment to IAS 1 'Presentation of Financial Statements' on Classification of Liabilities as Current or Non-current	The amendment clarifies that liabilities are classified as either current or non-current, depending on the rights that exist at the end of the reporting period. Classification is unaffected by expectations of the entity or events after the reporting date (for example, the receipt of a waiver or a breach of covenant).	1 January 2022
Amendment to IFRS 3 'Business combinations'	The IASB has updated IFRS 3 'Business combinations', to refer to the 2018 Conceptual Framework for Financial Reporting, in order to determine what constitutes an asset or a liability in a business combination. In addition, the IASB added a new exception in IFRS 3 for liabilities and contingent liabilities. The exception specifies that, for some types of liabilities and contingent liabilities, an entity applying IFRS 3 should instead refer to IAS 37 'Provisions, Contingent Liabilities and Contingent Assets', or IFRIC 21 'Levies', rather than the 2018 Conceptual Framework. The IASB has also clarified that the acquirer should not recognise contingent assets, as defined in IAS 37, at the acquisition date.	1 January 2022

ACCOUNTING POLICIES *continued*

STANDARD	SCOPE	EFFECTIVE DATE
IFRS 17: *Insurance contracts*	The Standard was issued in May 2017 and supersedes IFRS 4 'Insurance Contracts'. The Standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The Standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and takes into account any uncertainty relating to insurance contracts. The Standard provides for a simplified approach (premium allocation approach) for the measurement of a group of insurance contracts only if, at the inception of the group, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the general measurement model and if the coverage period is one year or less. Potential impact: The Scheme has assessed the requirements of the standard and agreed a project plan to implement the standard. The main outcomes of the assessment are summarised below. The coverage period for the Scheme's contracts is one year or less with the premium allocation approach being applied, resulting in similar treatment to current accounting. The contracts issued by the Scheme are subject to similar risks and managed together and fall into the same portfolio, with the level of aggregation set at the overall Scheme level. The contracts issued are in line with the Scheme's financial year and are recognised from 1 January of each year or inception if after 1 January other than for onerous contracts. With the contracts being viewed as a single portfolio, where pricing indicates a negative insurance service result for the following year, this amount shall be recognised in the current reporting period. Personal Medical Savings Accounts no longer meet the requirements for a separate investment component under IFRS 17 and will be accounted for as a non-distinct investment component, with the balances being part of the insurance contract and included under "Insurance Contract Assets or Liabilities" in the Statement of Financial Position and no longer separately disclosed as "Personal Medical Savings Account liabilities". In the context of IFRS 17, the presentation of the Statement of Financial Position (SOFP) using the non-current and current presentation has been assessed with a specific focus on the operating cycle of the Scheme and the uncertainty as to the period in which reserves generated under insurance contracts would be accessed by members for their healthcare events, which may only be utilised in future periods. Considering this uncertainty, presenting the SOFP using an order of liquidity presentation without segregating by current and non-current has been judged to be more relevant for users of medical scheme financial statements and provides more reliable information about the transactions and conditions on the financial position of medical schemes. The non-current and current classification of items presented on the SOFP will be presented in the respective note to the Financial Statements with an assessment as performed by management on what is expected to be recovered/settled within 12 months; what is expected to be recovered/settled after 12 months; and open ended, available on demand.	During the IASB board meeting held on 17 March 2021, the IASB decided to defer the effective date to 1 January 2023

ACCOUNTING POLICIES *continued*

FOREIGN CURRENCY TRANSLATION

Functional and presentation currency

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

Transactions and balances

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

CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, derivatives, and other receivables. Other receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Other receivables are disclosed under "Trade and other receivables".

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition. All purchases and sales of financial instruments are recognised on the trade date, which is the date on which the Scheme commits to purchase the financial asset or assume financial liability.

Offsetting financial instruments

This applies where a legally enforceable right to set off exists for recognised financial assets and financial liabilities, and there is an intention to realise the asset, and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position or accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

MEMBERS' FUNDS

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

FINANCIAL LIABILITIES

Financial liabilities are initially recognised at fair value, net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest rate method. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6) (c) of the Act. The Scheme therefore has no long-term financial liabilities.

PROVISIONS

The Scheme recognises a provision once the following conditions are met:

- It has a present legal or constructive obligation as a result of past events.
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation.
- A reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

CONTINGENT LIABILITY

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation.
  - The amount of the obligation cannot be measured with sufficient reliability.

MEMBER INSURANCE CONTRACTS

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

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 29.

RELEVANT HEALTHCARE EXPENDITURE

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

ACCOUNTING POLICIES *continued*

LIABILITY ADEQUACY TEST

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

INCOME TAX

In terms of Section 10 (1) (d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT PLANS

The following items are directly allocated to benefit plans:

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

The remaining items are allocated as detailed below:

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

STRUCTURED ENTITIES

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual agreements. A structured entity often has some or all of the following features or attributes:

- Restricted activities.
- A narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors.
- Insufficient equity to permit the structured entity to finance its activities without subordinated financial support.
- Financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has determined that some of its investments in pooled funds and in collective investments (funds) are investments in unconsolidated structured entities. Disclosure of these investments has been made in Note 31 to the Financial Statements. The objectives include achieving medium to long-term capital growth. The investment strategy does not include the use of leverage.

These funds are managed by independent asset managers who apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the Statement of Comprehensive Income in "Net fair value gains on financial assets".

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2020

1 Property and equipment

ACCOUNTING POLICY:

Property and equipment are stated at historical cost less depreciation and impairment. Historical cost includes expenditure that is directly attributable to the acquisition of the items.

Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme, and the cost of the item can be measured reliably. All other repairs and maintenance are charged to the surplus or deficit during the financial period in which they are incurred.

Property and equipment are depreciated using the straight-line method to allocate their cost to their residual values over their estimated useful lives, as follows:

Right-of-use asset – Land and Buildings	Shorter of estimated life or period of lease
Leasehold improvements	Shorter of estimated life or period of lease

The term of the lease and the right-of-use asset has been determined as 10 years when assessing the term under IFRS 16.

The asset's residual values and useful lives are reviewed at each reporting date and adjusted if appropriate. An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount. The recoverable amount is the higher of the asset's fair value less costs to dispose and value-in-use.

Gains or losses on disposals are determined by comparing the proceeds with the carrying amount. These are recorded in the surplus or deficit.

R'000 **Non-current**	**Right-of-use asset Land and Buildings**	**Leasehold Improvements**	**Total**
Gross carrying amount	**12 015**	**2 844**	**14 859**
Accumulated depreciation	(1 803)	(426)	(2 229)
Balance at 31 December 2019	**10 212**	**2 418**	**12 630**
Gross carrying amount	12 015	2 844	14 859
Accumulated depreciation	(3 004)	(711)	(3 715)
Balance at 31 December 2020	**9 011**	**2 133**	**11 144**

R'000 **Non-current**	**Right-of-use asset Land and Buildings**	**Leasehold Improvements**	**Total**
Balance at 1 January 2019	**11 414**	**2 702**	**14 116**
Additions	–	–	–
Depreciation charge	(1 202)	(284)	(1 486)
Balance at 31 December 2019	**10 212**	**2 418**	**12 630**
Depreciation charge	(1 201)	(285)	(1 486)
Balance at 31 December 2020	**9 011**	**2 133**	**11 144**

LEASED ASSETS

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

2 Leases

ACCOUNTING POLICY:

At inception of a contract, the Scheme assesses whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time in exchange for consideration. To assess whether a contract conveys the right to control the use of an identified asset, the Scheme assesses whether:

- The contract involves the use of an identified asset – this may be specified explicitly or implicitly, and should be physically distinct or represent substantially all of the capacity of a physically distinct asset. If the supplier has a substantive substitution right, then the asset is not considered to be an identified asset;
- The Scheme has the right to obtain substantially all of the economic benefits from the use of the asset throughout the period of use;
- The Scheme has the right to direct the use of the asset. The Scheme has this right when it has the decision-making rights that are most relevant to changing how, and for what purpose, the asset is used. In rare cases, where all the decisions about how and for what purposes the asset is used are predetermined, the Scheme has the right to direct the use of the asset if either:
  - the Scheme has the right to operate the asset; or
  - the Scheme designed the asset in a way that predetermines how and for what purpose it will be used.

At inception, or on reassessment of a contract that contains a lease component, the Scheme allocates the consideration in the contract to each lease component on the basis of their relative stand-alone prices.

The Scheme recognises a right-of-use asset and a lease liability at the lease commencement date.

RIGHT-OF-USE ASSET

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

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

LEASE LIABILITY

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

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

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

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

LEASES OF LOW-VALUE ASSETS

The Scheme has elected not to recognise right-of-use assets and lease liabilities for leases of low-value assets, with a value of less than R100 000.

DISCLOSURE

The Scheme represents right-of-use assets in "Property and equipment" and lease liabilities in "Leases" in the Statement of Financial Position. The Scheme recognises the lease payments associated with short-term leases and leases of low-value assets as an expense on a straight line basis over the lease term.

Note:

Nature of leasing activities

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

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

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

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

R'000	Land and Buildings	Total
2 Leases *continued*		
Right-of-use asset		
Gross carrying amount	12 015	12 015
Accumulated depreciation	(1 803)	(1 803)
Balance at 31 December 2019	**10 212**	**10 212**
Gross carrying amount	12 015	12 015
Accumulated depreciation	(3 004)	(3 004)
Balance at 31 December 2020	**9 011**	**9 011**
Lease liability		
Gross carrying amount	12 015	12 015
Interest expense	2 006	2 006
Lease payments	(2 375)	(2 375)
Balance at 31 December 2019	**11 646**	**11 646**
Gross carrying amount	12 015	12 015
Interest expense	3 299	3 299
Lease payments	(4 088)	(4 088)
Balance at 31 December 2020	**11 226**	**11 226**

R'000	2020	2019
Maturity analysis – contractual undiscounted cash flows		
Less than one year	**1 832**	1 713
One to five years	**11 275**	10 538
More than five years	**4 171**	6 741
Total undiscounted lease liabilities at 31 December 2020	**17 278**	18 992
Amounts recognised in the Statement of Comprehensive Income		
Depreciation	**1 201**	1 202
Interest on lease liabilities	**1 293**	1.331
Expenses relating to leases of low-value assets	**73**	71
Amounts recognised in the Statement of Cash Flows		
Total cash outflow for leases	**1 713**	1 601

3 Financial assets at fair value through profit or loss

ACCOUNTING POLICY:

The Scheme's investment strategy (business model objective) is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolios under management.

The business model objective is achieved through the selling of assets per the documented strategy for realisation of gains with the collection of contractual cash flows being incidental to the primary business model objective. The financial assets are managed together and grouped into specific portfolios. Based on the business model objective the financial assets are measured at fair value through profit and loss.

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

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value are recognised under "Other Income" in the Statement of Comprehensive Income within the period in which they arise.

Note:

R'000	2020	2019
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
	31 430 492	23 191 456
– Offshore bonds	**1 975 533**	876 156
– Equities	**4 658 899**	4 182 545
– Yield-enhanced bonds	**8 871 310**	6 620 669
– Inflation-linked bonds	**1 170 279**	1 125 768
– Money market instruments	**14 323 269**	9 799 918
– Listed property	**431 202**	586 400
	31 430 492	23 191 456
Open ended, available on demand (Included as non-current)	**16 252 910**	–
Expected to settle within twelve months (Included as current)	**15 177 582**	23 191 456
	31 430 492	23 191 456

For the year ended 31 December 2020, the Net healthcare result generated was R7.45 billion, an increase of 5 395% compared to the year ended 31 December 2019, with Total comprehensive income increasing to R9 billion after inclusion of investment and other income and expenditure. This performance increased accumulated funds by 47% to R28,22 billion with the statutory capital requirement increasing from 27.50% to 36.93%. The statutory solvency requirement exceeds the 25% minimum statutory requirement by R8.89 billion.

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

Pursuant to the improved financial position and excess solvency, there is a low expectation for the realisation of assets, with a maturity date longer than 12 months from the reporting date or with no defined maturity date, within 12 months of the reporting date of 31 December 2020.

MEASUREMENT CLASS	METHODOLOGY
Offshore bonds	Instruments in these portfolios have maturity dates that expire within 12 months from year-end, and after 12 months from year-end. The Scheme's intention is not to liquidate these portfolios however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.
Equities	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.
Yield-enhanced bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Inflation-linked bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Money market instruments	Assets that are expected to be realised to fund operating activities within 12 months from the reporting date are considered to be settled within 12 months. All other instruments are classified as open ended.
Listed property	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.

Reconciliation of the balance at the beginning of the year to the balance at the end of the year:

R'000	2020	2019
At the beginning of the year	**23 191 456**	20 519 767
Acquisitions	**11 887 221**	4 783 355
Disposals	**(3 470 050)**	(2 215 835)
Net gains/(losses) on revaluation of financial assets at fair value through profit or loss (Note 22)	**(178 135)**	104 169
At the end of the year	**31 430 492**	23 191 456

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

4 Trade and other receivables

ACCOUNTING POLICY:

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

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

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

IMPAIRMENT OF INSURANCE RECEIVABLES – LOSS EVENT

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

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

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

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

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

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

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

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

4 Trade and other receivables *continued*

IMPAIRMENT OF OTHER RECEIVABLES – EXPECTED CREDIT LOSS

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for other receivables. To measure the expected credit losses, other receivables are grouped based on shared credit risk characteristics and days past due. The Financial Risk Management Note 31 in the Financial Statements sets out information about impairment of other receivables.

Note:

R'000	2020	2019
Insurance receivables		
Contribution receivables	**2 200 791**	2 108 912
Contributions outstanding	**2 223 262**	2 126 734
Less: Provision for impairment	**(22 471)**	(17 822)
Member and service provider claims receivables	**98 725**	102 455
Amount due	**421 649**	443 355
Less: Provision for impairment	**(322 924)**	(340 900)
Other risk transfer arrangements	**2 695**	4 253
Recoveries due from other risk transfer arrangements	**489**	2 647
Share of outstanding claims provision (Note 6)	**2 206**	1 606
Broker fee receivables	**469**	885
Amounts due from brokers	**2 365**	2 220
Less: Provision for impairment	**(1 896)**	(1 335)
Other insurance receivables	**41 340**	96 129
Balance due by related party	**13 688**	16 383
Discovery Third Party Recovery Services (Pty) Ltd (Note 25)	**13 688**	16 383
Forensic receivables	**253 483**	214 212
Amount due	**265 262**	227 931
Less: Provision for impairment	**(11 779)**	(13 719)
Total receivables arising from insurance contracts	**2 611 191**	**2 543 229**
Other receivables		
Sundry accounts receivable	**13 297**	15 158
Interest receivable	**923**	2 038
Total receivables arising from other receivables	**14 220**	**17 196**
	2 625 411	**2 560 425**

At 31 December 2020, the carrying amounts of "Trade and other receivables" approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

5 Cash and cash equivalents

ACCOUNTING POLICY:

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value. These instruments are not held for investment purposes.

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

- Money on call and short notice.
- Balances with banks.

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes and are carried at cost, which, due to their short-term nature, approximates fair value.

Note:

R'000	2020	2019
Current accounts	**875 860**	827 030
Money market instruments	**3 132 808**	1 164 252
	4 008 668	1 991 282

At the reporting date cash and cash equivalents are carried at amortised cost, which approximates fair value.

The money market instruments are held in an actively managed portfolio by an independent asset manager. The asset manager invests in line with its best investment view, subject to the investment mandate which includes investment in interest bearing – money market and/or interest bearing short-term collective investment scheme portfolios, subject to the Collective Investment Schemes Control Act 2002 (CISCA). The targeted return if the Short Term Fixed Interest (STeFI) Call Deposit Index and the weighted average term to final maturity never exceeds 90 days. The portfolio is highly liquid with 100% of the portfolio being available within three working days. 60% of the portfolio must be available for same-day value with the balance available within two working days.

6 Outstanding claims provision

ACCOUNTING POLICY:

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

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

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

Note:

R'000	2020	2019
Outstanding claims provision – not covered by risk transfer arrangements	**1 766 802**	1 524 891
Outstanding claims provision – covered by risk transfer arrangements (Note 4)	**2 206**	1 606
	1 769 008	1 526 497
Analysis of movement in outstanding claims		
Balance at beginning of the year	**1 526 497**	1 499 227
Payments in respect of prior year	**(1 532 216)**	(1 508 343)
Under provision in prior year (Note 11)	**(5 719)**	(9 116)
Outstanding claims provision raised in current year	**1 774 727**	1 535 613
Not covered by risk transfer arrangements	**1 772 521**	1 534 007
Covered by risk transfer arrangements (Note 4)	**2 206**	1 606
Balance at the end of the year	**1 769 008**	1 526 497
Analysis of outstanding claims provision		
Estimated gross claims	**1 893 413**	1 623 483
Less:		
Estimated recoveries from savings plan accounts (Note 8)	**(124 405)**	(96 986)
Balance at the end of the year	**1 769 008**	1 526 497

R'000	2020	2019
7 Derivative financial instruments		
Note:		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	**193 030**	75 179
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**(34 723)**	(14 689)
Derivative financial asset at the end of the year	**158 307**	60 490
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset/(liability) at the beginning of the year	**60 490**	142 856
Net realised gain on derivative financial instruments (Note 27)	**(293 299)**	(22 447)
Realised gains on derivative financial instruments	**(333 865)**	(27 448)
– Zero-cost currency collars	**–**	–
– Zero-cost equity fences	**(333 865)**	(27 448)
Realised losses on derivative financial instruments	**40 566**	5 001
– Zero-cost equity fences		5 001
– Zero-cost currency collars	**40 566**	–
Net fair value (loss)/gain on derivative financial instruments (Note 22)	**391 116**	(59 919)
Gains on revaluation of derivative financial instruments to fair value	**403 665**	52 598
– Zero-cost equity fences	**309 412**	27 810
– Zero-cost currency collars	**94 253**	24 788
Losses on revaluation of derivative financial instruments to fair value	**(12 549)**	(112 517)
– Zero-cost equity fences	**(12 549)**	(112 517)
– Zero-cost currency collars	**–**	–
Derivative financial asset at the end of the year	**158 307**	60 490

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

Some of the Scheme's equity managers entered into futures contracts to generate an equity-related return on cash held in the equity portfolios.

Some of the Scheme's bond managers entered into bond futures to hedge the bond portfolios and provide protection against market risk.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 31).

8 Personal Medical Savings Account liabilities

ACCOUNTING POLICY:

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

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

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

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

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

Interest payable on members' PMSAs is expensed when incurred.

Unclaimed PMSA balances that have prescribed, that is funds older than three years, are written back and included under "Sundry income" on the face of the Statement of Comprehensive Income.

Note:

R'000	2020	2019
Balance on Personal Medical Savings Accounts at the beginning of the year	**5 522 613**	5 040 832
Add:		
Personal Medical Savings Accounts contributions received or receivable (Note 10)	**13 294 773**	12 632 907
Interest on Personal Medical Savings Accounts (Note 24)	**282 907**	246 267
Transfers received from other medical schemes	**16 479**	22 456
Less:		
Claims paid to or on behalf of members (Note 11)	**(11 785 757)**	(12 004 885)
Refunds on death or resignation	**(487 217)**	(413 396)
Unclaimed Personal Medical Savings Accounts written off to Scheme funds (Note 23)	**(2 379)**	(1 568)
COVID-19 support: Contributions funded from PMSA	**(165 474)**	–
Balance due to members on Personal Medical Savings Accounts at the end of the year	**6 675 945**	5 522 613

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2020 but not reported will amount to approximately R124 404 720 (2019: R96 986 357) (Note 6).

PMSAs contain a demand feature and members can call on the funds at any time, and these balances are categorised as "Available on demand". At 31 December 2020, the carrying amount of members' PMSAs were deemed to be equal to their fair values, which is the amount payable on demand.

Interest is determined from time to time by the Scheme at its discretion and added to the funds allocated to the member's PMSA in terms of the Scheme Rules. The Scheme does not charge interest on negative (overdrawn) PMSA balances.

The Scheme introduced the payment of contributions from positive MSA balances to assist in the adverse impact of COVID-19 on its stakeholders. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R165 474 325 affecting 15 202 policies. CMS granted DHMS an exemption on 9 April 2020 for a period of three months effective from 1 April 2020. An extension of the exemption was granted on 4 November 2020 for the period up to 31 December 2020.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

9 Trade and other payables

ACCOUNTING POLICY:

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities.

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate method.

UNALLOCATED FUNDS

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, those are funds older than three years, are written back and included under "Sundry income" in the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under "Trade and other payables". The liability is measured at amortised cost using the effective interest rate method.

Note:

R'000	2020	2019
Insurance payables		
Contributions received in advance	**190 991**	164 395
Contribution refunds due to employers	**711**	689
Reported claims not yet paid	**635 017**	634 337
Balance at the beginning of the year	**634 337**	628 147
Net movement for the year	**680**	6 190
Broker fee creditors	**95 036**	93 250
Accredited brokers	**95 036**	93.250
Total liabilities arising from insurance contracts	**921 755**	892 671
Financial liabilities		
Balances due to related parties (Note 25)	**602 596**	609 002
Discovery Health (Pty) Ltd	**602 483**	598 846
Discovery Life Limited	**30**	120
Discovery Vitality (Pty) Ltd	**–**	9 898
Discovery Central Services (Pty) Ltd	**83**	138
Unallocated funds	**13 621**	10 382
Total accruals	**30 823**	39 913
General accruals	**30 652**	39 757
Leave pay provision	**171**	156
Total arising from financial liabilities	**647 040**	659 297
	1 568 795	1 551 968

At 31 December 2020, the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

10 Risk contribution income

ACCOUNTING POLICY:

Gross contributions comprise risk contributions and Personal Medical Savings Account contributions. Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

Risk contributions are shown before the deduction of broker service fees.

Note:

R'000	2020	2019
Gross contributions per registered Scheme Rules	**74 537 501**	69 855 135
Less:		
Personal Medical Savings Account contributions (Note 8)	**(13 294 773)**	(12 632 907)
	61 242 728	57 222 228

11 Net claims incurred

ACCOUNTING POLICY:

CLAIMS INCURRED

Gross claims incurred comprises of the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether or not reported by the end of the year.

Risk claims incurred comprise:

- Claims submitted and accrued for services rendered during the year.
- Payments under provider contracts for services rendered to members.
- Over or under provisions relating to prior year claims estimates.
- Claims incurred but not yet reported.
- Claims settled in terms of risk transfer arrangements.

Net of:

- Claims from members' Personal Medical Savings Accounts.
- Recoveries from members for co-payments.
- Recoveries from third parties.
- Discount received from service providers.

Anticipated recoveries under risk transfer arrangements are disclosed separately as assets, and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

11 Net claims incurred *continued*

REIMBURSEMENTS FROM THE ROAD ACCIDENT FUND

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made against the Road Accident Fund, administered in terms of the Road Accident Fund Act No 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged, contractually, to cede that payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and measurability of the Road Accident Fund amounts, the Scheme accounts for these amounts on a cash basis. These amounts are recognised as a reduction of net claims incurred.

Note:

R'000	2020	2019
Current year claims per registered Scheme rules	**56 500 744**	60 650 075
Claims not covered by risk transfer arrangements	**56 198 295**	60 268 128
Claims covered by risk transfer arrangements (Note 13)	**302 449**	381 947
Movement in outstanding claims provision	**242 511**	27 270
Under provision in prior year (Note 6)	**5 719**	9 116
Adjustment for current year	**236 792**	18 154
	56 743 254	60 677 345
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 8)	**(11 785 757)**	(12 004 885)
Claims incurred	**44 957 497**	48 672 460
Third-party claim recoveries	**(141 543)**	(156 703)
	44 815 954	48 515 757

12 Accredited managed healthcare services (no risk transfer)

ACCOUNTING POLICY:

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred.

Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Note:

R'000	2020	2019
The accredited managed healthcare services (no risk transfer) have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Active Disease Risk Management Services and Disease Risk Management Support Services	**601 002**	561 058
Hospital Benefit Management Services	**557 702**	520 453
Managed Care Network Management Services and Risk Management Services	**535 040**	507 555
Pharmacy Benefit Management Services	**189 337**	176 761
	1 883 081	1 765 827

13 Net income on risk transfer arrangements

ACCOUNTING POLICY:

Risk transfer arrangements are contractual arrangements entered into by the Scheme and third parties who undertake to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees (including "Managed care: healthcare services") are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions, and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for insurance receivables. The impairment loss is also calculated following the same method used for these receivables. These processes are described in the "Trade and other receivables" note in the Financial Statements.

Note:

R'000	2020	2019
Risk transfer arrangement fees	**(260 068)**	(299 464)
Recoveries under risk transfer arrangements (Note 11)	**302 449**	381 947
	42 381	82 483

14 Broker service fees

ACCOUNTING POLICY:

Broker service fees are fees paid as acquisition costs for the introduction and provision of ongoing services to members and are expensed as incurred.

Note:

R'000	2020	2019
Brokers' fees	**1 489 823**	1 444 563
	1 489 823	1 444 563

15 Other operating expenses

ACCOUNTING POLICY:

Fees paid to the Scheme administrator are included in "Expenses for administration" and are expensed as incurred. Other operating expenses include expenses, other than administration fees, and are expensed as incurred.

Note:

R'000	2020	2019
Association fees	**1 779**	1 423
Audit fees	**9 345**	10 497
Audit services for the year ended 2020	**3 182**	–
Audit services for the year ended 2019	**4 296**	1 709
Audit services for the year ended 2018	**–**	3 713
Other services	**1 867**	5 075
Audit Committee and Risk Committee fees (Note 16)	**1 431**	1 817
Audit Committee	**1 145**	1 270
Risk Committee	**286**	547
Bank charges	**10 388**	9 938
Benefit management services (Note 25)	**11 703**	–
Clinical Governance Committee fees (Note 16)	**544**	644
Council for Medical Schemes	**52 292**	52 255
Debt collecting fees	**2 693**	3 104
Depreciation	**1 486**	1 486
Dispute Committee fees	**1 701**	1 587
Fidelity Guarantee Insurance	**471**	252
General meeting costs	**2 982**	6 374
Investment Committee fees (Note 16)	**236**	418
Investment reporting fees	**4 523**	3 865
Legal fees	**325**	509
Nomination Committee fees (Note 18)	**250**	515
Office operating costs	**4 162**	3 788
Other expenses	**24 549**	27 940
Principal Officer fees – Remuneration	**4 647**	4 849
Principal Officer fees – Unvested long-term employee benefit	**285**	4 039
Printing, postage and stationery	**47**	122
Professional fees	**8 577**	8 154
Remuneration Committee fees (Note 16)	**161**	95
Scheme Office costs	**950**	2 968
Staff costs (Note 19)	**23 799**	23 578
Sundry amounts written off	**9**	6
Trustees' remuneration and consideration expenses (Note 20)	**8 028**	9 720
	177 363	179 943

16 Board Committee fees and considerations

Note:

2020 R'000	**Audit**	**Risk**	**Clinical Governance**	**Investment**	**Remuneration**	**Total**
S Ludolph	**194**					**194**
N Luthuli					**161**	**161**
P Maphumulo				**37**		**37**
N Mlaba			**249**			**249**
S Smith			**295**			**295**
E Mackeown	**721**	**128**		**199**		**1 048**
A Burger	**230**	**158**				**388**
Total	**1 145**	**286**	**544**	**236**	**161**	**2 372**

2019 R'000	Audit	Risk	Clinical Governance	Investment	Remuneration	Total
S Green	200	149				349
S Ludolph	194	85				279
N Luthuli					95	95
P Maphumulo	147	85		199		431
N Mlaba			256			256
S Smith			227			227
E Mackeown	228	100		61		389
B Stott	501	128		158		787
Z Van Der Spuy – fees			126			126
Z Van Der Spuy – travel			35			35
Total	1 270	547	644	418	95	2 974

For detail of the Chairperson of the respective Committee refer to pages 47 – 48 and page 60.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

17 Net impairment losses on healthcare receivables

Note:

R'000	2020	2019
Insurance receivables		
Contributions that are not recoverable	**4 648**	3 089
Movement in provision	**4 648**	3 089
Members' and service providers' portions that are not recoverable	**56 602**	100 014
Movement in provision	**56 602**	100 014
Amounts due by brokers that are not recoverable	**562**	71
Movement in provision	**562**	71
Forensic debtors that are not recoverable	**(1 940)**	2 409
Movement in provision	**(1 940)**	2 409
Payables/receivables written off directly to the Statement of Comprehensive Income	**19 224**	525
	79 096	106 108

18 Other committee fees

Note:

R'000	2020	2019
Nomination Committee fees		
P Goss – Independent Member (Chairperson)	**154**	223
T Wixley – Independent Member	**25**	146
R Shough – Independent Member	**71**	146
	250	515

19 Staff costs

ACCOUNTING POLICY:

PENSION OBLIGATIONS

All employees of the Scheme are members of defined contribution plans. Defined contribution plans are plans under which the Scheme pays fixed contributions to separate legal entities.

The Scheme has no legal or constructive obligation to pay further contributions if the funds do not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

OTHER POST-EMPLOYMENT OBLIGATIONS

The Scheme has no liability for the post-retirement medical benefits of employees.

OTHER LONG-TERM EMPLOYEE BENEFIT

The long-term employee benefit plan refers to awards made to qualifying employees.

The amount recognised in the Statement of Financial Position in respect of the defined benefit plan is the present value of the defined benefit obligation at the end of the reporting period less the fair value of plan assets out of which the obligations are to be settled directly. The defined benefit obligation is calculated using the projected unit credit method.

LEAVE PAY ACCRUAL

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

BONUSES

Management and staff bonuses are recognised as an expense in staff costs as incurred.

Note:

R'000	2020	2019
Salaries and bonuses	**18 944**	19 822
Pension costs – defined contribution plans	**1 273**	1 165
Medical and other benefits	**1 001**	843
Long-term employee benefit service cost	**2 558**	1 697
Increase in leave pay accrual	**23**	51
	23 799	23 578
Number of employees at 31 December	**12**	12

20 Trustees' remuneration and considerations

Note:
The following table records the remuneration and consideration paid to Trustees during the year:

2020 R'000	**Services as Trustee**	**Committee fees**							**Travel**	**Training**	**Total**
		Audit	**Risk**	**Investment**	**Clinical Governance**	**Product**	**Re-muneration**	**Stakeholder Relations and Ethics**			
N Morrison (Chairperson)	**895**			**229**			**98**	**49**			**1 271**
D Moodley	**574**			**277**	**311**	**147**		**147**	**10**		**1 466**
D King	**543**		**179**				**107**	**128**	**23**		**980**
J Adams SC	**567**		**170**		**261**	**15**		**147**		**3**	**1 163**
J Butler SC	**557**	**196**					**98**	**183**	**27**		**1 061**
J Human	**574**	**196**		**229**		**184**			**41**		**1 224**
S Brynard	**486**					**115**	**98**	**128**	**36**		**863**
Total	**4 196**	**392**	**349**	**735**	**572**	**461**	**401**	**782**	**137**	**3**	**8 028**

The following table records the remuneration and consideration paid to Trustees during the prior year:

2019 R'000	Services as Trustee	Committee fees								Travel	Training	Total
		Audit	Risk	Investment	Clinical Governance	Product	Non-Healthcare Expenses	Re-muneration	Stakeholder Relations and Ethics			
N Morrison (Chairperson)	1 002			228			77	98	147		2	1 554
D Moodley	601			278	311	147			147	28	2	1 514
D King	644		80				66	117	128	109	2	1 146
D Naidoo	272	83	66	114		66	77				10	688
J Adams SC	583	136	171		261				49		6	1 206
J Butler SC	534	90					77	110	184	116	2	1 113
J Human	661	196	98	182		184				194	2	1 517
S Brynard	477					128		96	128	131	22	982
Total	4 774	505	415	802	572	525	297	421	783	578	48	9 720

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

21 Investment income

ACCOUNTING POLICY:

Investment income comprises dividends and interest received and accrued on investments at fair value through profit or loss and interest on cash and cash equivalents.

Interest income is recognised using the effective interest method, taking into account the principal amount outstanding and the effective interest rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income from investments is recognised when the right to receive payment is established – this is on the "last day to trade" for listed shares and on the "date of declaration" for unlisted shares.

Note:

R'000	2020	2019
Financial assets at fair value through profit or loss:	**1 462 783**	1 473 813
Dividend income	**156 310**	183 989
Interest income	**1 306 473**	1 289 824
Cash and cash equivalents interest income	**227 587**	224 014
Investment income per Statement of Comprehensive Income	**1 690 370**	1 697 827
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Cash and cash equivalents interest income	**227 587**	224 014
Financial assets at fair value through profit or loss:		
Interest income	**1 306 473**	1 289 824
Total interest income	**1 534 060**	1 513 838

22 Net gains/(losses) on financial assets

Note:

R'000	2020	2019
Net fair value gains/(losses) on financial assets at fair value through profit or loss (Note 3):	**(178 135)**	104 169
Fair value gains on financial assets at fair value through profit or loss:	**470 681**	219 791
– Equities	**301 446**	69 580
– Money market instruments	**23 499**	57 636
– Inflation-linked bonds	**2 568**	
– Offshore bonds	**124 434**	29 167
– Yield-enhanced bonds	**18 734**	63 408
Fair value losses on financial assets at fair value through profit or loss:	**(648 816)**	(115 622)
– Equities	**(341 765)**	(67 092)
– Offshore bonds	**(69 227)**	–
– Money market instruments	**(8 625)**	–
– Inflation-linked bonds	**(15 549)**	(26 242)
– Listed property	**(211 580)**	(22 288)
– Yield-enhanced bonds	**(2 070)**	–
Net fair value (losses)/gains on derivative financial instruments (Note 7):	**391 116**	(59 919)
Fair value gains on derivative financial instruments	**403 665**	52 598
Fair value losses on derivative financial instruments	**(12 549)**	(112 517)
	212 981	44 250

23 Sundry income

Note:

R'000	2020	2019
Prescribed amounts written back	**14 970**	13 956
Unclaimed Personal Medical Savings Accounts written off to Scheme funds (Note 8)	**2 379**	1 568
	17 349	15 524
Reversal of stale cheques written back	**(2 372)**	(5 938)
	14 977	9 586

24 Finance costs

Note:

R'000	2020	2019
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings Accounts (Note 8)	**282 907**	246 267
	1 429	1 373
Interest paid – other	**136**	42
Interest on lease liability (Note 2)	**1 293**	1 331
	284 336	247 640

25 Related party transactions

The Scheme is governed by the Board of Trustees, the majority of which are elected by the members of the Scheme.

KEY MANAGEMENT PERSONNEL AND THEIR CLOSE FAMILY MEMBERS

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the non-executive Board of Trustees and the Executive Officers of the Scheme. The disclosure deals with full-time Executive Officers who are compensated on a salary basis, and non-executive Board of Trustees who are compensated on a fee basis.

Close family members include close family members of the Board of Trustees and Executive Officers of the Scheme.

PARTIES WITH SIGNIFICANT INFLUENCE OVER THE SCHEME

Administrator

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and wellness programmes. As Discovery Health (Pty) Ltd is a related party, its subsidiaries and fellow subsidiaries within the Discovery Ltd group are related parties to the Scheme. Discovery Ltd's Annual Report provides detail of its group structure.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

25 Related party transactions *continued*

PARTIES WITH SIGNIFICANT INFLUENCE OVER THE SCHEME *continued*

Transactions with related parties

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members which includes Trustees and Executive Officers:

R'000	2020	2019
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	**(23 053)**	(31 819)
Unvested long-term employee benefit	**(2 843)**	(5 736)
Contributions and claims		
Gross contributions received	**1 230**	1 161
Claims paid from the Scheme	**(282)**	(299)
Claims paid from the Personal Medical Savings Account	**(318)**	(258)
Interest paid on Personal Medical Savings Accounts	**(22)**	(3)
Statement of Financial Position transactions		
Long-term employee benefit plan asset	**6 427**	5 796
Plan asset	**10 797**	19 198
Plan liability	**(4 370)**	(13 402)
Long-term employee benefit plan asset	**6 427**	5 796
Balance at the beginning of the year	**5 796**	8 261
Additions	**4 618**	3 504
Withdrawals	**(1 144)**	(233)
Unvested long-term employee benefit	**(2 843)**	(5 736)
Contribution debtors	**92**	93
Personal Medical Savings Account balances	**(96)**	(68)

The terms and conditions of the related party transactions were as follows:

TRANSACTIONS	NATURE OF TRANSACTIONS AND THEIR TERMS AND CONDITIONS
Compensation	This constitutes remuneration and consideration paid to Trustees and Executive Officers, short-term employee benefits and unvested long-term employee benefits.
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the Rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates determined by the Scheme from time to time at its discretion. The amounts are all current and would need to be payable on demand as applicable to other members.

25 Related party transactions *continued*

R'000	2020	2019
TRANSACTIONS WITH ENTITIES THAT HAVE SIGNIFICANT INFLUENCE OVER THE SCHEME		
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(5 389 056)**	(5 156 926)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 9)*	**(445 612)**	(429 839)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 12)	**(1 866 263)**	(1 763 579)
Diabetes management services (Note 12)	**(16 818)**	(2 248)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)*	**(156 871)**	(169 007)
Discovery Health (Pty) Ltd – Lifestyle and health assessments		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(29 843)**	(6 630)
Transactions between Discovery Health (Pty) Ltd's subsidiaries and the Scheme are provided below		
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third-party collection fees	**(18 625)**	(23 255)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 4)	**13 688**	16 383
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(328 398)**	(286 951)
Statement of Financial Position transactions		
Claims due to provider	**(571)**	(304)
Grove Nursing Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(34 856)**	(13 565)
COVID-19 management services (Note 15)	**(11 703)**	–
Statement of Financial Position transactions		
Balance due to provider	**(2 154)**	–

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R603 million (2019: R599 million), disclosed in Note 9.*

25 Related party transactions *continued*

R'000	2020	2019
Discovery Bank Ltd		
Statement of Financial Position transactions		
Negotiable Certificates of Deposits	**141 636**	–
Discovery Ltd		
Statement of Financial Position transactions		
Floating Rate Notes	**69 781**	–
Discovery Life Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Life Limited at year-end (Note 9)	**(30)**	(120)
Discovery Vitality (Pty) Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Vitality (Pty) Ltd at year-end (Note 9)	**–**	(9 898)
Discovery Connect Distribution Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Broker fees paid	**(82 600)**	(72 279)
Statement of Financial Position transactions		
Balance due to Discovery Connect Distribution Services (Pty) Ltd at year-end	**(7 735)**	(6 573)
Discovery Central Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Contractual lease and non-lease payments	**(5 875)**	(5 388)
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note 9)	**(83)**	(138)

The terms and conditions of the transactions with entities with significant influence over the Scheme were as follows:

ADMINISTRATION AGREEMENT

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Trustees. The agreement is for a five-year period effective from 1 January 2018. The Scheme and the administrator shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The administration fees are an all-inclusive fee, calculated on a per member per month basis. The total expense for administration cost changes in line with membership growth and inflation.

The main categories of service provided can be broken down as follows:

- Member and provider servicing;
- Marketing and advertising;
- Financial and actuarial services; and
- Governance, risk, compliance and internal audit.

MANAGED HEALTHCARE AGREEMENT

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

The Scheme has contracted with the administrator to provide accredited managed healthcare services (no risk transfer). These services include bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis.

This agreement is in accordance with instructions given by the Trustees. The agreement is for a five-year period and effective from 1 January 2018. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

25 Related party transactions *continued*

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Management Services
- Pharmacy Benefit Management Services

THIRD-PARTY COLLECTION SERVICES

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third-party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2020 to 31 December 2020 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R10 million (2019: R16 million).

SPECIALIST PHARMACEUTICAL SERVICES

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide specialist pharmaceutical services to members of the Scheme.

LIFESTYLE AND HEALTH ASSESSMENTS

Discovery Health (Pty) Ltd provides wellness experiences through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

HOME-BASED NURSING SERVICES

The Scheme is contracted with Grove Nursing Services also known as Discovery HomeCare, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based care to members of the Scheme in the comfort of their home.

BROKER SERVICE FEES

The Scheme contracted with Discovery Connect Distribution Services (Pty) Ltd to provide broker services directly to the consumer. The amounts were determined and paid based on the terms and conditions applicable to other brokers.

CONTRACTUAL LEASE PAYMENTS

The Scheme has contracted with Discovery Central Services (Pty) Ltd, a wholly owned subsidiary of Discovery Ltd, to lease land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of five years. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

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

INTERNATIONAL TRAVEL SERVICES AGREEMENT

The Scheme contracted with Medical Services Organisation International (Pty) Ltd (MSOI) to deliver the following benefit offered by Discovery Health Medical Scheme to its members who are working or travelling outside the borders or the Republic of South Africa (RSA):

- **The International Travel Benefit**
  Members are covered for emergency medical assistance outside of the RSA for a period of 90 (ninety) days from date of departure from the RSA. This cover includes in-hospital treatment, repatriation and out-of-hospital treatment above a US$D150 or €100 (one hundred and fifty US Dollars or one hundred Euros) excess payment by the member. This benefit is available to all members, except members on KeyCare plans.

- **The Africa Evacuation Benefit**
  Members are covered for emergency medical assistance with or without evacuation to the RSA and pre-authorised in-hospital elective procedures at the South African Rand equivalent in accordance with their respective health plans. Cover commences on the Member's date of departure from the RSA and continues for an unlimited period in those specified African countries. This benefit is available to all members, except members on KeyCare plans.

This agreement is in accordance with instructions given by the Trustees. The agreement is effective from 1 October 2020. The Scheme and Medical Services Organisation International (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 90 days written notice.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

26 Surplus/(deficit) from operations per benefit plan

2020 R'000	**Executive**	**Classic Comp**	**Classic Smart Comp**	**Classic Core**	**Classic Saver**	**Classic Priority**	**Essential Comp**	**Essential Saver**	**Essential Core**
Risk contribution income	**951 977**	**10 354 136**	**45 382**	**2 430 943**	**14 934 631**	**4 819 694**	**1 001 525**	**5 485 672**	**1 861 332**
Net claims incurred	(993 385)	(8 834 342)	(15 061)	(1 625 793)	(10 268 730)	(3 522 039)	(785 866)	(3 231 359)	(1 168 799)
Risk claims incurred	(996 396)	(8 862 328)	(15 100)	(1 630 812)	(10 299 519)	(3 532 740)	(788 336)	(3 241 697)	(1 172 622)
Third-party claim recoveries	3 011	27 986	39	5 019	30 789	10 701	2 470	10 338	3 823
Accredited managed healthcare services (no risk transfer)	(12 491)	(169 069)	(845)	(67 790)	(441 385)	(113 788)	(19 028)	(196 894)	(65 490)
Net income/(expense) on risk transfer arrangements	(69)	(471)	(466)	(178)	406	122	(5)	285	45
Risk transfer arrangement fees paid	(2 055)	(25 812)	(585)	(1 611)	(10 845)	(4 724)	(2 265)	(2 764)	(1 191)
Recoveries from risk transfer arrangements	1 986	25 341	119	1 433	11 251	4 846	2 260	3 049	1 236
Relevant healthcare expenditure	**(1 005 945)**	**(9 003 885)**	**(16 372)**	**(1 693 762)**	**(10 709 709)**	**(3 635 705)**	**(804 899)**	**(3 427 968)**	**(1 234 244)**
Gross healthcare result	**(53 968)**	**1 350 252**	**29 010**	**737 181**	**4 224 922**	**1 183 989**	**196 626**	**2 057 704**	**627 087**
Broker service fees	(10 778)	(149 437)	(599)	(53 363)	(398 847)	(104 057)	(17 187)	(159 084)	(48 758)
Expenses for administration	(37 520)	(509 195)	(2 120)	(211 705)	(1 377 948)	(353 513)	(57 832)	(616 587)	(204 814)
Other operating expenses	(1 085)	(15 152)	(64)	(6 161)	(42 061)	(10 540)	(1 785)	(19 410)	(6 014)
Net impairment losses on healthcare receivables	(505)	(6 851)	(29)	(2 855)	(18 551)	(4 755)	(778)	(8 311)	(2 769)
Net healthcare result	**(103 856)**	**669 619**	**26 198**	**463 098**	**2 387 515**	**711 123**	**119 044**	**1 254 311**	**364 733**
Investment income	10 817	146 809	611	60 956	396 989	101 872	16 671	177 495	58 855
Net gains/(losses) on financial instruments	1 082	14 459	55	7 830	47 015	11 343	1 735	24 589	10 188
Other income	110	1 487	6	627	4 055	1 038	169	1 830	619
Other income	**12 009**	**162 755**	**672**	**69 413**	**448 059**	**114 253**	**18 575**	**203 914**	**69 662**
Asset management fees	(500)	(6 777)	(28)	(2 838)	(18 418)	(4 717)	(770)	(8 279)	(2 772)
Other expenses	(15)	(209)	(1)	(85)	(560)	(144)	(24)	(248)	(80)
Interest paid	(9)	(124)	(1)	(52)	(336)	(86)	(14)	(150)	(50)
Interest paid on savings accounts	(2 831)	(38 420)	–	–	(104 116)	(26 697)	(4 365)	(46 654)	–
Other expenditure	**(3 355)**	**(45 530)**	**(30)**	**(2 975)**	**(123 430)**	**(31 644)**	**(5 173)**	**(55 331)**	**(2 902)**
Total comprehensive income for the year	**(95 202)**	**786 844**	**26 840**	**529 536**	**2 712 144**	**793 732**	**132 446**	**1 402 894**	**431 493**

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

26 Surplus/(deficit) from operations per benefit plan *continued*

2020 R'000	**Essential Priority**	**Coastal Saver**	**Coastal Core**	**KeyCare Plus**	**KeyCare Core**	**KeyCare Start**	**Classic Smart**	**Essential Smart**	**Total**
Risk contribution income	**287 271**	**7 550 459**	**3 270 534**	**5 452 069**	**316 508**	**95 957**	**1 693 343**	**691 295**	**61 242 728**
Net claims incurred	(168 365)	(5 465 976)	(2 420 551)	(4 709 901)	(200 235)	(45 862)	(1 028 678)	(331 012)	(44 815 954)
Risk claims incurred	(168 929)	(5 483 294)	(2 428 229)	(4 725 795)	(200 957)	(46 053)	(1 032 241)	(332 449)	(44 957 497)
Third-party claim recoveries	564	17 318	7 678	15 894	722	191	3 563	1 437	141 543
Accredited managed healthcare services (no risk transfer)	(7 447)	(245 830)	(107 675)	(292 707)	(20 702)	(8 389)	(64 286)	(49 265)	(1 883 081)
Net income/(expense) on risk transfer arrangements	5	374	163	41 341	–	330	489	10	42 381
Risk transfer arrangement fees paid	(230)	(4 577)	(1 823)	(196 982)	–	(4 103)	(282)	(219)	(260 068)
Recoveries from risk transfer arrangements	235	4 951	1 986	238 323	–	4 433	771	229	302 449
Relevant healthcare expenditure	**(175 806)**	**(5 711 431)**	**(2 528 062)**	**(4 961 268)**	**(220 937)**	**(53 921)**	**(1 092 473)**	**(380 267)**	**(46 656 654)**
Gross healthcare result	**111 465**	**1 839 028**	**742 471**	**490 801**	**95 571**	**42 036**	**600 870**	**311 029**	**14 586 074**
Broker service fees	(6 717)	(212 158)	(83 210)	(164 361)	(9 748)	(3 057)	(46 265)	(22 197)	(1 489 823)
Expenses for administration	(23 207)	(768 615)	(336 814)	(499 363)	(18 954)	(14 311)	(201 876)	(154 682)	(5 389 056)
Other operating expenses	(694)	(22 797)	(9 695)	(27 901)	(1 953)	(814)	(6 250)	(4 987)	(177 363)
Net impairment losses on healthcare receivables	(312)	(10 347)	(4 539)	(12 430)	(884)	(357)	(2 727)	(2 096)	(79 096)
Net healthcare result	**80 534**	**825 110**	**308 214**	**(213 254)**	**64 033**	**23 497**	**343 751**	**127 066**	**7 450 736**
Investment income	6 685	221 441	96 982	265 432	18 713	7 601	58 063	44 378	1 690 370
Net gains/(losses) on financial instruments	811	25 760	12 245	32 415	3 497	1 090	9 119	9 748	212 981
Other income	68	2 263	998	2 720	199	79	605	476	17 349
Other income	**7 564**	**249 464**	**110 225**	**300 567**	**22 409**	**8 770**	**67 787**	**54 602**	**1 920 700**
Asset management fees	(310)	(10 270)	(4 512)	(12 338)	(886)	(355)	(2 724)	(2 114)	(78 608)
Other expenses	(9)	(312)	(136)	(373)	(25)	(11)	(80)	(60)	(2 372)
Interest paid	(6)	(187)	(82)	(224)	(16)	(6)	(49)	(37)	(1 429)
Interest paid on savings accounts	(1 754)	(58 070)	–	–	–	–	–	–	(282 907)
Other expenditure	**(2 079)**	**(68 839)**	**(4 730)**	**(12 935)**	**(927)**	**(372)**	**(2 853)**	**(2 211)**	**(365 316)**
Total comprehensive income for the year	**86 019**	**1 005 735**	**413 709**	**74 378**	**85 515**	**31 895**	**408 685**	**179 457**	**9 006 120**

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

26 Surplus/(deficit) from operations per benefit plan *continued*

2019 R'000	Executive	Classic Comp	Classic Smart Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**962 444**	**10 374 065**	**77 909**	**2 279 078**	**13 616 672**	**4 746 448**	**1 004 132**	**4 797 023**	**1 585 191**
Net claims incurred	(1 216 092)	(10 674 040)	(79 594)	(1 758 507)	(10 604 808)	(4 019 294)	(897 602)	(3 130 178)	(1 122 838)
Risk claims incurred	(1 219 769)	(10 706 975)	(79 850)	(1 764 254)	(10 639 873)	(4 032 089)	(900 490)	(3 140 549)	(1 126 529)
Third-party claim recoveries	3 677	32 935	256	5 747	35 065	12 795	2 888	10 371	3 691
Accredited managed healthcare services (no risk transfer)	(12 531)	(168 954)	(1 278)	(64 574)	(408 112)	(112 636)	(19 088)	(175 290)	(56 491)
Net income/(expense) on risk transfer arrangements	1 127	14 131	120	6	785	372	1 398	295	70
Risk transfer arrangement fees paid	(4 000)	(52 675)	(356)	(501)	(3 884)	(1 678)	(5 035)	(951)	(417)
Recoveries from risk transfer arrangements	5 127	66 806	476	507	4 669	2 050	6 433	1 246	487
Relevant healthcare expenditure	**(1 227 496)**	**(10 828 863)**	**(80 752)**	**(1 823 075)**	**(11 012 135)**	**(4 131 558)**	**(915 292)**	**(3 305 173)**	**(1 179 259)**
Gross healthcare result	**(265 052)**	**(454 798)**	**(2 843)**	**456 003**	**2 604 537**	**614 890**	**88 840**	**1 491 850**	**405 932**
Broker service fees	(11 648)	(161 176)	(1 186)	(52 376)	(379 750)	(108 453)	(18 562)	(144 251)	(42 509)
Expenses for administration	(39 688)	(535 334)	(4 067)	(206 000)	(1 301 881)	(359 124)	(60 578)	(559 346)	(180 233)
Other operating expenses	(1 271)	(17 154)	(131)	(6 584)	(41 665)	(11 502)	(1 940)	(17 863)	(5 738)
Net impairment losses on healthcare receivables	(746)	(10 060)	(76)	(3 882)	(24 503)	(6 752)	(1 139)	(10 557)	(3 411)
Net healthcare result	**(318 405)**	**(1 178 521)**	**(8 303)**	**187 161**	**856 738**	**129 059**	**6 621**	**759 833**	**174 040**
Investment income	11 968	161 433	1 226	62 123	392 604	108 294	18 267	168 698	54 360
Net gains/(losses) on financial instruments	341	4 564	35	1 646	10 268	2 969	512	4 035	1 348
Other income	110	1 480	11	568	3 595	993	167	1 540	495
Other income	**12 419**	**167 477**	**1 272**	**64 337**	**406 467**	**112 256**	**18 946**	**174 273**	**56 203**
Asset management fees	(536)	(7 225)	(55)	(2 801)	(17 676)	(4 860)	(819)	(7 653)	(2 473)
Other expenses	(42)	(571)	(4)	(218)	(1 377)	(382)	(65)	(584)	(188)
Interest paid	9	131	(1)	(50)	317	(87)	(15)	136	(44)
Interest paid on savings accounts	(2 683)	(36 189)	–	–	(88 051)	(24 281)	(4 095)	(37 858)	–
Other expenditure	**(3 270)**	**(44 116)**	**(60)**	**(3 069)**	**(107 421)**	**(29 610)**	**(4 994)**	**(46 231)**	**(2 705)**
Net surplus/(deficit) for the period	**(309 256)**	**(1 055 160)**	**(7 091)**	**248 429**	**1 155 784**	**211 705**	**20 573**	**887 875**	**227 538**

26 Surplus/(deficit) from operations per benefit plan *continued*

2019 R'000	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Smart	Essential Smart	Total
Risk contribution income	**291 762**	**7 151 844**	**3 056 879**	**5 187 124**	**279 123**	**94 912**	**1 233 159**	**484 463**	**57 222 228**
Net claims incurred	(187 224)	(6 037 913)	(2 567 481)	(4 915 340)	(185 220)	(38 524)	(853 241)	(227 861)	(48 515 757)
Risk claims incurred	(187 828)	(6 057 714)	(2 575 848)	(4 931 543)	(185 831)	(38 672)	(855 989)	(228 659)	(48 672 460)
Third-party claim recoveries	604	19 801	8 367	16 203	611	148	2 748	798	156 703
Accredited managed healthcare services (no risk transfer)	(7 670)	(238 468)	(103 575)	(286 413)	(18 443)	(8 409)	(48 428)	(35 467)	(1 765 827)
Net income/(expense) on risk transfer arrangements	14	482	169	48 827	–	521	18 569	(4 403)	82 483
Risk transfer arrangement fees paid	(77)	(2 014)	(631)	(194 700)	–	(4 267)	(22 266)	(6 012)	(299 464)
Recoveries from risk transfer arrangements	91	2 496	800	243 527	–	4 788	40 835	1 609	381 947
Relevant healthcare expenditure	**(194 880)**	**(6 275 899)**	**(2 670 887)**	**(5 152 926)**	**(203 663)**	**(46 412)**	**(883 100)**	**(267 731)**	**(50 199 101)**
Gross healthcare result	**96 882**	**875 945**	**385 992**	**34 198**	**75 460**	**48 500**	**350 059**	**216 732**	**7 023 127**
Broker service fees	(7 150)	(212 739)	(81 760)	(160 686)	(8 687)	(3 098)	(35 043)	(15 489)	(1 444 563)
Expenses for administration	(24 467)	(760 870)	(330 502)	(495 536)	(17 123)	(14 548)	(154 582)	(113 047)	(5 156 926)
Other operating expenses	(783)	(24 349)	(10 564)	(29 177)	(1 871)	(855)	(4 916)	(3 581)	(179 943)
Net impairment losses on healthcare receivables	(460)	(14 319)	(6 227)	(17 264)	(1 116)	(508)	(2 931)	(2 156)	(106 108)
Net healthcare result	**64 022**	**(136 332)**	**(43 061)**	**(668 465)**	**46 663**	**29 491**	**152 587**	**82 459**	**135 587**
Investment income	7 378	229 450	99 670	275 773	17 757	8 095	46 626	34 105	1 697 827
Net gains/(losses) on financial instruments	203	6 078	2 642	7 295	439	211	1 084	580	44 250
Other income	68	2 101	912	2 517	161	74	424	308	15 524
Other income	**7 649**	**237 629**	**103 224**	**285 585**	**18 357**	**8 380**	**48 134**	**34 993**	**1 757 601**
Asset management fees	(331)	(10 323)	(4 492)	(12 470)	(810)	(368)	(2 131)	(1 587)	(76 610)
Other expenses	(26)	(806)	(349)	(963)	(61)	(28)	(160)	(114)	(5 938)
Interest paid	(6)	(185)	(81)	(223)	(14)	(7)	(38)	(28)	(1 373)
Interest paid on savings accounts	(1 654)	(51 457)	–	–	–	–	–	–	(246 267)
Other expenditure	**(2 017)**	**(62 771)**	**(4 922)**	**(13 656)**	**(885)**	**(403)**	**(2 329)**	**(1 729)**	**(330 188)**
Net surplus/(deficit) for the period	**69 654**	**38 526**	**55 241**	**(396 536)**	**64 135**	**37 468**	**198 392**	**115 723**	**1 563 000**

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

27 Cash flows generated/(utilised) from operations before working capital changes

R'000	2020	2019
Net surplus for the year	**9 006 120**	1 563 000
Adjustments for:		
Impairment losses (Note 17)	**79 096**	106 108
Depreciation (Note 1)	**1 486**	1 486
Interest received (Note 21)	**(1 534 060)**	(1 513 838)
Dividend income (Note 21)	**(156 310)**	(183 989)
Interest paid (Note 24)	**284 336**	247 640
Unvested long-term employee benefit	**2 843**	5 735
Net (gains)/losses on financial assets (Note 22)	**(212 981)**	(44 250)
	7 470 530	181 892

Reconciliation of movements in the cash flow statement

	2020	2019
INCREASE IN TRADE AND OTHER RECEIVABLES	**(144 082)**	(308 631)
Opening balance	**2 560 425**	2 357 902
Closing balance (Note 4)	**(2 625 411)**	(2 560 425)
Impairment losses	**(79 096)**	(106 108)
(DECREASE)/INCREASE IN TRADE AND OTHER PAYABLES	**16 825**	(3 068 085)
Opening balance	**(1 551 968)**	(4 620 053)
Closing balance (Note 9)	**1 568 793**	1 551 968
PROCEEDS FROM SALE OF FINANCIAL ASSETS	**3 763 349**	2 238 283
Financial assets at fair value through profit or loss (Note 3)	**3 470 050**	2 215 835
Derivative financial instruments (Note 7)	**293 299**	22 448

28 Events after the reporting period

Subsequent to the reporting date, an amalgamation has been proposed between the Scheme and Quantum Medical Aid Society. The amalgamation will not have a material impact on the Scheme's financial position. No other significant events occurred between the reporting date and the date the financial statements were authorised for issue.

29 Insurance risk management report

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and the requirements of legislation.

This section summarises these risks and the way in which they are managed.

INSURANCE RISK

The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated.

A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier induced demand and the cost of new technologies or drugs.

As the following graph illustrates, claims are expected to increase with age. In the absence of mandatory membership and a continuous inflow of young, healthy lives, the average age of lives covered by the Scheme is expected to increase year-on-year. The increases expected from demographic changes are allowed for in the annual benefit and contribution reviews, but if this differs from the expected it may result in higher than expected inflationary increases in claims.

The following graph indicates the distribution of beneficiaries by age band for 2019 and 2020, as well as the risk claims paid. The risk claims are indexed to a value of 100 for the "<1" age band in 2019. There has been an increase in the proportion of beneficiaries older than 45 over the past year.

Membership distribution and risk claims (risk claims indexed to age bank "<1" 2019 = 100)

29 Insurance risk management report *continued*

INSURANCE RISK *continued*

The risks that the Scheme faces can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Hospital benefits

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional fees, medication, equipment and consumables.

Day-to-day benefits

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the Personal Medical Savings Account (PMSA) and an insurance risk element. This includes the Day-to-day Extender Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits.

Chronic benefits

The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 50 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions. These include conditions such as HIV/Aids, high blood pressure, cholesterol and asthma.

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

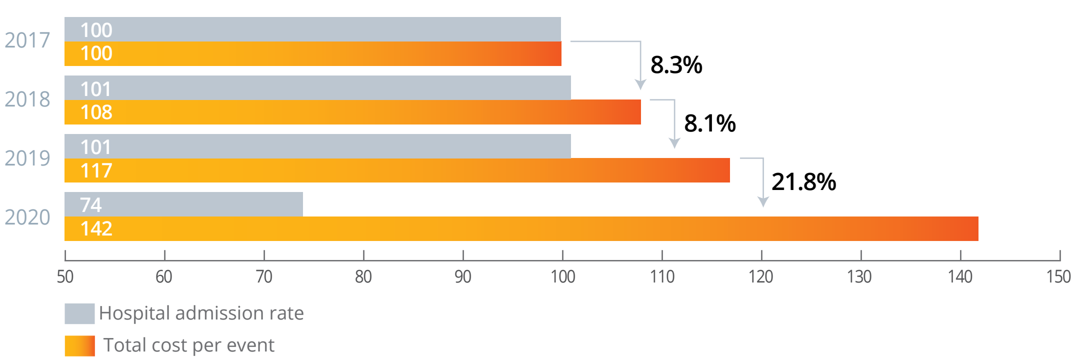
Hospital benefit risk

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result in an increase in the cost of claims.

An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The following graph indicates the change in the admission rate over the past four years as well as the impact on the costs per event (which have not been case-mix adjusted). This graph is indexed to a value of 100 as at 2016.

Hospital claims experience



The number of hospital admissions reduced significantly from April 2020. This was due to the five-stage lockdown imposed by the South African Government in response to the COVID-19 pandemic. This meant there were minimal elective procedures, and only emergency and high-risk cases were admitted. The number of admissions remained well below the expected level until around September 2020, when there was an increase towards expected levels. Given that the type of admissions that did occur were higher-risk and more complex, the cost per event (CPE) increased significantly from 2019. This was also largely due to the impact of COVID-19.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

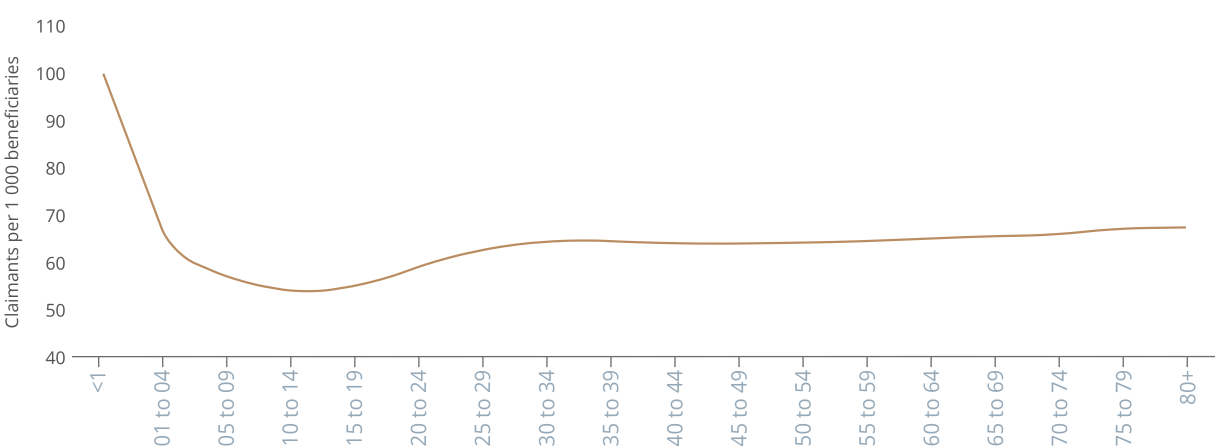
29 Insurance risk management report *continued*

INSURANCE RISK *continued*

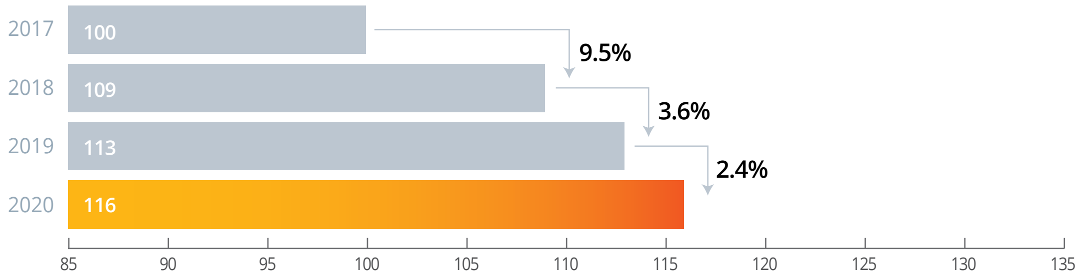
Day-to-day benefits risk

The frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options, as well as an increase in the number of claims categorised as Prescribed Minimum Benefit (PMB) claims, will also have an impact on the claims. The frequency of the ATB claims increases throughout the year as an increased number of members run out of their medical savings.

2020 Claimants Per 1 000 Beneficiaries From OH Risk Benefits (Indexed to Age Band "<1" 2020 = 100)



Cost per OH claimant (indexed to January 2017 = 100)



The out-of-hospital (OH) benefits for 2020 did not increase by as much as expected. This was again largely due to the government imposed lockdowns limiting access to healthcare services from April 2020. There was however a significant increase in pathology spend. This was due to the claims paid for PCR testing, which is the means used to identify positive COVID-19 cases. These PCR test costs offset some of the reduction seen in other OH claim categories for 2020.

NOTES TO THE FINANCIAL STATEMENTS *continued*

FOR THE YEAR ENDED 31 DECEMBER 2020

29 Insurance risk management report *continued*

INSURANCE RISK *continued*

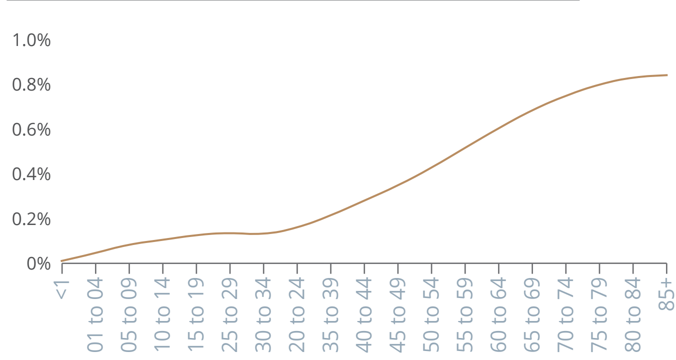
Chronic benefits risk

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

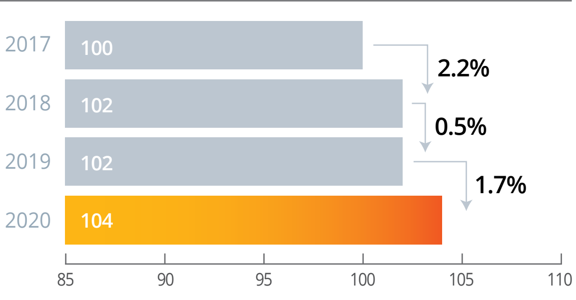
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and the presence of multiple chronic conditions per person will have an impact on the severity of the claims.

The following graphs indicate the percentage of chronic registrations by age band for 2020, as well as the change in the cost per claimant over the past four years. The cost per claimant graph is indexed to a value of 100 as at 2017.

Proportion of chronic registrations by age band



Cost per chronic claimant (indexed to 2017 = 100)



RISK MANAGEMENT

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include:

- Members have to be referred by a doctor prior to an elective admission.
- All hospital admissions have to be pre-authorised.
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times.
- The work of the Centre for Clinical Excellence, which evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these.
- The development of protocols around various high-cost conditions, such as lower back surgery.
- A dedicated unit to focus on reducing surgical consumable spend.
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.
- A Co-ordinated Care Programme (CCP). This is a dedicated unit to ensure direct co-ordination of care from medical providers to high-risk beneficiaries that are exposed to conditions that would generate multiple admissions if not managed.
- An Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients who are terminally ill.
- A disease management unit dedicated to managing high-risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Centre for Clinical Excellence is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

29 Insurance risk management report *continued*

CONCENTRATION OF INSURANCE RISK

As the largest open medical scheme by membership in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme also offers a wide range of benefit plans which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

An annual actuarial valuation is performed, which specifies the contributions to be charged in return for the benefits to be provided given the expected demographic profile of each benefit option.

Risk transfer arrangements

The Scheme has three risk transfer agreements in which suppliers are paid a capitation fee to provide certain minimum benefits to Scheme members, as and when it is required by the members. Capitation arrangements fix the cost to the Scheme of providing these benefits.

The first two risk transfer arrangements cover out-of-hospital optometry and dentistry benefits for members on the KeyCare Plus and KeyCare Start plans. The third arrangement covers the treatment for members diagnosed with diabetes (type I and II) on all plans excluding KeyCare plans.

Risk in terms of risk transfer arrangements

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. This is to mitigate against the reputational and operational risks that the Scheme faces should a supplier not meet its obligations. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims which are included in the arrangement.

Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments are typically resolved within one year, with the majority of cases being resolved within three months. At year-end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chain ladder method and another method using the estimated cost per event and pre-authorised admissions is also followed.

The estimation of the December 2020 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this guidance note, the following factors are considered to determine whether they would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

Based on the processing patterns and claims development up to the end of January 2021 in respect of treatment dates during 2020, the recommended provision for outstanding claims at December 2020 is R1 769 million (2019: R1 526 million).

29 Insurance risk management report *continued*

CONCENTRATION OF INSURANCE RISK *continued*

Claims development *continued*

The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:

R'000	2020	2019
Total estimate of incurred claims		
In-hospital claims incurred	**32 366 608**	35 844 867
Chronic claims incurred	**2 982 270**	2 868 279
Out-of-hospital risk claims incurred	**9 347 126**	9 583 273

The table below outlines the sensitivity of insured liability estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables.

R'000	**Change in variable %**	**Impact on outstanding claims provision 2020**	Impact on outstanding claims provision 2019
In-hospital claims incurred	1% slower claims processing	**501 329**	396 064
Chronic claims incurred	1% slower claims processing	**7 125**	12 270
Out-of-hospital risk claims incurred	1% slower claims processing	**129 094**	92 272

LIQUIDITY RISK

The main component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time, approximately 98% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Liquidity risk can also arise when the Scheme's investment mix does not match the nature of the liabilities. However, investments are managed by professional asset managers and finance professionals who ensure that investments, including cash and cash equivalents, are always sufficiently liquid to meet current liabilities while excess reserves are invested to maximise investment return within the scope of regulations of the Medical Schemes Act.

ASSUMPTION RISK

The Scheme's reserves and therefore solvency are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include utilisation trends, the impact of new technology and the expected demographic profile of Scheme membership.

30 Financial risk management report

OVERVIEW

The Scheme is exposed to financial risk through its financial assets, insurance assets, financial liabilities and insurance liabilities. In particular, the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

The Trustees have overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

The Scheme manages the financial risks as follows:

- The Investment Committee, a Committee of the Board of Trustees, recommends the Scheme's Investment Policy to the Trustees for approval. The Investment Committee meets at least quarterly and reports back to the Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- Independent valuation of the Scheme's investments is performed by a third party.

MARKET RISK

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

R'000	Total	Currency risk	Price risk	Interest rate risk
2020				
Investments	**31 430 492**			
Offshore bonds	**1 975 533**	✓		✓
Equities	**4 658 899**		✓	
Yield-enhanced bonds	**8 871 310**			✓
Inflation-linked bonds	**1 170 279**			✓
Money market instruments	**14 323 269**			✓
Listed property	**431 202**		✓	
2019				
Investments	23 191 456			
Offshore bonds	876 156	✓		✓
Equities	4 182 545		✓	
Yield-enhanced bonds	6 620 669			✓
Inflation-linked bonds	1 125 768			✓
Money market instruments	9 799 918			✓
Listed property	586 400		✓	

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently, changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

30 Financial risk management report *continued*

CURRENCY RISK

The majority of the Scheme's benefits are rand-denominated and therefore the Scheme does not have significant net currency risk relating to benefits.

For the purpose of seeking investment diversification, the Scheme continued to invest in offshore bond portfolios (reference currency is the US Dollar). Derivative financial instruments are utilised by the independent bond managers within these portfolios for risk mitigation and efficient portfolio construction. At 31 December 2020, R1 976 million (2019: R876 million) (Note 3) was invested in these portfolios.

- **Currency derivatives financial instrument (zero-cost currency collars)**

The Scheme enters into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in the rand/US Dollar exchange rate with respect to its offshore bond portfolios. The following table provides details of the open contracts at year end.

			2020		
Contract	Expiry date	Nominal USD value $'000	**USD put ("floor")**	**USD call ("cap")**	**% above floor**
1	10/06/2021	$34 000	**R16.86**	**R18.36**	**8.87%**
2	14/09/2021	$30 000	**R16.51**	**R18.03**	**9.21%**
3	13/10/2021	$21 000	**R16.45**	**R18.03**	**9.56%**
4	25/10/2021	$21 300	**R16.16**	**R17.67**	**9.36%**
5	05/11/2021	$21 600	**R15.81**	**R17.35**	**9.76%**

The zero-cost currency collars are categorised as at fair value through profit or loss.

At the time of expiry of the zero-cost currency collars the following transactions could occur depending on the rate at which the rand is trading against the US Dollar:

- If the spot rate is higher than the cap, the Scheme would be required to pay the difference between the cap and the spot rate to the counterparty.
- If the spot rate is trading lower than the cap but higher than the floor, no action would take place.
- If the spot rate is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the spot rate to the Scheme.

The fair value of these contracts have been included in financial assets. Gains and losses on these arrangements are included in the "Net surplus" (Note 7).

- **Currency risk sensitivity analysis**

The sensitivity of the rand appreciating and depreciating against the US Dollar is presented below. This impact would be recognised in the "Net surplus". The potential outcomes of the sensitivity are based on the assumption that the rand has strengthened or weakened against the US Dollar by 5% *(increase or decrease of R0.70)* or 15% *(increase or decrease of R2.10)* from a spot level of R14.68 to the US Dollar, with all other variables held constant. The analysis is presented including and excluding the impact of the zero-cost currency collars, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost currency collars would be based on the exchange rate at the date of expiry of the respective contracts.

R'000	**15% appreciation of ZAR against USD**	**5% appreciation of ZAR against USD**	**5% depreciation of ZAR against USD**	**15% depreciation of ZAR against USD**
(Loss)/gain arising from currency appreciation/depreciation *before zero-cost currency collars*	**(296 330)**	**(98 777)**	**98 777**	**296 330**
Gain arising from currency appreciation/depreciation *after zero-cost currency collars*	**148 171**	**169 119**	**202 501**	**262 744**

30 Financial risk management report *continued*

PRICE RISK

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as at fair value through profit or loss. The value of the Scheme's listed equity and property investments amounted to R5.1 billion (2019: R4.8 billion) (Note 3).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios is performed by independent asset managers in accordance with the mandate set by the Scheme. The strategy to manage price risk, by limiting exposure to any constituent of the benchmark to a maximum weight of 15%, remains in place.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market. The derivative strategy considers the impact of the decision to limit the maximum exposure to 15% of any constituent of the benchmark.

■ Equity derivative financial instrument (zero-cost equity fence)

The Scheme entered into zero-cost equity fence arrangements to hedge approximately 100% of the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 15% after a reduction in equity prices of 5% (ie. the Scheme is at risk for the first 5% drop in equity prices but protected for the next 15%). To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the pre-determined level (the cap). The cap for these contracts range between 13% and 14% above the pre-determined level. These contracts expire during 2021.

	2020					
Contract	Nominal value R'000	Index	Index level at trade date	Short put level ("lower floor")	Long put level ("upper floor")	Call level ("cap")
1	**340 000**	**DCAP[1]**	**14 360**	**80.00%**	**95.00%**	**113.98%**
2	**500 000**	**DCAP**	**14 647**	**83.00%**	**95.00%**	**114.40%**
3	**550 000**	**DCAP**	**15 109**	**83.00%**	**95.00%**	**114.10%**

1 DCAP – FTSE/JSE CAPPED SWIX TOP 40 Index.

The zero-cost equity fences are categorised as at fair value through profit or loss.

At the time of expiry, the following transactions could occur depending on the level at which the equity index trades:

- If the index level is higher than the cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the upper floor, no action would take place.
- If the index level is trading between the upper floor and the lower floor, the counterparty would be required to pay the difference between the index level and the lower floor to the Scheme.
- If the index level is trading lower than lower floor, the Scheme would be required to pay the difference between the lower floor and the index level minus 15% to the counterparty.

The fair value of these contracts have been included in financial assets and financial liabilities. Gains and losses on these arrangements are included in the "Net surplus" (Note 7).

30 Financial risk management report *continued*

PRICE RISK *continued*

Equity price risk sensitivity analysis

The analysis reflecting the impact of increases or decreases in equity prices has been presented below. This impact would be recognised in the "Net surplus". The potential outcomes of the sensitivity are based on the assumption that equity prices had increased or decreased by 5% or 15%, spot reference levels of 16 148 (DCAP), with all other variables held constant. The analysis is presented including and excluding the impact of the zero-cost equity fences, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost equity fences would be based on the reference level at the date of expiry of the respective contracts.

The following table indicates the 5% or 15% change in the respective index.

Index	5% increase or decrease in the Index	15% increase or decrease in the Index
DCAP	**807**	**2 422**

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase *before zero-cost equity fences*	**(704 585)**	**(234 862)**	**234 862**	**704 585**
(Loss)/gain arising from price decrease/increase *after zero-cost equity fences*	**(632 857)**	**(222 221)**	**171 582**	**539 172**

The analysis reflecting the impact of increases or decreases in prices of the listed property portfolio has been presented below. This impact would be recognised in the "Net surplus". The potential outcomes of the sensitivity are based on the assumption that prices had increased or decreased by 5% or 15%, with all other variables held constant. The Scheme has not hedged this portfolio.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase	**(67 090)**	**(22 363)**	**22 363**	**67 090**

30 Financial risk management report *continued*

INTEREST RATE RISK

The Scheme is exposed to interest rate risk as it places funds in short dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk.

The table below summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

At 2020 R'000	**0 – 3 Months**	**3 – 12 Months**	**>12 Months**	**Total**
Cash and cash equivalents	**4 008 668**	**–**	**–**	**4 008 668**
Money market instruments carried at fair value through profit or loss	**–**	**14 323 269**	**–**	**14 323 269**
Yield-enhanced bonds carried at fair value through profit or loss	**–**	**8 871 310**	**–**	**8 871 310**
Inflation-linked bonds carried at fair value through profit or loss	**–**	**–**	**1 170 279**	**1 170 279**
Offshore bonds carried at fair value through profit or loss	**–**	**1 975 533**	**–**	**1 975 533**

At 2019 R'000	0 – 3 Months	3 – 12 Months	>12 Months	Total
Cash and cash equivalents	1 991 282	–	–	1 991 283
Money market instruments carried at fair value through profit or loss	–	9 799 918	–	9 799 863
Yield-enhanced bonds carried at fair value through profit or loss	–	6 620 669	–	6 620 669
Inflation-linked bonds carried at fair value through profit or loss	–	–	1 125 768	1 125 823
Offshore bonds carried at fair value through profit or loss	–	876 156	–	876 156

- ### Interest rate risk sensitivity analysis

A sensitivity analysis indicating results of increases/decreases in interest rates has been presented below. This impact would be recognised in the "Net surplus". The sensitivity is based on the assumption that local or foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

Gains/(losses) arising from change in:

R'000	**2% interest rate decrease**	**1% interest rate decrease**	**1% interest rate increase**	**2% interest rate increase**
Local portfolios	**328 619**	**164 309**	**(164 309)**	**(328 619)**
Foreign portfolios	**105 019**	**52 509**	**(52 509)**	**(105 019)**

The majority of the Scheme's assets are invested in variable interest rate instruments with a significant portion of the fixed rate instruments maturing in the short term. At 31 December 2020, 74% of the investments were invested in variable interest rate instruments and 10% in fixed rate instruments. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets due to the short duration thereof.

30 Financial risk management report *continued*

LEGAL RISK

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2020, the Scheme did not consider there to be any significant concentration of legal risk and no provision has been raised.

INVESTMENT RISK

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities.

The Scheme's Investment Committee oversees that the funds are invested in line with the Act.

The investment philosophy is to hold a diversified pool of assets. The assets are selected as being most appropriate given the liquidity and solvency requirements of the Scheme. In contemplating solvency, the return goals of the Scheme, as well as the risk associated with all assets and asset classes are considered. Diversification is across securities, issuers, asset classes, geographic regions as well as managers within asset classes where practical. The Scheme diversifies its investment portfolio by investing in short-term deposits, money market, bond, listed property and equity portfolios managed by reputable asset managers.

The Scheme's investment objective statement is:

- Maximise targeted investment returns, which is dependent on contribution increases implemented over the next year and the evaluation of the solvency level above the statutory minimum requirement from time to time.
- The return target will be reviewed at the end of every year taking into account the actual returns achieved, projected operating surplus and finalised contribution increases.
- The return target is subject to a low risk appetite for:
  - Solvency reducing below 25% due to poor investment returns; or
  - Achieving returns in any year that are lower than the return assumed by the actuary in the pricing budget.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure performance in accordance with the agreed mandates.

BREAKDOWN OF INVESTMENTS

The investments are split between the following in the Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

R'000	Segregated funds	Collective investment schemes	Policy of insurance	Total
2020				
Investments	**28 345 211**	**1 975 533**	**1 109 748**	**31 430 492**
Offshore bonds	**–**	**1 975 533**	**–**	**1 975 533**
Equities	**4 658 899**	**–**	**–**	**4 658 899**
Yield-enhanced bonds	**8 871 310**	**–**	**–**	**8 871 310**
Inflation-linked bonds	**1 170 279**	**–**	**–**	**1 170 279**
Listed property	**431 202**	**–**	**–**	**431 202**
Money market instruments	**13 213 521**	**–**	**1 109 748**	**14 323 269**
Cash and cash equivalents	**875 860**	**3 132 808**	**–**	**4 008 668**
	29 221 071	**5 108 341**	**1 109 748**	**35 439 160**
2019				
Investments	21 189 476	1 117 978	884 002	23 191 456
Offshore bonds	–	536 884	339 272	876 156
Equities	4 182 545	–	–	4 182 545
Yield-enhanced bonds	6 620 669	–	–	6 620 669
Inflation-linked bonds	1 125 768	–	–	1 125 768
Listed property	586 400	–	–	586 400
Money market instruments	8 674 094	581 094	544 730	9 799 918
Cash and cash equivalents	794 043	1 197 239	–	1 991 282
	21 983 519	2 315 217	884 002	25 182 738

30 Financial risk management report *continued*

BREAKDOWN OF INVESTMENTS *continued*

Money market portfolios:

Local portfolios

These money market portfolios are managed by independent asset managers. The investment mandates are for actively managed portfolios of financial instruments aimed at maximising return on the investments, on a long-term basis, with due regard to the relevant risks and the constraints imposed by the mandates.

For the first portfolio, the mandate stipulates liquidity requirements that 5% of the assets must be available within 24 hours and 15% within five working days. The weighted modified duration of the portfolio may not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed two years. The term of each individual instrument is also limited. The average weighted credit rating of this portfolio will not be less than A+.

The liquidity requirements of the second portfolio also stipulate that 5% of the assets must be available on 24 hours' notice and an additional 15% within five working days. The average portfolio duration is limited to 180 days. There are a number of additional liquidity requirements included in the mandate, such as requiring that all investments with a maturity longer than 18 months must be of a negotiable nature. The key feature of being of a negotiable nature is that the instrument can be sold by the holder of that instrument to another party without requiring explicit consent from the issuer of the instrument.

The performance benchmark for these portfolios is measured against STeFI plus 130 basis points per annum over rolling one-year periods.

The Scheme has also allocated assets to an enhanced income money market strategy managed by an independent asset manager, to maximise long-term investment performance with due regard to relevant risks and constraints imposed by the mandate. The targeted return is the STeFI Composite Index plus 200 basis points over any rolling 12-month period. The weighted average modified duration of the portfolio is limited to 360 days, with all instruments being of a floating interest rate nature.

The local money market portfolios comprise approximately 46% (2019: 42%) of the Scheme's financial assets at fair value through profit or loss.

Yield-enhanced bond portfolios:

Local portfolios

The Scheme has two bond portfolios, managed by independent asset managers.

The one portfolio uses a specialist fixed income strategy with South African exposure and invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include but are not limited to asset types such as listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is STeFI three-month index plus 150 basis points per annum. To manage liquidity, the asset manager endeavours to invest in securities such that the repayment of capital in relation to securities matches the Scheme's liabilities, as communicated to the asset manager from time to time.

The second portfolio is a specialist low interest rate yield enhanced portfolio with moderate risk limits that seeks diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions. This is achieved by investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is STeFI. The weighted average credit quality is A+, with a weighted average term-to-maturity of less than five years. A minimum of 10% of the portfolio will be held in money market instruments with an expected term to maturity of less than 91 days. A minimum of 20% of the portfolio must be held in money market instruments.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty, and sets exposure limits to unrated investments. These portfolios comprise approximately 28% (2019: 29%) of the Scheme's financial assets at fair value through profit or loss.

30 Financial risk management report *continued*

BREAKDOWN OF INVESTMENTS *continued*

Offshore portfolios

The Scheme has three offshore portfolios managed by independent asset managers.

The first portfolio aims to produce a positive total return, consisting of both income and capital gains, over rolling three-year periods, regardless of market conditions, by investing primarily in fixed interest bearing instruments and related derivatives. The majority of these assets are denominated in major currencies and exposure to minor currencies is managed on a cautious basis. The fund is benchmarked against three month USD LIBOR.

The second portfolio is a multi-asset credit strategy invested in an open-ended specialised investment fund on a non-discretionary basis. The fund is benchmarked against three-month USD LIBOR plus 400 basis points.

The third portfolio is actively managed on a discretionary basis, investing in a portfolio of foreign offshore financial products. The primary objective is the long-term growth of capital and income referencing participatory interests in a foreign collective investment scheme investing in fixed income instruments. The benchmark for this portfolio is the FTSE World Government Bond Index (USD).

These portfolios comprise approximately 6% (2019: 4%) of the Scheme's financial assets at fair value through profit or loss.

Inflation-linked bonds

The Scheme has two inflation-linked bond portfolios, each managed by an independent asset manager.

The primary mandate of the first portfolio is aimed at generating inflation-linked bond returns on initial capital invested. The benchmark is the JSE Composite Inflation-Linked Index (CILI). The portfolio duration may vary to a maximum of 1.5 years greater than the benchmark and not less than three years less than the benchmark. The duration of the benchmark at the reporting date was 9.12 years.

The second portfolio is a fully discretionary, actively managed portfolio of inflation-linked and fixed income instruments. The portfolio only invests funds in domestic instruments. The benchmark for this portfolio is the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV Index). The portfolio duration is limited to a modified duration range of one year around the benchmark duration. The duration of the benchmark at the reporting date was 9.38 years.

These portfolios comprise approximately 4% (2019: 5%) of the Scheme's financial assets at fair value through profit or loss.

Equity portfolios

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. These risks are mitigated by blending investment mandates across different manager styles and sectors.

The portfolios may only be invested in South African equities and are to be as fully invested as can practically be achieved at all times. One portfolio has a maximum cash allocation of 2% and the remaining portfolios a maximum allocation of 5%. The portfolios must comply with the Act and are prohibited from investing in Discovery Ltd. The Scheme has mitigated exposure to any single benchmark constituent by limiting investment in any single benchmark constituent to a maximum of 15%.

The Scheme considers responsible investing in all its investments. Managers are required to exclude tobacco manufacturers and related exposures by utilising negative screening. This includes all direct investments and indirect investments greater than 5%.

The performance of the actively managed portfolios is measured against the benchmark, which is the FTSE/JSE Shareholder Weighted Index (SWIX) adjusted to exclude tobacco (as per the Scheme's Responsible Investment Policy) and capping the exposure of any benchmark constituent to 15%. The performance of the passive portfolio is measured against the FTSE/JSE SWIX 40 (J400) adjusted to exclude tobacco and capping the exposure of any benchmark constituent to 15%.

These portfolios comprise approximately 15% (2019: 17%) of the Scheme's financial assets at fair value through profit or loss.

Listed property

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. Prior to July 2018 the benchmark was the FTSE/JSE SA Listed Property Index. From July 2018, the benchmark was changed to a custom benchmark being the FTSE/JSE SA All Property Index.

The mandate does not permit investment in foreign listed shares or direct property investments and requires that there will always be more than six holdings in the portfolio.

This portfolio comprises approximately 1% (2019: 3%) of the Scheme's financial assets at fair value through profit or loss.

30 Financial risk management report *continued*

BREAKDOWN OF INVESTMENTS *continued*

The following table compares the fair value and carrying amounts of assets and liabilities per class of assets and liabilities.

	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
2020						
Investments						
– Offshore bond portfolio	**1 975 533**	**–**	**–**	**–**	**1 975 533**	**1 975 533**
– Listed equities	**4 658 899**	**–**	**–**	**–**	**4 658 899**	**4 658 899**
– Yield-enhanced bond portfolio	**8 871 310**	**–**	**–**	**–**	**8 871 310**	**8 871 310**
– Inflation-linked bond portfolio	**1 170 279**	**–**	**–**	**–**	**1 170 279**	**1 170 279**
– Listed property	**431 202**	**–**	**–**	**–**	**431 202**	**431 202**
– Money market portfolios	**14 323 269**	**–**	**–**	**–**	**14 323 269**	**14 323 269**
Cash and cash equivalents	**–**	**4 008 668**	**–**	**–**	**4 008 668**	**4 008 668**
Trade and other receivables	**–**	**14 220**	**2 611 191**	**–**	**2 625 411**	**2 625 411**
Personal Medical Savings Accounts	**–**	**–**	**–**	**(6 675 945)**	**(6 675 945)**	**(6 675 945)**
Trade and other payables	**–**	**–**	**(921 755)**	**(647 040)**	**(1 568 795)**	**(1 568 795)**
Derivative financial instruments	**158 307**	**–**	**–**	**–**	**158 307**	**158 307**
Outstanding claims provision	**–**	**–**	**(1 769 008)**	**–**	**(1 769 008)**	**(1 769 008)**
	31 588 799	**4 022 888**	**(79 572)**	**(7 322 985)**	**28 209 130**	**28 209 130**

	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
2019						
Investments						
– Offshore bond portfolio	876 156	–	–	–	876 156	876 156
– Listed equities	4 182 545	–	–	–	4 182 545	4 182 545
– Yield-enhanced bond portfolio	6 620 669	–	–	–	6 620 669	6 620 669
– Inflation-linked bond portfolio	1 125 768	–	–	–	1 125 768	1 125 768
– Listed property	586 400	–	–	–	586 400	586 400
– Money market portfolios	9 799 918	–	–	–	9 799 918	9 799 918
Cash and cash equivalents	–	1 991 282	–	–	1 991 282	1 991 282
Trade and other receivables	–	17 196	2 543 229	–	2 560 425	2 560 425
Personal Medical Savings Accounts	–	–	–	(5 522 613)	(5 522 613)	(5 522 613)
Trade and other payables	–	–	(892 671)	(659 297)	(1 551 968)	(1 551 968)
Derivative financial instruments	60 490	–	–	–	60 490	60 490
Outstanding claims provision	–	–	(1 526 497)	–	(1 526 497)	(1 526 497)
	23 251 946	2 008 478	124 061	(6 181 910)	19 202 575	19 202 575

30 Financial risk management report *continued*

CREDIT RISK

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are through its trade and other receivables, investments and cash.

Trade and other receivables

Trade and other receivables comprise of insurance receivables and other receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt.

Exposure to credit risk

The carrying amount of trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis, as set out in the approved Debt Management Policy. The tables below highlights "Trade and other receivables" which are due and past due (by number of days).

Based on past experience, the Scheme believes that no provision for impairment is required in respect of contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. For forensic debtors that are past due and outstanding for less than three years, past experience has indicated that no provision is required. The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

PROVISION FOR IMPAIRMENT

Insurance receivables

For insurance receivables, the Scheme establishes an allowance for impairment that represents its estimate of incurred losses. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparty.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures; and
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified.

The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

Other receivables

The Scheme applies the IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for other receivables.

To measure the expected credit losses associated with other receivables, these have been grouped based on shared credit risk characteristics and the days past due. Other receivables comprise sundry accounts receivable and interest receivable and are all current and not in a past due status. An immaterial expected loss rate is assigned to receivables that are not past due. Any loss associated to these receivables is negligible and no provision raised. No further analysis is presented.

R'000	Current	Total
2020		
Expected loss rate	**0%**	
Gross carrying amount – other receivables	**14 220**	**14 220**
Sundry accounts receivable	**13 297**	**13 297**
Interest receivable	**923**	**923**
2019		
Expected loss rate	0%	
Gross carrying amount – other receivables	17 196	17 196
Sundry accounts receivable	15 158	15 158
Interest receivable	2 038	2 038

30 Financial risk management report *continued*

CREDIT RISK *continued*

The movement in the provision for impairment, for each component of insurance receivables has been presented below:

R'000	Contribution receivables	Member and service provider claims receivables	Other risk transfer arrangements	Broker fee receivables	Forensics receivables	Total
Balance at 1 January 2019	14 733	305 092	–	1 264	11 310	332 399
Increase in provision for impairment	3 089	100 014	–	71	2 409	105 583
Amounts utilised during the year		(64 206)				(64 206)
Balance at 31 December 2019	17 822	340 900	–	1 335	13 719	373 776
Balance at 1 January 2020	**17 822**	**340 900**	**–**	**1 335**	**13 719**	**373 776**
In/(de)crease in provision for impairment	**4 649**	**56 602**	**–**	**561**	**(1 940)**	**59 872**
Amounts utilised during the year		**(74 578)**				**(74 578)**
Balance at 31 December 2020	**22 471**	**322 924**	**–**	**1 896**	**11 779**	**359 070**

30 Financial risk management report *continued*

CREDIT RISK *continued*

R'000	Total member and service provider claims receivables											
	Active member claims receivables	Withdrawn member claims receivables	Service provider claims receivables	Total	Contribution receivables	Other risk transfer arrange-ments	Broker fee receivables	Other insurance receivables	Forensics receivables	Related party	Other receivables	Total
31 December 2020												
Not past due	**5 003**	**6 556**	**3 617**	**15 176**	**2 170 918**	**2 695**	**62**	**41 340**	**74 391**	**13 688**	**14 220**	**2 332 490**
Past due 30 – 60 days	**3 563**	**7 400**	**1 874**	**12 837**	**18 488**	**–**	**87**	**–**	**5 006**	**–**	**–**	**36 418**
Past due 61 – 90 days	**4 272**	**9 851**	**1 830**	**15 953**	**40 169**	**–**	**26**	**–**	**7 793**	**–**	**–**	**63 941**
Past due 91 – 120 days	**3 394**	**9 965**	**2 292**	**15 651**	**(38 353)**	**–**	**34**	**–**	**11 226**	**–**	**–**	**(11 442)**
Past due 121 – 150 days	**6 227**	**11 899**	**1 155**	**19 281**	**32 040**	**–**	**232**	**–**	**6 845**	**–**	**–**	**58 398**
Past due 151 – 180 days	**3 393**	**12 478**	**3 956**	**19 827**	**–**	**–**	**28**	**–**	**2 908**	**–**	**–**	**22 763**
181 days to more than one year	**31 684**	**255 911**	**35 329**	**322 924**	**–**	**–**	**1 896**	**–**	**157 093**	**–**	**–**	**481 913**
Gross receivables	**57 536**	**314 060**	**50 053**	**421 649**	**2 223 262**	**2 695**	**2 365**	**41 340**	**265 262**	**13 688**	**14 220**	**2 984 481**
Provision for impairments	**(31 684)**	**(255 911)**	**(35 329)**	**(322 924)**	**(22 471)**	**–**	**(1 896)**	**–**	**(11 779)**	**–**	**–**	**(359 070)**
Trade and other receivables neither past due nor impaired	**25 852**	**58 149**	**14 724**	**98 725**	**2 200 791**	**2 695**	**469**	**41 340**	**253 483**	**13 668**	**14 220**	**2 625 411**
2019												
Not past due	4 864	7 659	2 132	14 655	2 103 081	4 253	120	96 129	64 663	16 383	17 196	2 318 480
Past due 30 – 60 days	4 925	9 462	8 241	22 628	21 411	–	583	–	8 126	–	–	52 748
Past due 61 – 90 days	5 762	10 772	474	17 008	5 074	–	58	–	3 288	–	–	25 428
Past due 91 – 120 days	3 487	10 055	289	13 831	3 060	–	50	–	4 334	–	–	21 275
Past due 121 – 150 days	3 921	12 080	1 047	17 048	(5 892)	–	42	–	5 277	–	–	16 475
Past due 151 – 180 days	3 929	12 957	399	17 285	–	–	32	–	2 343	–	–	19 660
181 days to more than one year	48 465	238 847	53 588	340 900	–	–	1 335	–	139 900	–	–	482 135
Gross receivables	75 353	301 832	66 170	443 355	2 126 734	4 253	2 220	96 129	227 931	16 383	17 196	2 934 201
Provision for impairments	(48 465)	(238 847)	(53 588)	(340 900)	(17 822)	–	(1 335)	–	(13 719)	–	–	(373 776)
Trade and other receivables neither past due nor impaired	26 888	62 985	12 582	102 455	2 108 912	4 253	885	96 129	214 212	16 383	17 196	2 560 425

30 Financial risk management report *continued*

CREDIT QUALITY

The credit quality of trade and other receivables that are neither past due nor impaired as presented on page 148 can be assessed by reference to historical information about counterparty default.

Contributions debtors

The Scheme collects over 95% of outstanding contributions in the month following the contributions being due. Therefore, we can establish that the credit quality of contribution debtors is high and no additional disclosure of the credit quality is provided.

Active member claims debtors

A provision for impairment covering 55% (2019: 64%) of the debtors has been raised and the Trustees are satisfied that this is adequate.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 81% (2019: 79%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Other insurance receivables and other receivables

These debtors mainly comprise of amounts due by hospitals, which are inherently of high quality. As agreed with the providers, the majority of these receivables are recovered by reducing future provider payments thereby providing a high certainty of recoverability, thus no further analysis has been performed on these receivables.

Financial assets held at fair value through profit or loss, cash and cash equivalents and derivative financial instruments

The Scheme's credit risk exposures at 31 December for the respective years were as follows:

R'000	2020	2019
– Offshore bonds	**1 975 533**	876 156
– Yield-enhanced bonds	**8 871 310**	6 620 669
– Inflation-linked bonds	**1 170 279**	1 125 768
– Money market instruments	**14 323 269**	9 799 918
– Cash and cash equivalents	**4 008 668**	1 991 282
– Derivative financial instruments	**158 307**	60 490
	30 507 366	20 474 283

EXPOSURE TO CREDIT RISK

The Scheme manages credit risk on its investment portfolios through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Cash and cash equivalents comprise cash deposits with financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 151.

Derivative counterparties are limited to high credit quality financial institutions.

The Scheme's Credit Risk Policy guides the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The Policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure;
- Industry exposure; and
- Expected loss.

Compliance with the limits are regularly monitored with a quarterly report back presented to the Scheme's Investment Committee.

The Scheme has assessed whether the above financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market value stated above.

30 Financial risk management report *continued*

EXPOSURE TO CREDIT RISK *continued*

Credit rating scales

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indicators of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

Long-term rating scales

AAA: Highest credit quality

AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: Very high credit quality

AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: High credit quality

A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

BB: Speculative

BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time, however business or financial flexibility exists which supports the servicing of financial commitments.

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met, however capacity for continued payment is vulnerable to deterioration in the business and economic environment.

CCC: Possibility of default

Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

CC: Very high levels of credit risk

Default of some kind appears probable.

30 Financial risk management report *continued*

EXPOSURE TO CREDIT RISK *continued*

The following table discloses the Scheme's asset credit ratings using official credit ratings where available, or the asset manager's rating and is presented using a Fitch national scale rating. The Credit Risk Policy limits investments in non-investment grade instruments to a maximum of 10% after considering official credit ratings and asset manager assigned internal credit ratings where official ratings are not available. Less than 1% (2019: Less than 1%) of the instruments are invested in non-investment grade instruments after consideration of internally assigned credit ratings.

		Long-term rating									
R'000	**Total**	**Govt**	**AAA**	**AA+ to AA-**	**A+ to A-**	**BBB- to BBB+**	**BB- to BB+**	**B- to B+**	**CCC+ to CCC-**	**CC+**	**Not rated**
2020											
At fair value through profit or loss	**26 340 391**	**1 446 801**	**2 374 896**	**17 711 496**	**1 181 971**	**487 828**	**292 345**	**456 501**	**16 048**	**–**	**2 372 505**
– Offshore bond portfolio	**1 975 533**	**–**	**294 837**	**36 461**	**302 626**	**410 951**	**250 947**	**208 270**	**16 048**	**–**	**455 393**
– Yield-enhanced bond portfolio	**8 871 310**	**662 248**	**1 131 365**	**5 072 194**	**416 673**	**2 325**	**–**	**104 731**	**–**	**–**	**1 481 774**
– Inflation-linked bond portfolio	**1 170 279**	**614 599**	**288 155**	**249 643**	**4 545**	**–**	**–**	**13 337**	**–**	**–**	**–**
– Money market portfolios	**14 323 269**	**169 954**	**660 539**	**12 353 198**	**458 127**	**74 552**	**41 398**	**130 163**	**–**	**–**	**435 338**
Cash and cash equivalents	**4 008 668**	**343 140**	**803 241**	**2 856 762**	**–**	**–**	**–**	**–**	**–**	**–**	**5 525**
Total*	**30 349 059**	**1 789 941**	**3 178 137**	**20 568 258**	**1 181 971**	**487 828**	**292 345**	**456 501**	**16 048**	**–**	**2 378 030**
% per rating band		**5.90%**	**10.47%**	**67.77%**	**3.89%**	**1.61%**	**0.96%**	**1.50%**	**0.05%**	**0.00%**	**7.84%**
2019											
At fair value through profit or loss	18 422 511	310 316	3 561 834	10 798 617	665 504	603 053	22 322	628	–	–	2 460 237
– Offshore bond portfolio	876 156	–	181 161	5 670	83 284	586 568	22 322	–	–	–	(2 849)
– Yield-enhanced bond portfolio	6 620 669	–	1 744 709	3 409 178	323 308	5 189	–	628	–	–	1 137 657
– Inflation-linked bond portfolio	1 125 768	294 323	358 811	450 018	3 786	1 372	–	–	–	–	17 458
– Money market portfolios	9 799 918	15 993	1 277 153	6 933 751	255 126	9 924	–	–	–	–	1 307 971
Cash and cash equivalents	1 991 282	3 000	711 007	1 251 750	–	–	–	–	–	–	25 525
Total*	20 413 793	313 316	4 272 841	12 050 367	665 504	603 053	22 322	628	–	–	2 485 762
% per rating band		1.53%	20.93%	59.03%	3.26%	2.95%	0.11%	0.00%	0.00%	0.00%	12.18%

* *Excludes derivative financial instruments*

30 Financial risk management report *continued*

EXPOSURE TO CREDIT RISK *continued*

The Scheme's investments in securitisations and collective investment schemes (funds) are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers. The Scheme does not control these funds as it has no voting rights, is not able to call meetings and in addition, has no ability to direct the relevant activities of these funds. As the Scheme does not control these funds, its investments in these structured entities are not consolidated in the Scheme's Financial Statements.

All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the Statement of Financial Position and no other material risks relating to these investments have been identified other than those already disclosed in previous sections of this report.

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and description	2020 R'000	Authorised programme size	% of Authorised programme size	Fair value hierarchy		Debt ranking		Credit rating		Underlying assets	
				Level	**%**	**Ranking**	**%**	**Rating**	**%**	**Asset**	**%**
Asset-backed commercial paper	**23 844**	R3.5 billion	0.68%	Level 2	100%	Senior secured	100%	AA	100%	Diversified portfolio of money market instruments	100%
Residential mortgage-backed securitisations	**382 761**	R5 billion	7.66%	Level 1	70%	Senior secured	64%	AAA	41%	Residential mortgages	100%
				Level 2	30%	Secured	36%	AA- to AA+	29%		
								A+	0%		
								NR	30%		
Asset-backed securitisations	**184 410**	R25 billion	0.74%	Level 1	83%	Senior secured	70%	AAA	59%	Equipment leases	5%
				Level 2	17%	Secured	30%	AA- to AA+	24%	Unsecured loans	37%
						Senior unsecured	1%	NR	17%	Vehicle loans	58%
Commercial mortgage-backed securitisations	**8 105**	R3 billion	0.27%	Level 1	100%	Secured	100%	AAA	100%	Commercial mortgage loans	100%

30 Financial risk management report *continued*

EXPOSURE TO CREDIT RISK *continued*

Name and description	**2020 R'000**	**Portfolio size R'000**	**% of portfolio size**	**Fair value hierarchy**	**Credit rating**	**Fund**
Collective investment schemes	**501 398**	17 196 710	2.92%	Level 2	AA+	Nedgroup Investments Money Market Fund Class C2
	361 175	42 462 551	0.85%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C2
	785 368	59 161 745	1.33%	Level 2	AA	Nedgroup Investments Core Income Fund Class C2
	249	30 744 186	0.00%	Level 2	AA+	Ninety One Corporate Money Market Fund Class A
	1 477 679	37 894 301	3.90%	Level 2	AA+	Ninety One Money Market Fund Class A
	11	48 031 681	0.00%	Level 2	AA+	Stanlib Corporate Money Market Fund
	6 611	85 397 393	0.01%	Level 2	AA+	ABSA Money Market Fund
	766 831	2 778 174	27.60%	Level 2	A	Ninety One Gsf Target Return Bond
	799 844	8 928 263	8.96%	Level 2	AA+	Legg Mason Brandywine Global Opportunistic Fixed Income Fund
	408 897	5 120 456	7.99%	Level 2	BB	Ninety One Ga Multi-asset Credit

Name and description	2019 R'000	Authorised programme size	% of Authorised programme size	Fair value hierarchy		Debt ranking		Credit rating		Underlying assets	
				Level	%	Ranking	%	Rating	%	Asset	%
Asset-backed commercial paper	34 823	R3.5 billion	0.99%	Level 2	100%	Senior secured	100%	AA	100%	Diversified portfolio of money market instruments	100%
Residential mortgage-backed securitisations	793 513	R3.0 billion	0.30%	Level 1	89%	Senior secured	73%	AAA	74%	Residential mortgages	100%
				Level 2	11%	Secured	27%	AA- to AA+	16%		
								A+	0%		
								NR	10%		
Asset-backed securitisations	470 076	R18.5 billion	2.54%	Level 1	83%	Senior secured	73%	AAA	75%	Equipment leases	21%
				Level 2	17%	Secured	26%	AA- to AA+	11%	Unsecured loans	16%
						Senior unsecured	0%	NR	11%	Vehicle loans	63%
Commercial mortgage-backed securitisations	83 742	R10 billion	0.84%	Level 1	100%	Secured	100%	AAA	100%	Commercial mortgage loans	100%

30 Financial risk management report *continued*

EXPOSURE TO CREDIT RISK *continued*

Name and description	2019 R'000	Portfolio size R'000	% of portfolio size	Fair value hierarchy	Credit rating	Fund
Collective investment schemes	846 472	13 510 113	6.27%	Level 2	AA+	Nedgroup Investments Money Market Fund Class C2
	312 809	29 725 582	1.05%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C2
	581 094	43 756 848	1.33%	Level 2	AA	Nedgroup Investments Core Income Fund Class C2
	33 330	14 073 000	0.24%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C20
	864	30 077 964	0.00%	Level 2	AA+	Investec Money Market Fund
	1 208	37 720 000	0.00%	Level 2	AA+	Stanlib Corporate Money Market Fund
	1 277	20 814 258	0.01%	Level 2	AA+	Investec Corporate Money Market Fund
	1 279	71 461 683	0.00%	Level 2	NR	ABSA Money Market Fund
	536 884	2 528 982	21.23%	Level 2	BBB	Investec Target Return Bond Fund

LIQUIDITY RISK

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 97% (R2.1 billion) (2019: 98% – R2.1 billion) of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

30 Financial risk management report *continued*

LIQUIDITY RISK *continued*

A maturity analysis for financial liabilities carried at amortised cost, excluding liabilities arising from insurance contracts is provided below:

R'000	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
At 2020			
Personal Medical Savings Accounts (Note 8)	**6 675 945**	**–**	**–**
Trade and other payables (Note 9)	**647 040**	**–**	**–**
Derivative financial liabilities (Note 7)	**34 723**		
	7 357 708	**–**	**–**
At 2019			
Personal Medical Savings Accounts (Note 8)	5 522 613	–	–
Trade and other payables (Note 9)	659 297	–	–
Derivative financial liabilities (Note 7)	14 689		
	6 196 599	–	–

FAIR VALUE ESTIMATION

Financial instruments

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short-term nature.

Personal Medical Savings Accounts

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore, the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

30 Financial risk management report *continued*

FAIR VALUE HIERARCHY FOR FINANCIAL ASSETS MEASURED AT FAIR VALUE

Assets measured at fair value

	Fair value measurement at the end of the year using:			
R'000	Total	Level 1	Level 2	Level 3
2020				
Current assets				
– Offshore bonds	**1 975 533**	**–**	**1 975 533**	**–**
– Equities	**4 658 899**	**4 642 646**	**16 253**	**–**
– Yield-enhanced bonds	**8 871 310**	**5 307 607**	**3 563 703**	**–**
– Inflation-linked bonds	**1 170 279**	**1 157 179**	**13 100**	**–**
– Listed property	**431 202**	**419 875**	**11 327**	**–**
– Money market instruments	**14 323 269**	**8 408 443**	**5 914 826**	**–**
– Derivative financial instruments	**158 307**	**–**	**158 307**	**–**
	31 588 799	**19 935 750**	**11 653 049**	**–**
2019				
Current assets				
– Offshore bonds	876 156	–	876 156	–
– Equities	4 182 545	4 172 291	10 254	–
– Yield-enhanced bonds	6 620 669	4 055 864	2 564 805	–
– Inflation-linked bonds	1 125 768	1 098 520	27 248	–
– Listed property	586 400	585 580	820	–
– Money market instruments	9 799 918	4 411 112	5 388 806	–
– Derivative financial instruments	75 179	–	75 179	–
	23 266 634	14 323 367	8 943 267	–

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market.

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable.

Level 3 – These are assets measured using inputs that are not based on observable market data.

30 Financial risk management report *continued*

FAIR VALUE HIERARCHY FOR FINANCIAL ASSETS MEASURED AT FAIR VALUE *continued*

The table below details the valuation techniques and observable inputs for assets falling under Level 2:

Description R'000	**Fair value at 2020**	Fair value at 2019	Valuation techniques	Observable input
Financial assets at fair value through profit or loss				
Unlisted:				
Debt securities	**5 552 336**	3 468 209	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**5 926 153**	5 389 626	Discounted cash flow valuation, Black-Scholes model	Published exchange swap curve, published interest rate curve, published credit spread curve/implied credit spread curve, risk free yield to maturity curve, risk free zero curve, swap yield to maturity curve, swap zero curve
Unlisted equity	**16 253**	10 254	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
Derivative financial instruments	**158 307**	75 179	Discounted cash flow valuation, Black-Scholes model	Published index levels, published exchange swap curve, published interest rate curve, published credit spread curve, implied volatilities
	11 653 049	8 943 267		

CAPITAL MANAGEMENT

The Scheme is subject to the capital requirement imposed by Regulation 29 (2) of the Act, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross annual contributions of 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Act, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

The calculation of the regulatory capital requirement is set out below.

R'000	**2020**	2019
Total members' funds per Statement of Financial Position	**28 215 475**	19 209 355
Less: Cumulative unrealised net gain on remeasurement of investments to fair value	**(686 683)**	–
Accumulated funds per Regulation 29	**27 528 792**	19 209 355
Gross annual contribution income	**74 537 501**	69 855 135
Solvency margin		
= Accumulated funds/gross annual contribution income x 100	**36.93%**	27.50%

At 2020, the Scheme's regulatory capital level of 36.93% (2019: 27.5%) was R8.9 billion (2019: R1.75 billion) more than the statutory capital requirement of 25%.

31 Critical accounting estimates and judgements

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

OUTSTANDING CLAIMS PROVISION

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 30.

OTHER RISK TRANSFER ARRANGEMENTS

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 11.

IMPAIRMENT OF ASSETS

The critical estimates made by the Scheme are set out under Note 31 and judgements relating to the impairment of assets are set out under Note 4.

CLASSIFICATION OF INVESTMENTS AS CURRENT AND NON-CURRENT

The critical estimates and judgements relating to the classification of investments are set out under Note 3.

CLASSIFICATION OF MONEY MARKET FUNDS AS CASH AND CASH EQUIVALENTS

The critical estimates and judgements relating to the classification of money market funds are set out under Note 5.

32 Non-compliance matters

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

During 2020, the Scheme did not comply with the following Sections and Regulations of the Act:

- **Sustainability of benefit plans**

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

  For the year ended 2020 the following plans did not comply with Section 33 (2):

R'000	Net healthcare result	Net (deficit)/ surplus
Benefit plan		
Executive	**(103 856)**	**(95 203)**
KeyCare Plus	**(213 255)**	**74 378**

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

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

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

32 Non-compliance matters *continued*

Annual General Meeting not held

In terms of Scheme Rule 25.1.1, the Scheme must convene an annual general meeting on or before 30 June each year. As a result of COVID-19 restrictions on gatherings, the Scheme applied for an exemption to deviate from its Rules as well as Section 32 of the Act and postpone the 2020 AGM. This exemption was granted by the CMS in line with Section 8 (h) of the Act on 14 May 2020.

Investments in employer groups and medical scheme administrators

Section 35 (8) (a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide. CMS has granted DHMS an exemption for a period of three years effective from 1 December 2019.

Investments in other assets in territories outside the Republic of South Africa

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

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS an exemption for a period of three years effective from 1 December 2019.

Contributions received after due date

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

Broker fees paid

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

In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.01% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the administrator has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

Prescribed Minimum Benefits

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

Claims paid in excess of 30 days

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

During the year, there were instances where claims were not paid within 30 days. These represent less than 1% of total claims paid for the year. There is a defined process to identify claims that have not been paid within 30 days to ensure that the claims are paid expeditiously.

32 Non-compliance matters *continued*

- **Disclosure of personal information**

Regulation 15J (2) (b) requires the Scheme to ensure that there are provisions for ensuring confidentiality of clinical and proprietary information, including the diagnosis and treatment pertaining to any beneficiary. POPIA Condition 7 requires that personal information should be kept secure against the risk of loss, unauthorised access, interference, modification, destruction or disclosure.

During the year under review, a dashboard meant for one employer was mistakenly sent to another employer contact. The dashboard contained information on COVID-19 risk assessments and contact tracing for 19 employees. The data included personal identification information. The data was only sent to a specific person who confirmed deletion of the information. The information was not shared for criminal or malicious intent.

- **Contribution not billed for new dependants**

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. Contributions must be received within a prescribed time when becoming due. The failure in not including dependants in the billing process constitutes non-compliance with the Act.

136 memberships were added through the online platform (new business system) and contributions since 2015 were not billed, resulting in a gross financial loss for the Scheme of R633 318, the majority of which has been written off.

The underwriting system has been enhanced to recognise active and historical additions, to ensure there are no duplicates. The data issues created by the addition of dependants through the online platform has been corrected, to ensure the system does not create historical records that cause data discrepancies.

- **Commission paid to brokers with expired CMS accreditation**

Section 65 (3) states that no broker shall be compensated for providing broker services unless the CMS has granted accreditation to such broker.

There was a total of 151 brokers over a two-year period where commission was paid to brokers whose accreditation had expired. The total value of these payments was R1.5 million. Commission paid to brokers with expired accreditation has been reversed and a process is underway to recover these amounts.

Enhancements to the commission system have been made to ensure this is not repeated.

- **COVID-19 initiatives**

The Scheme introduced specific initiatives to support stakeholders in managing the adverse impact of COVID-19. For the Scheme to offer these initiatives, exemptions from the following provisions of the Act were obtained from the CMS.

Payment of contributions from positive Personal Medical Savings Account balances

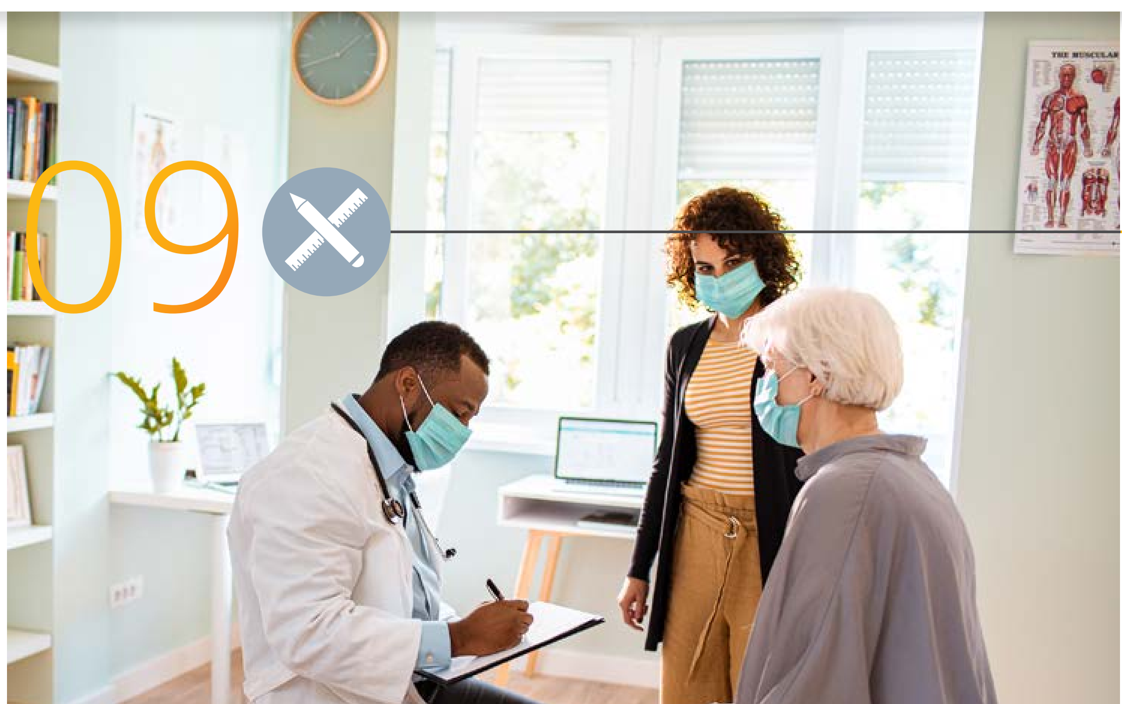
Section 26 (7) of the Act states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment becomes due. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R165 474 000 affecting 15 202 policies. The CMS granted DHMS a three-month exemption on 9 April 2020 effective from 1 April 2020. An extension was granted on 4 November 2020 up to 31 December 2020.

SME employer contribution concessions

Also relating to Section 26 (7) and Section 35 (8) (a) of the Act, financial relief to SMEs through contribution concessions amounted to R206 872 000 affecting 532 SMEs. The concession balance at 31 December 2020 was R86 172 000. Four SMEs with a balance of R71 000 defaulted on their repayments. The CMS granted DHMS a three-month exemption on 9 April 2020 effective from 1 April 2020.

Payment of Commissions to brokers prior to receipt of contributions

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. The CMS granted DHMS a three-month exemption on 11 June 2020 effective from 1 April 2020.



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RESOURCES

Important sources of information

Contact details

PRINCIPAL OFFICER

Email principalofficer@discovery.co.za or call +27 11 529 2888 and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

COUNCIL FOR MEDICAL SCHEMES (CMS)

DHMS is regulated by the CMS. The CMS can be contacted by telephone on 0861 123 267 or via email on information@medicalschemes.co.za. The CMS is located at Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157.

Complaints, compliments or disputes

DHMS is committed to providing you with the highest standard of service and your feedback is important to us. To lodge a complaint, compliment or dispute, please follow the process outlined on the website:

Feedback on the Scheme's Integrated Report

We welcome any comments or specific feedback on the following:

- Was the Integrated Report (this Report) understandable to you?
- Were you able to find the information you were looking for, and if not, what were you looking for?
- Did this Report cover all the information relevant to your relationship with the Scheme?
- Was this Report presented in a format that worked for you, and if not, what you would prefer?

Email your feedback to dhms_stakeholders@discovery.co.za.

Reporting fraud or unethical behaviour

As the Scheme's administrator and managed care provider, Discovery Health (Pty) Ltd (Discovery Health) provides a fraud hotline and investigates possible instances of fraud. If you even slightly suspect someone of committing fraud or behaving unethically, please report all information to the fraud hotline on the number below. This facility is independently managed by Deloitte and you may remain anonymous if you prefer:

- Toll-free call: 0800 0045 00
- Email: discovery@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks, 4320

You can also email our fraud department directly at forensics@discovery.co.za to investigate the matter.

Registered addresses

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Charlotte Mbewu

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REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS

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PO Box 786722, Sandton, 2146

ADMINISTRATOR AND MANAGED CARE PROVIDER

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PO Box 786722, Sandton, 2146

AUDITORS

PricewaterhouseCoopers Incorporated,
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PRINCIPAL BANKERS

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ABAX INVESTMENTS (PTY) LTD

Coronation House, The Oval, 1 Oakdale Road, Newlands, 7700

ALLAN GRAY INVESTMENTS (PTY) LTD

1 Silo Square, V&A Waterfront, Cape Town, 8001

ALL WEATHER CAPITAL (PTY) LTD

1 Park Ln, Wierda Valley, Sandton, 2196

ALUWANI CAPITAL PARTNERS (PTY) LTD

EPPF Office Park, 24 Georgian Crescent East, Bryanston East, 2152

FAIRTREE CAPITAL (PTY) LTD

Willowbridge Place, Cnr Carl Cronje Drive & Old Oak Road, Bellville, 7530

FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD

3rd Floor, Great Westerford Building, 240 Main Road, Rondebosch, 7700

MAZI ASSET MANAGEMENT (PTY) LTD

4th Floor North Wing, 90 Rivonia Road, Sandton, 2196

NINETY ONE SA (PTY) LTD

36 Hans Strijdom Avenue, Foreshore, Cape Town, 8001

100 Grayston Drive, Sandown, Sandton, 2196

SESFIKILE CAPITAL (PTY) LTD

2nd Floor, 18 The High Street, Melrose Arch, Johannesburg, 2076

STANLIB ASSET MANAGEMENT (PTY) LTD

17 Melrose Blvd, Melrose Arch, Johannesburg, 2076

TAQUANTA ASSET MANAGERS (PTY) LTD

7th Floor, Newlands Terraces, Boundary Road, Newlands, 7700

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