Discovery
Health Medical Scheme

WE EXIST
FOR OUR
MEMBERS

INTEGRATED REPORT 2021

Discovery Health Medical Scheme registration number 1125

In this Report

WHY JOIN DHMS?

We exist for our members.

We provide sustainable access to affordable and equitable 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, innovative, 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 THROUGH ROBUST GOVERNANCE

Discovery Health Medical Scheme (DHMS or the Scheme) 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 working to meet the needs of 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.

OUR PLACE IN SOCIETY

We take our corporate social responsibility seriously, which is underpinned by our ethics, values and culture, and our support of Treating Customers Fairly principles. We pay great attention to engaging constructively with our key stakeholders, including members, healthcare professionals, financial advisers, employees and regulatory bodies.

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.

VIEWING THIS REPORT

This interactive PDF is best viewed in Adobe Acrobat for desktop, mobile or tablet*.

Click to download or update to the latest Adobe Acrobat Reader.

ADOBE ACROBAT READER

* *Functionality may differ according to device and app version used.*

NAVIGATING 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 2 784 793 beneficiaries at 31 December 2021, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.5%[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), of which the majority is member-elected, 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 professionals, 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.

1 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2021 (www.medicalschemes.co.za/wpfd_file/quarterly-report-for-30-september-2021/). At the end of 2020 there were 18 open schemes registered with the CMS, with approximately 55% of the total medical schemes market and 58 restricted schemes, with approximately 45% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 1.9 million beneficiaries. Source: Annexures to the CMS Annual Report 2020/21.*

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

SCHEME RULES

THE ACT

THE CMS WEBSITE

THE SCHEME AND OUR KEY STAKEHOLDERS

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.

OUR PURPOSE AND VISION | STRATEGY | WE OUTSOURCE ADMINISTRATION AND MANAGED CARE TO DISCOVERY HEALTH

Discovery Health Medical Scheme registration number 1125

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, an approach that reimburses healthcare professionals based on health outcomes and not only the volume of services they deliver. It gives our members access to programmes and professionals 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 DH 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.

VALUE PROVIDED BY DISCOVERY HEALTH

We exist for our members

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

FOR OUR MEMBERS

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.

SCHEME PERFORMANCE

KEY OUTCOMES MEASURES FOR ENSURING THE SCHEME'S SUSTAINABILITY

WE MAKE SURE YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

The Scheme's income is derived only from member contributions and investment returns. 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[1]. This accords with the fundamental operating principles of a non-profit organisation that must meet the claims needs of its members as well as maintain a statutory level of reserves.

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

HEALTHCARE INFLATION AND UTILISATION

1 *These may relate to various sources of healthcare inflation, and include uncertainty about the timing and severity of the disease burden that is expected to cause increased utilisation post-COVID-19.*

2021 EXPENSE BREAKDOWN

89.1%
Claims
(2020: 76.5%)

(1.4%)
(Loss)/surplus to member reserves
(2020: 11.4%)

9.9%
Administration and managed care expenses
(2020: 9.8%)

2.4%
Financial adviser and Scheme expenses
(2020: 2.3%)

2020 marked a radical shift in healthcare seeking behaviour, with stringent COVID-19 lockdown measures set in place by government and concerns about the risk of infection at places of care, resulting in 3.5 million fewer member claims than in 2019 and 76.5% of Scheme income funding claims (vs 87.3% in 2019). In 2021, members began utilising healthcare again, increasing the number of claims made to 54 556 179 (vs 47 675 525 in 2020) and the percentage of Scheme income spent on funding claims to 89.1%.

The Scheme's deferral of the 2021 contribution increase to 1 July 2021, providing relief to its members and passing on the benefit of excess reserves, resulted in the Scheme generating a planned negative net healthcare result for the year.

02 ABOUT OUR REPORT

Our Integrated Report demonstrates the accountability of the Board of Trustees of Discovery Health Medical Scheme (DHMS or the Scheme) to our members in the context of our core service to our members. This constitutes 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 DHMS. 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 continues to exert substantial economic, social and psychological pressure in an environment already characterised by high uncertainty, above-inflation increases in healthcare costs and significant regulatory and policy change. 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 Medical Schemes 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.

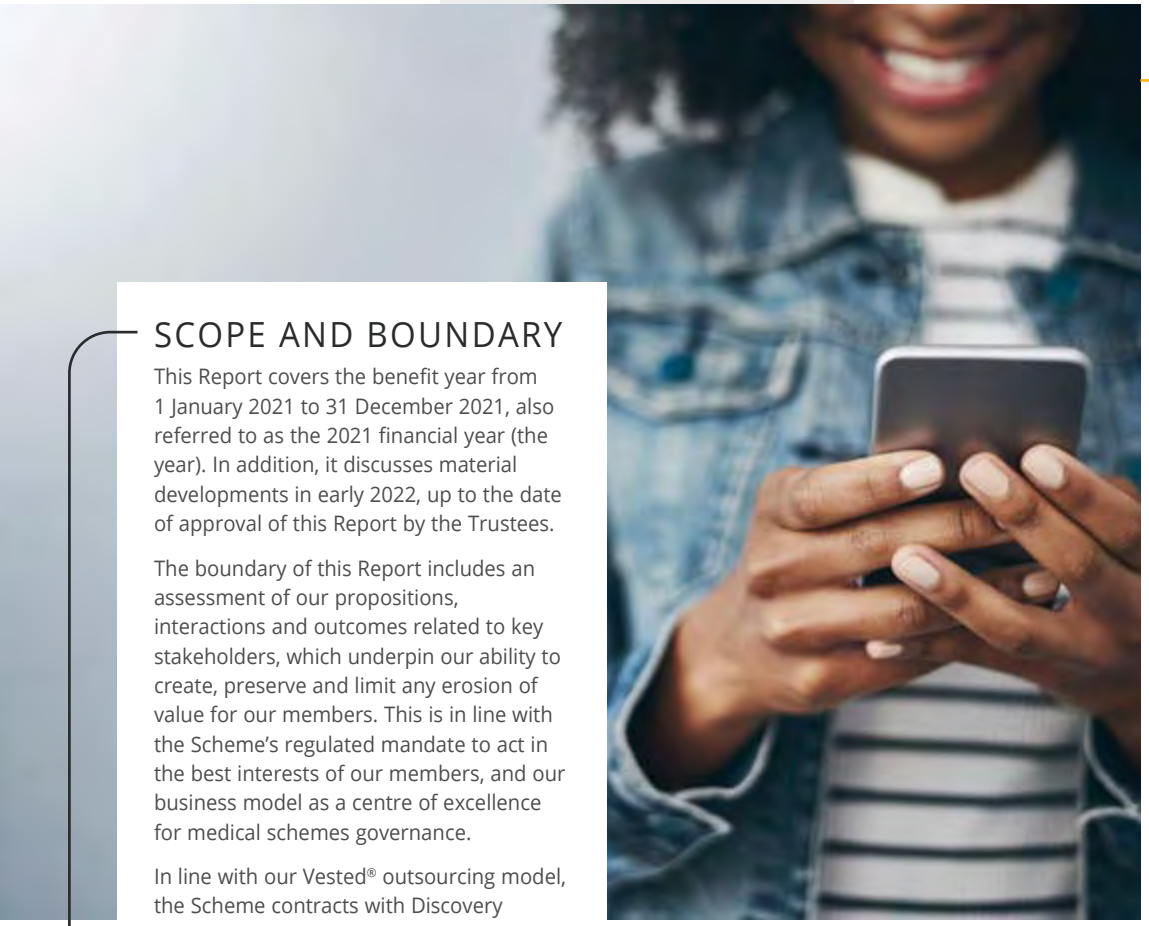
SIGNED ON BEHALF OF THE TRUSTEES ON 13 APRIL 2022

John Butler
Chairperson

Johan Human
Trustee

Selwyn Kahlberg
Acting Principal Officer

Discovery Health Medical Scheme registration number 1125



SCOPE AND BOUNDARY

This Report covers the benefit year from 1 January 2021 to 31 December 2021, also referred to as the 2021 financial year (the year). In addition, it discusses material developments in early 2022, 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 or DH) 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.

In 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.

This Report covers the benefit year from 1 January 2021 to 31 December 2021, also referred to as the 2021 financial year (the year). In addition, it discusses material developments in early 2022, up to the date of approval of this Report by the Trustees.

PROCESS DISCLOSURES

Reporting frameworks

The Scheme takes guidance from the King IV™ Report on Corporate Governance for South Africa 2016 (King IV), the SAICA[1] Medical Schemes Accounting Guide, and uses the International <IR> Framework (as of January 2021) of the Value Reporting Foundation[2] as the basis for preparing and improving its reporting. The IIRF is applied insofar as it is relevant and applicable to medical schemes in South Africa.

For the 2020 Integrated Report, we updated our business model and used our material matters to improve the connectivity of the Report, particularly as these pertain to our core capital inputs, how we manage these through our strategy and how we mitigate our residual risks to drive differentiated value outcomes for our members and other stakeholders. We consider our 2021 Integrated Report to be as fully aligned to the International <IR> Framework (January 2021) as is possible while still meeting the requirements of our regulatory stakeholders.

Materiality determination

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

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

The 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.

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

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Auditor independence

PricewaterhouseCoopers Inc has audited the Scheme's Financial Statements (comprising the statement of financial position at 31 December 2021, the statement of comprehensive income, the statement of changes in funds and reserves and the statement of cashflows) and the notes to the financial statements for the financial year ended 31 December 2021. Rotation of the designated partner forms part of the independence assessment, and the current audit partner assumed the role for the audit of the financial year ended 31 December 2019.
The Audit Committee is satisfied that the auditor remains independent of the Scheme[1].

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.

Report preparation and approval

Under the direction and oversight of an experienced and expert executive, Scheme management is responsible for the preparation of the Integrated Report.

- The Head: Special Projects and Stakeholder Relations is responsible for gathering, vetting, drafting and co-ordinating reviews and approval of qualitative and quantitative information submitted by relevant content owners within DHMS.
- Support, in the form of content provision and verification, is provided by specialist internal and Discovery Health functions such as governance, regulatory, clinical, financial, actuarial, risk management and strategy development and implementation.
- Subject matter experts contribute to data validation, interpretation and contextualisation to ensure that the data relating to the Scheme's initiatives is faithfully presented in the Integrated Report.
- The reporting project team has unfettered access to the Chairperson, the Principal Officer, Scheme Management and Committee Members, who provide input during report preparation and review and approve their relevant sections before these are submitted to the full Board for review.
- Following a detailed review by the Audit and Stakeholder Relations and Ethics Committees, the Audit Committee recommends the Integrated Report to the Trustees for approval. 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.

1 *The rule on mandatory audit firm rotation as issued by the Independent Regulatory Board for Auditors is only effective for financial years commencing on or after 1 April 2023. The Scheme will therefore appoint new auditors for its financial year ending 31 December 2024.*

03 LEADERSHIP REVIEWS

NEIL MORRISON

Our Chairperson's statement

The implications of the COVID-19 pandemic continued to dominate the global and local landscape in 2021.

We congratulate and thank our Ministerial Advisory Committee on COVID-19, the National Coronavirus Command Council and the Presidency for managing the difficult balance between restrictions and reopening the economy as quickly and responsibly as possible. We also congratulate the Solidarity Fund for outstanding work done in the service of the nation. Job losses across formal and informal sectors of the economy have elevated the risk of social instability, as the unrest in July 2021 showed. The balance between lives and livelihoods, with the path of the pandemic still uncertain, remains critical.

Vaccination is the best way to protect our citizens from COVID-19. Higher rates of vaccination to achieve broader coverage are required to manage pressure on the healthcare system, and return to more normal levels of social and economic activity. Unfortunately, we have seen a high degree of vaccine hesitancy. This is despite unquestionable research that shows COVID-19 vaccines reduce the risk of severe disease and mortality[1].

At 6 March 2022, some 32 million doses had been administered, equating to 19 million fully vaccinated individuals – about 48% of the eligible population[2]. With vaccine apathy growing, further COVID-19 waves, complicated by new variants, may follow. Improving the pace of the country's vaccination rollout, specifically by advocating the evidence-based safety and efficacy of vaccination, is therefore critical if we are to limit further loss of life and socio-economic hardship due to COVID-19.

Discovery Health Medical Scheme (DHMS or the Scheme) has focused our response to COVID-19 on protecting and supporting our members. The Scheme provided proactive COVID-19 risk mitigation services to our members, especially those at high risk of serious disease, hospitalisation and mortality. Calls were made to these members to educate them about the risks, how to avoid infection and improve their physical and mental wellbeing. This included information on safely accessing care and treatment during lockdowns, and steps to take should they become infected. Data confirmed the effectiveness of this intervention, with lower hospitalisation rates among members who were successfully contacted compared to those who were not[3].

The reduction in healthcare screening and wellness checks is gravely concerning. From 2019 to 2021 (year to date September 2021), per 1000 DHMS beneficiaries:

- ***HIV screenings reduced 38%;***
- ***Pap smears for women over 25 years of age reduced 13%;***
- ***Mammograms for women over 50 years of age reduced 14%;***
- ***Health and wellbeing screening checks reduced 52%.***

We urge all our members to attend their recommended disease and wellness screenings regularly to support better health outcomes.

1 *Source: "Duration of Protection against Mild and Severe Disease by Covid-19 Vaccines", https://www.nejm.org/doi/full/10.1056/NEJMoa2115481.*
2 *Source: https://sacoronavirus.co.za/latest-vaccine-statistics/.*
3 *Some members in this cohort were not contactable, and some did not wish to participate in the call.*

We continually focus on ensuring that our benefit plans are affordable and the Scheme remains financially sustainable. To this end, we continued to provide innovative solutions, including funding, to our members. Some of these solutions have targeted high-risk cohorts, providing maximum protection to these members and their dependants. The Scheme will continue to fund and ensure access to clinically proven and appropriate healthcare solutions as they become available.

In 2021, we continued to experience unusual trends in healthcare claims, common across the industry. At the end of 2021 members' funds had grown to R30.4 billion (2020: R28.2 billion). This growth is largely attributable to reduced healthcare-seeking behaviour (including wellness screening). We expect this delayed utilisation to manifest in higher and more severe burden of disease in the short to medium term, as members who may have neglected their care or have been diagnosed late return to the healthcare system. We urge all our members to attend their recommended disease and wellness screenings regularly to support better health outcomes.

A strong financial position bodes well for the sustainability of the Scheme. This has allowed us to ease the financial burden on our members. We delayed our contribution increase to July 2021, at a maximum average contribution increase for the year of 2.95%. We will do so again in 2022, maximising the use of the Scheme's solvency levels to offer some financial relief to our members.

We are heartened to have grown DHMS membership by 22 499 in 2021[1]. This was achieved despite the economic hardship that has seen much of the industry experiencing membership declines. We believe this is due to the extent of cover, quality and comprehensive nature of our benefits, and the broad range of options tailored to meet members' needs.

MORE ABOUT OUR HIGH LEVELS OF COVER

1 *Net principal member increase at 31 December 2021 vs 2020.*
2 *Source: https://www.discovery.co.za/corporate/health-insights-omicron-severity.*
3 *Deloitte Touche Tohmatsu Limited.*
4 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2020, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R1.88 (2019: R2.03) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*

As I retire from my role as the Chair of the Board of Trustees, I extend thanks to my fellow Trustees for their counsel and commitment. A special word of thanks to Advocate Joan Adams whose term as a Trustee ended in August 2021.

This growth is also an indication of the trust that consumers have in us as an avenue to access high-quality healthcare. Moreover, at a time of deep uncertainty, fear and misinformation, the Scheme and Discovery Health (DH) have proven to be a valuable source of information on COVID-19. We applaud the work done by Discovery Health's clinical and actuarial teams to support the national COVID-19 response. Their research on, among others, Omicron severity and the efficacy of vaccines against the Delta and Omicron variants[2] has been world class.

The Trustees take their responsibility to ensure impeccable governance of the Scheme very seriously. As we do every year, we engaged Deloitte[3] to perform an actuarial peer review on a calculation of value received by the Scheme for work done by Discovery Health. This calculation has been done for seven years now, and we are pleased to report that once again, for 2020, the Scheme received R1.88 in value for every R1.00 paid to Discovery Health[4]. This is lower than in 2019 (R2.03) and this decrease is due to the decrease in utilisation experienced in 2020 as a result of the COVID-19 pandemic, as verified by Deloitte.

The Scheme contracts with Discovery Health for administration and managed care services, and these contracts expire at the end of 2022. The Scheme was required to notify Discovery Health of the renewal or termination of the agreements by 31 December 2021. The Trustees appointed an ad hoc Board subcommittee, the Services Renewal Committee, to comprehensively review the options available to the Scheme and to make recommendations to the Board. The Committee reviewed extensive reports, and engaged Deloitte to conduct an independent review of the administration and managed healthcare services landscape using publicly available information. Based on these investigations, the Trustees resolved to renew the managed care and administration agreements with Discovery Health, subject to final terms being agreed during 2022.

MORE ABOUT THE SERVICES RENEWAL PROCESS

As I retire from my role as the Chair of the Board of Trustees, I extend thanks to my fellow Trustees for their counsel and commitment. A special word of thanks to Advocate Joan Adams whose term as a Trustee ended in August 2021. Joan was a dedicated and knowledgeable Trustee who brought valuable perspectives to our deliberations, and we wish her the best with her future endeavours. We welcome Dr Susette Brynard back to the Board after her re-election in 2021, and also welcome our newly elected trustee, Mrs Gita Harie. Mrs Harie has a strong background in the healthcare system, specifically in mental health.

I also welcome our new Independent Committee Members (ICMs): Ms Melanie Bosman; Ms Henda Van Deventer; Professor Laurel Baldwin-Ragaven; Mr Andrew Bryce; Ms Berenice Marais; and Mrs Alexandra Muller. They are taking up positions on the Audit, Investment, Clinical Governance and Nomination Committees respectively, replacing ICMs whose terms have expired. We say farewell and thank you for the diligent and informed performance of their duties to Mrs Sue Ludolph; Dr Selma Smith; Dr Peter Goss; Mr Tom Wixley; and Mr Roy Shough.

On behalf of the Trustees I thank the Scheme Office team, so ably led by Ms Charlotte Mbewu. The smooth running and excellent performance of the Scheme in another challenging year is due to their knowledge, experience, expertise and dedication.
I congratulate my colleague, Advocate John Butler, who assumed the position of Chair of the Board from 1 January 2022. I wish him well in the important work of leading the Trustees of this Scheme, entrusted with providing sustainable access to quality healthcare to our members.

I have no doubt that the Scheme will continue to be a trusted provider and thought leader in an industry so critical to our nation's recovery and wellbeing.

MR NEIL MORRISON
Chairperson (2016-2021)

Message from our incoming Chairperson

We move forward, intent on realising our purpose to meet our members' healthcare needs in an affordable, equitable and quality value-based way now and into the future.

MR JOHN BUTLER, SC

My thanks go to Mr Morrison, who has been a steady hand at the helm – especially in the last two years – and who has adroitly facilitated debate and deliberations among the Trustees, alongside the expertise he brought in the form of counsel and oversight.

I am pleased that the Scheme will continue to benefit from his experience as a member of the Audit, Investment, and Remuneration Committees until his second term ends in June 2022.

As the incoming Chair of the Board, allow me to outline the approach I intend to take in my leadership responsibility. The Scheme faces complex challenges in the years ahead, in many instances compounded by the varied implications of the global pandemic. These challenges are described in more detail elsewhere in this integrated report. South Africans face a steep road to economic recovery. This will constrain even further the affordability of medical scheme membership, irrespective of its importance to individual and national wellbeing.

More concerning, whether COVID-19 persists with variants that spread more easily and are more elusive of immunity, or becomes an endemic disease, our burden of disease will be heavier than ever before.

Despite the hardships – the tragic loss of life, severe disease, Long COVID[1] and associated mental health concerns – the pandemic has taught us valuable lessons. It has also accelerated opportunities for more effective and efficient care solutions and delivery models, with the potential to improve population health outcomes dramatically. Many of these are already in development or operation, and we hope to lead the way to an improved healthcare system and better health for our members in this way.

As we move forward, intent on realising our purpose to meet our members' healthcare needs in an affordable, equitable and quality value-based way ***now and into the future***, the Scheme will need to remain conscious of the broader landscape of disease management, and to consider it over the longer term – as we had to do in response to the pandemic. And we will need to consider the trends in our industry but also the political, social and environmental factors that influence health outcomes, not only in South Africa but also in other parts of the world. As climate change becomes the next generation-defining global threat, and a formidable vector of disease and injury, this issue will require an increasingly prominent place in our thinking and problem solving.

It falls on us to refrain from forgetting our past experience, and to contribute momentum to the extraordinary efforts made locally and globally to combat COVID-19, including rapid innovation and global research collaboration, access to unprecedented and understandable information from

1 *The World Health Organisation defines Long COVID as: "Post COVID-19 condition occurs in individuals with a history of probable or confirmed SARS CoV-2 infection, usually 3 months from the onset of COVID-19 with symptoms and that last for at least 2 months and cannot be explained by an alternative diagnosis. Common symptoms include fatigue, shortness of breath, cognitive dysfunction but also others and generally have an impact on everyday functioning. Symptoms may be new onset following initial recovery from an acute COVID-19 episode or persist from the initial illness. Symptoms may also fluctuate or relapse over time." Source: https://www.who.int/srilanka/news/detail/16-10-2021-post-covid-19-condition.*

global experts in their various fields (with the concomitant need to discriminate between legitimate and misinformation), and public-private partnerships newly galvanised for real-world delivery.

As the world rebalances, we do not foresee a return to what was considered normal. Rather, we foresee a re-negotiation of what constancy means in a world that will continue to change dramatically. We need to become accustomed to uncertainty, to testing new boundaries and to continual adaptation, with our purpose and our values as our unchanging orientation. This applies to many spheres – the workplace, where remote or hybrid environments are being tested; social spaces, where we have learned new habits of hygiene and infection management; and the healthcare industry, where opportunities for innovation in care settings and platforms, aside from new medical technologies and treatments, are already within reach.

For instance, during the pandemic's peaks, many healthcare engagements made use of virtual facilities to protect all parties. This opened new ways for patients to interact with healthcare professionals and for care to be delivered – in many cases with improved health outcomes. But during periods of low infections, many of these returned to in-person interactions. The Scheme's experience shows that virtual care offers many advantages, such as access for remote or travelling patients; lower costs and a lower carbon footprint of care; comfort for members who can remain at home during treatment; efficiencies for healthcare professionals; and opportunities to involve diverse or multi-disciplinary teams to provide carefully co-ordinated care as needed. However, the right blend of virtual and physical care still needs to be found for the spectrum of patients, capabilities and needs. This will take some testing and development and we look forward to embarking on this journey with our members and our partners in all aspects of healthcare provision.

In addition to the direction described by Mr Morrison and Ms Mbewu, we have taken heed of the Health Market Inquiry's recommendations and will launch, during 2022, a regional efficiency-discounted option in the form of the existing Keycare Start plan. This plan is targeted at the low-income segment. It is region-based, and will effectively improve access to medical scheme cover through reduced contributions at the lowest entry price point in the Scheme.

No matter the challenges, I am invigorated by the opportunity that we have to create new value for our members, and to play our part in the reform and improvement of the national health system, armed with the lessons of the pandemic. I am also pleased that we will continue to do so alongside our highly competent and innovative administrator and managed care provider, Discovery Health, and look forward to working with Ms Mbewu and the excellent Scheme Office team.

MR JOHN BUTLER, SC
Chairperson

No matter the challenges, I am invigorated by the opportunity we have to create new value for our members, and to play our part in the reform and improvement of the national health system, armed with the lessons of the pandemic.

Our Principal Officer's review

MS CHARLOTTE MBEWU

Immunity from prior COVID-19 infection has a limited lifespan, and it has been comprehensively proven that vaccination decreases both asymptomatic and symptomatic infections; hospitalisation and death; and progression to Long COVID.

In 2021, we led a concerted effort to give our members access to vaccinations as quickly as possible, in line with the Department of Health's guidelines and age-based progression. We were strongly supported by DH, who opened several mass vaccination sites, and mounted a comprehensive campaign to counter vaccine hesitancy.

At 28 February 2022, approximately 48% of our members have been fully vaccinated, with older and higher-risk members leading the way at around 80% for those over 60. I am deeply concerned, however, to see the drop off in vaccination rates and growing vaccine apathy, driven in part by misperceptions, including that infection with COVID-19 obviates the need to be vaccinated or to get a booster. Immunity from prior COVID-19 infection has a limited lifespan, and it has been comprehensively proven that vaccination decreases both asymptomatic and symptomatic infections; hospitalisation and death; and progression to Long COVID[1]. Beyond the benefits to individuals, transmission is reduced through lower and shorter infectiousness and so, the whole of society benefits[2]. Although the responsiveness to vaccines by COVID-19 variants differs, the benefits of vaccination are irrefutable.

As was the case last year, COVID-19 again created significant uncertainty for the Scheme, making planning and provisioning considerably more challenging. Utilisation continues to be lower than 2019, and reserves are therefore higher than expected. While total utilisation has reduced, there are some areas of specific concern where utilisation and costs related to the pandemic have increased materially.

These include far higher pathology costs mainly due to the volume of COVID-19 polymerase chain reaction (PCR) and antigen testing, and other tests associated with the management of the condition both in and out of hospital. Another area where utilisation and costs have risen is mental health, due to the prevalence of mental illness during the pandemic – a global phenomenon. The Scheme is paying close attention to improving access to mental health and wellbeing services, including exploring digital and self-care tools, and enhancing Scheme benefits where appropriate. Oncology programme registrations have also increased in the past year, as have the costs of novel high-cost oncology drugs, some of which the Scheme is able to partially fund on certain plans from 2022.

1 *Sources: "Duration of Protection against Mild and Severe Disease by Covid-19 Vaccines", https://www.nejm.org/doi/full/10.1056/NEJMoa2115481; "Risk factors and disease profile of post-vaccination SARS-CoV-2 infection in UK users of the COVID Symptom Study app: a prospective, community-based, nested, case-control study", https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00460-6/fulltext; "Reduced Incidence of Long-COVID Symptoms Related to Administration of COVID-19 Vaccines Both Before COVID-19 Diagnosis and Up to 12 Weeks After", https://www.medrxiv.org/content/10.1101/2021.11.17.21263608v1.*

2 *Sources: "Protection against SARS-CoV-2 after Covid-19 Vaccination and Previous Infection", https://www.nejm.org/doi/full/10.1056/NEJMoa2118691; "What is the vaccine effect on reducing transmission in the context of the SARS-CoV-2 delta variant?", https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8554481/.*

For the year ended 31 December 2021, DHMS delivered a negative net healthcare result of R1 165 million (2020: positive R7 451 million). This decline was mainly attributable to the delayed contribution increase for the 2021 benefit year, and the result was considerably better than expected. Worryingly, this indicated that our members continued to defer their healthcare needs during COVID-19 waves in 2021. We expect the reversal, as pent-up healthcare needs – likely exacerbated by worsened states of health due to postponing care – result in steep increases in utilisation.

The better-than-expected financial performance boosted members' funds to R30.4 billion (2020: R28.2 billion) with a solvency level of 38.01% (2020: 36.9%), exceeding the regulatory requirement of 25% by an atypically large margin. Adding to the net surplus of R2 044 million (2020: R9 006 million) for the year, was healthy investment income of R1 772 million (2020: R1 690 million), generated despite volatile and uncertain investment markets.

The latent effects of the pandemic mean that we cannot easily make reliable assumptions and must take a cautious approach in determining appropriate contribution increases to maintain the sustainability of the Scheme. We were able to delay our contribution increases to 1 October 2022, making the best use of our unusual solvency position. We were careful to do this in a way that eases the financial pressure on our members and preserves sufficient surplus in advance of the expected increase in utilisation. On balance of these imperatives, we contained the effective increase for members to 2.0% from a base of annualised rates at December 2021.

Uncertainty and challenges aside, the COVID-19 pandemic has also created opportunities to improve the healthcare system. To protect healthcare workers and patients, the adoption of virtual care increased dramatically during the year and, while finding the optimal balance of virtual versus physical care requires evolution, as does the appropriate platform, we believe that virtual care offers tremendous opportunities for access and ease of use for both patients and healthcare professionals.

We are excited to extend care at home capabilities for our members. It is entirely possible, and desirable, to deliver hospital-level care safely and effectively in a patient's home for numerous medical and surgical conditions that would otherwise require admission to hospital, subject to the recommendation of the treating physician. This eases the burden on the healthcare system, especially in times of significant disease burden, and gives comfort to members as they can remain in a familiar setting, with the support of their family, without compromising health outcomes. Qualifying members will have their care at home funded from their hospital benefit with access to relevant and appropriate care devices, medication and services, as well as a dedicated care team. This offering evolved from the home-based care provided to members, successfully treated for COVID-19 during 2021. In these cases, we saw similar or improved clinical outcomes and a better patient experience[1].

HEAR FROM OUR MEMBERS IN A VIDEO ON HOSPITAL AT HOME

In 2022, we will be launching an anaesthetic pre-operative management programme for out of hospital assessments and care for members undergoing major surgeries such as arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy and mastectomy. This will promote improved health outcomes and reduce morbidity and downstream costs associated with elective surgery, where the patient was not sufficiently well and stable enough to do well with the procedure prior to the admission.

We have also been able to enhance several benefits to expand access to healthcare to more members. This includes the Assisted Reproductive Therapy Benefit, offering the Oncology Innovation Benefit on additional plans, and enhancing the Allied and Psychology Extender Benefit, the Trauma Recovery Extender Benefit and the palliative care offering.

OUR BENEFIT CHANGES FOR 2022

We continue to engage with our regulators, directly and in various industry initiatives. We await the outcome of the final report of the Section 59 Investigation into fraud, waste and abuse (FWA). The allegations made about our practices have not yet been conclusively laid to rest, despite the interim report finding no fault with them. In the interim, we have worked with DH on finding ways to further improve our processes for the management of FWA. This has included establishing a Health Professionals Reference Group to contribute to the review, development and redesign of DH's forensic investigation processes, which will be facilitated by independent professionals with healthcare management, legal and dispute resolution expertise. Improvements to the process will be based on the principle that any action taken to manage FWA by DH are fully lawful, but conducted with respect and fairness, and in a way that causes the least disruption to the majority of healthcare professionals whose practices are justifiably not subject to forensic investigation.

Our ongoing engagement alongside DH on key matters affecting the healthcare industry and its funding model continued in 2021. The Parliamentary Portfolio Committee on Health (PCH) heard presentations on the National Health Insurance (NHI) Bill during 2021, and these continued into 2022. DH presented our joint written submission to the PCH, which conveyed our full support of the principles of Universal Health Coverage and the need for structural reforms to improve social justice. Nonetheless, we believe there is a substantial amount of work required on the NHI Bill to avoid challenges to its Constitutionality, specifically in that it limits the right of access to healthcare and the role of medical schemes, among other potential weaknesses. We will continue to support constructive progress towards achievement of the principles expressed in our Constitution in respect of the right of access to healthcare services.

With the objective of expanding access to private healthcare, we continue to advocate for the finalisation of a framework for low-cost benefit options. This would allow medical schemes to offer these to the sizeable proportion of the population that

1 *For example, average length of stay was 4.1 days versus 7 days for an average COVID-19 ward admission, according to a comparison of DHMS care at home claims data versus hospital claims data. Patient-reported outcomes were also documented, and patient experience was assessed through surveys.*

are not currently members of schemes but that could afford these scheme options.

Following extensive industry engagement since 2017, during which both DHMS and DH made written submissions, the Department of Health issued a declaration of undesirable practices relating to designated service provider (DSP) networks in April 2021. The declaration is concerning as it hinders schemes' ability to select healthcare professionals for these networks and to ensure that members benefit from savings when using these networks, which schemes have negotiated on their behalf. In response, the Health Funders Association (HFA) has lodged a Promotion of Administrative Justice Act request to the Registrar and Council at the Council for Medical Schemes (CMS) and Department of Health to understand the basis for the declaration.

The HFA has also lodged a Section 50 Appeal regarding the declaration of undesirable business practices in relation to DSP arrangements. Consistent with our submissions to the CMS, we hold a different view to the declaration, as DSP networks are of great benefit to members. Schemes have limited ability to control healthcare costs; we – and by extension our members – are largely at the mercy of service and product pricing. When schemes construct DSPs, they do so to be able to negotiate specific rates with the healthcare professionals concerned on behalf of members. Increasingly, such arrangements also include quality of care requirements. For these networks to be viable, schemes must be able to direct their members to utilise professionals in the network, and this is achieved by the imposition of co-payments as a penalty should members choose to go outside of the network applicable to their chosen plan.

An area where DH has done excellent work to benefit our members is in the accessibility and pricing of medication. In 2021, the DH medicines team worked with the Competition Commission on six cases including Trastuzumab (Herceptin), flu vaccines, anti-coagulants in haemophilia, pharmacy networks and fee structures, and industry mergers. In 2022, the team is working with the Competition Commission on the investigation into the pricing of therapeutics for the treatment of idiopathic pulmonary fibrosis.

In 2022, the focus is on price negotiation of biosimilar equivalents to affordably expand access to Priority, Saver, Core and Smart plans by 2023.

After several years of persistent negotiations by DH, the price of the life-saving oncology medicine, Herceptin, was reduced substantially from approximately R23 000 per treatment cycle in 2018 to less than R5 000 in 2021, and we were pleased to note that the Commission has published a finding on Herceptin in 2022.

A highlight of 2021 was the price negotiation for biologics used in the management of rheumatoid arthritis and inflammatory bowel disease. Price reductions of 20% to 43% were negotiated with pharmaceutical organisations in addition to obtaining a price freeze until the end of 2023. The Scheme will save more than R52 million in 2022, without the need to switch to biosimilar alternatives and retaining full cover on the Specialty Medicine and Technology Benefit for rheumatoid arthritis, Crohn's disease and ulcerative colitis. Key opinion leaders and prescribers in rheumatology and gastroenterology were also engaged as part of our initiative to make biologics and biosimilars more accessible to our members.

In 2022, the focus is on price negotiation of biosimilar equivalents to affordably expand access to Priority, Saver, Core and Smart plans by 2023. The medicines team collectively saved DHMS approximately R310 million in Single Exit Price negotiations in 2021. This allowed richer benefits and lower co-payments for our members, but also benefitted the entire private healthcare industry with lower-priced medicines. The Discovery Health Centre for Clinical Excellence leadership team will continue to engage with and support the South African Health Regulatory Products Authority on affordable and prioritised access to biologics and biosimilars in addition to the Medicines Pricing Committee on high-cost novelty medicines, particularly where prevailing legislation precludes affordable access.

REGULATORY AND INDUSTRY MATTERS DEALT WITH IN 2021

To protect and support our employees during this period, we instituted a work from home policy at the start of the pandemic. We now look forward to a time when, protected by vaccinations and with all precautions in place, we are able to move to a hybrid work environment to maintain our culture and optimise collaboration. We expect to implement a hybrid work strategy during the course of 2022, remaining agile in response to the developments in the pandemic as well as to treatments and guidelines.

As a small and highly efficient team, I thank my colleagues for their support and hard work on behalf of the Scheme and its members. My appreciation also goes to our Trustees and Independent Committee Members whose expert counsel and oversight has steered the Scheme safely through the COVID-19 storm. I also extend a word of gratitude to our stakeholders including our members, the Council for Medical Schemes, DH and healthcare professionals.

I am deeply proud of the balance we have achieved between competing imperatives and in making difficult trade-offs, amidst the turmoil that has characterised the last two years. Our duty of care has been strongly rooted in our unwavering focus on acting in the best interests of our members, now and into the future.

C Mbewu

MS CHARLOTTE MBEWU
Principal Officer

04 OUR VALUE STORY

Our operating context

HOW SCHEMES OPERATE

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 Act established the CMS 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 contributing members.
- 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 vets scheme trustees[1] and principal officers.

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

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 for members with other imperatives. These include holding sufficient reserves to weather times of economic difficulty and unexpected claims, providing for variations in utilisation and escalation in the cost of treatment, optimising benefits according to availability, costs and the health needs of scheme membership, and equitable treatment of all scheme members.

At the end of 2020, there were 75 medical schemes registered with the CMS, consisting of 18 open schemes and 57 restricted schemes, covering over 8 896 000 beneficiaries (2019: 8 953 000)[2]. These schemes paid out approximately R178 billion in total healthcare benefits[3] in 2020 (2019: R185 billion). The average age of total registered scheme members in 2020 increased by 0.3 years to 33.6 from 33.3 in 2019, and the proportion of pensioners increased to 9.0% from 8.7%[4].

1 *Discovery Health Medical Scheme's (DHMS or the Scheme) Nomination Committee provides an additional layer of oversight in approving the vetting of nominees and candidates eligible for election.*
2 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2021 (https://www.medicalschemes.co.za/wpfd_file/quarterly-report-for-30-september-2021/).*
3 *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.*
4 *Source: Annexures to the CMS Annual Report 2020–2021. Data includes both open and restricted schemes, but does not include data for 2021 (https://www.medicalschemes.co.za/cms-annual-report-2020-21/).*

THE OUTLOOK FOR MEDICAL SCHEMES

As indicated, medical schemes operate under the principle of social solidarity: they 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. However, the social solidarity framework initially proposed has not been fully implemented. Missing elements like mandatory membership for economically active citizens have left schemes vulnerable to anti-selection and exposed members to elevating contribution levels[1].

The Health Market Inquiry acknowledged this regulatory constraint, and made recommendations "...designed to complete the regulatory framework, and to create a market environment conducive to effective competition on pro-consumer metrics... ". The social solidarity principles of open enrolment (where schemes must accept all applicants) and community rating (where schemes must charge a contribution price for a particular plan which is identical for all members no matter age, sex or pre-existing conditions) were always intended for implementation alongside a risk-adjustment mechanism (through which schemes with above average risk profiles are balanced through funds received from schemes with below average risk-profiles) and mandatory membership[2].

It is to be hoped that these recommendations are implemented swiftly in tandem with other healthcare reform currently underway. The expansion of healthcare funding, to counter increasing affordability constraints for both individual citizens and the state, is especially necessary as South Africa seeks to accelerate its socio-economic recovery from the COVID-19 pandemic, and to find and fund effective solutions to an ever-intensifying burden of disease.

Given its global reach and widespread effects at macro and micro levels, COVID-19 continues to impact the healthcare industry. In particular, the physical and emotional burden on frontline healthcare workers and facilities during the waves of the pandemic has been severe, and well documented. The unexpected effects of the pandemic included substantially decreased utilisation in many parts of the healthcare system during 2020 and 2021, as members deferred non-emergency and elective care. Whereas this negatively impacted the financial outcomes of healthcare professionals, it resulted in an unprecedented increase in reserves for medical schemes as claims reduced even though COVID-19 related utilisation increased.

Despite these robust solvency levels, medical schemes face a complex interplay of challenges. Factors that have been evident over several years include aging scheme membership and stagnant membership growth, which reflect adverse demographic trends and prevailing economic stresses. This is pitted against the increase in non-communicable diseases, including mental health disease and cancer, and compounded by the release of pent-up demand for healthcare deferred during the pandemic and the long-term health impacts of Long COVID. These factors are a cause for concern in the medium and long term, having negative implications for cross-subsidisation within scheme risk pools, and the healthcare industry as a whole.

Besides these considerations, uncertainty remains around the path that COVID-19 will take. Experts are divided on whether the disease will become a manageable endemic disease, or whether the continued circulation of the virus (aided by relatively low and inconsistent vaccination rates) will result in novel and potentially more transmissible or vaccine-resistant variants. As South Africa looks beyond the pandemic for higher rates of economic growth and social development, it faces an even heavier burden of disease to manage within the parameters of healthcare funding and provisioning that is sustainable and achievable. Medical schemes have a vital part to play in achieving this difficult balance by working towards better cost management, optimising the use of new technology and encouraging screening and the most appropriate use of healthcare in collaboration with stakeholders in the system.

Removing inappropriate costs while maintaining benefits and ensuring high quality of care, which value-based healthcare models seek to achieve, are therefore key drivers for medical schemes. The fragmentation and siloed operational models in the South African healthcare system undermines health outcomes by presenting barriers to integrated healthcare and information, healthcare system navigation, and co-ordination of care across disciplines and processes. Improving healthcare delivery efficiency and quality of care requires further development of managed care and care-co-ordination programmes that target specific conditions, supported wherever possible by innovative reimbursement mechanisms and increased adoption of digital healthcare.

Digital enablement supports shifting settings of care to more cost-effective and patient-centric environments. This includes home admissions where nurses can effectively manage patients in a familiar home environment, with supervision and oversight provided remotely by admitting physicians. Disintermediation of traditional healthcare professionals by non-traditional models, for example the provision of on-demand virtual primary care instead of an in-person GP consultation being the first port of call, is an interesting trend which is seeing new players, such as large technology companies, entering the market. Further, the development of highly innovative high-cost medical technology and drugs, albeit expensive, provides new hope in the scope of diagnostics and treatment protocols.

The Scheme continues to respond to the difficult trade-offs that these trends in the healthcare landscape imply, for the benefit of our members and our partners in the healthcare value chain. More broadly, we remain closely engaged with the development of national health policy and regulatory imperatives, including supporting the move to Universal Health Coverage (UHC), for the benefit of the healthcare system as a whole.

OUR STRATEGIC THEMES

REGULATORY AND INDUSTRY MATTERS DEALT WITH IN 2021

1 *"It has been estimated that prices in a voluntary environment are some 17%–23% more expensive than they could be under mandatory cover (McLeod & Grobler, 2009). Similarly, it is estimated that open scheme contributions could be lower by 23% in an environment without anti-selection (Childs, 2012)." Source: Anti-selection in voluntary health insurance markets: A focus on medical schemes in South Africa by R Harris and S Besesar, published in the South African Actuarial Journal in 2021.*

2 *Source: Health Market Inquiry Final Findings and Recommendations Report, September 2019.*

Our material matters

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

The Scheme's material matters are the most important factors 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 Board of Trustees (the Board or the Trustees) on an annual basis.

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

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

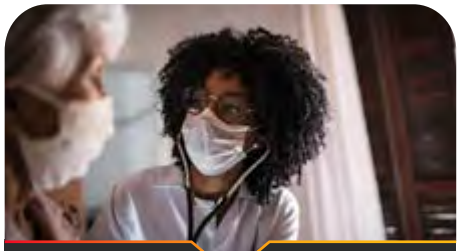
We deliver services to our members through our contractual relationship with Discovery Health (DH). The relationship is governed by the Vested® outsourcing model, a critical factor in our ability to manage these interrelated material matters most effectively.

OUR STRATEGIC THEMES

PERFORMANCE

OUR RESIDUAL RISKS

HOW DISCOVERY HEALTH SUPPORTS THE SCHEME'S VALUE CREATION



COVID-19 PANDEMIC

The impact of the COVID-19 pandemic on our members, the South African healthcare system as well as the economic environment and, in turn, its implications for the Scheme.

Advancements in COVID-19 disease management and funding of treatments and vaccines where evidence and safety protocols are in place and in alignment with national guidelines and priorities.

Healthcare system transformation stimulated by the COVID-19 pandemic, such as shifts in healthcare delivery settings. Changes in digital health capabilities and systems to provide an optimal balance of telehealth and in-person care.

Future pandemic preparedness and management.

MEMBER NEEDS

Member-centred, value-based, high-quality healthcare journeys incorporating leading healthcare technology and treatments, balanced with Scheme sustainability and affordability.

Active member participation in their health and wellness; digital health platforms and tools to enable quality care in their homes in collaboration with healthcare professionals.

The increasing and changing 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.

Discovery Health Medical Scheme registration number 1125

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

Ethical leadership, fairness and social responsibility towards a better society.

Partnerships with government, business and the industry to rapidly drive healthcare imperatives and co-create a stronger healthcare system.

Stakeholder engagement for a mutual understanding of, and a collaborative approach to, benefit design and healthcare funding models, in the context of healthcare inflation and the need for equitable access to advanced high-cost health technologies and treatments.

The impact of inadequate governance, controls and capacity 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.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

Robust and fair fraud, waste and abuse management to protect member funds, while treating stakeholders with respect and fairness.

Slow economic growth, increasing cost of living and rising unemployment, increasing the burden on the public healthcare system.

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 access, delivery of quality healthcare, affordability and social solidarity for all.

Our material matters are derived from an assessment of the emerging events, risks and opportunities in our operating context, and the needs and concerns of our members and other stakeholders.

Our business model

Sustaining the Scheme's financial, operational and relational wellbeing serves the current and future access to 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 centres on delivering excellence and innovation in our core service to our members, which is governance best practice and thought leadership in our industry.

As a funder that connects our members to the private healthcare value chain, the quality of our relationships with all our stakeholders is essential to realising our vision and creating sustainable value in the interests of our members and a better healthcare system, in line with our purpose.

The Scheme's business model is people-led, capability-driven and relationship based, which clearly reflects 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 opportunities 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 long-term value outcomes our stakeholders expect, which promote the financial, operational and relational wellbeing of the Scheme for the benefit of our members.

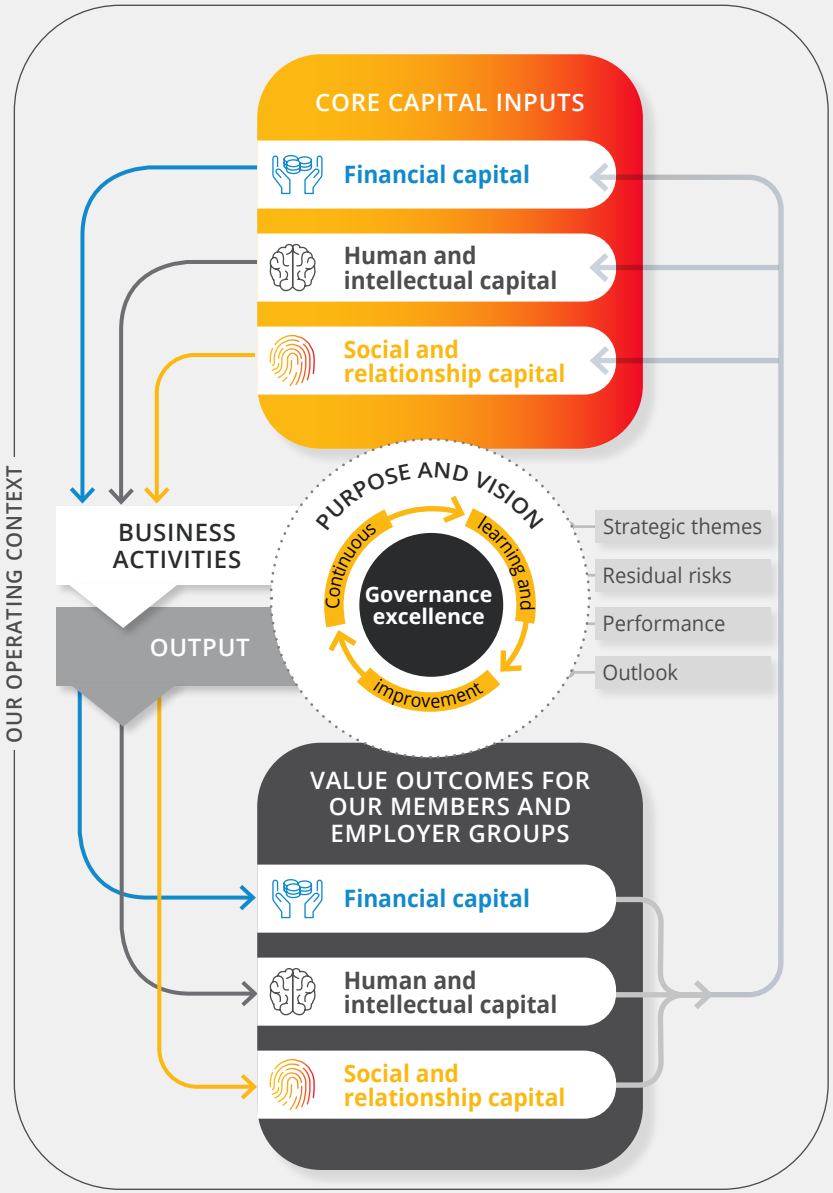
We apply global best practice in the best interests of our members through outsourcing administration and the provision of managed care.

Fundamental to understanding the Scheme's business model is our use of the Vested outsourcing model which governs 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, allowing for innovation, improved service and continuous value creation.



Discovery Health Medical Scheme registration number 1125

CORE CAPITAL INPUTS

Financial capital

- **Member contributions** of R75.8 billion (2020: R74.5 billion).
- **Investment income** of R1 772 million (2020: R1 690 million), generated from Scheme assets.

Human and intellectual capital

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

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.

BUSINESS ACTIVITIES

OUTPUT

VALUE OUTCOMES FOR OUR MEMBERS AND EMPLOYER GROUPS

- Financial capital
- Human and intellectual capital
- Social and relationship capital

Links to material matters, indicating key risks and opportunities in managing our inputs

Financial capital

COVID-19 PANDEMIC
- Impact on healthcare system and economic environment.
- Advancements in COVID-19 disease management.

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

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS
- Partnerships to drive healthcare imperatives.
- Collaborative approach to equitable access to high-cost health technologies and treatments.
- Governance, controls and capacity in the broader environment.
- Best practice governance for innovation, efficiency, excellence and value.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY
- Robust and fair protection of member funds.
- Economic growth, cost of living, unemployment.
- Scheme stability and sustainability.

Human and intellectual capital

COVID-19 PANDEMIC
- Future pandemic preparedness.

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

Social and relationship capital

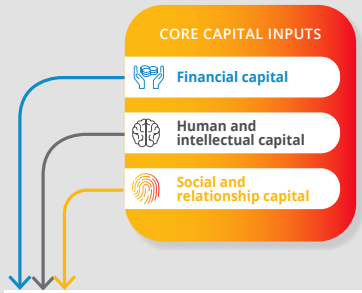
COVID-19 PANDEMIC
- Access to evidence-based treatments and vaccines.
- Impact on healthcare system and economic environment.
- Future pandemic preparedness and management.

MEMBER NEEDS
- Access to affordable quality care in the face of healthcare inflation.
- Member-centred, value-based, high-quality healthcare.
- Participatory care and access to digital healthcare.
- Impact on high utilisation, increasing costs, burden of disease, climate change.

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.

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY
- Protection of member funds.
- Future of private healthcare and supporting universal healthcare.
- Regulatory complexity and policy uncertainty.
- Economic growth, cost of living, unemployment.

Discovery Health Medical Scheme registration number 1125



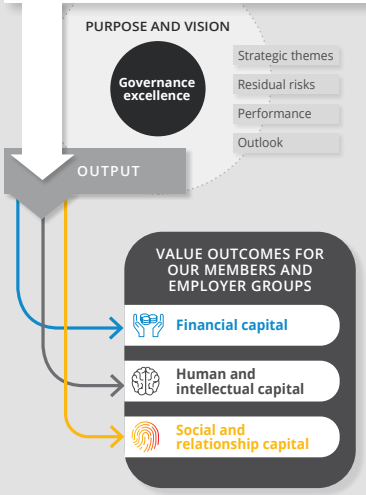
OUR PURPOSE

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.

BUSINESS ACTIVITIES



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

- **Regulatory compliance:** discharging our fiduciary duty and compliance obligations, supported by mature governance systems, ongoing monitoring and adaptation to a complex and dynamic healthcare environment, and managing risk and opportunity effectively.
- **Operational excellence:** guided by social solidarity principles, we work to ensure Scheme sustainability for the benefit of all our members.
- **Responsible corporate citizenship:** we 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:

OUR OPERATING CONTEXT
GOVERNANCE
OUR STRATEGIC THEMES
PERFORMANCE
OUR RESIDUAL RISKS

BUSINESS ACTIVITIES FOLLOW A CYCLE OF:

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

Discovery Health Medical Scheme registration number 1125

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 2 784 793 beneficiaries[1] and 57.5%[2] market share.
- Favourable demographics, with an average age of 34.9 and a pensioner ratio of 10.2% (versus 35.8 and 11.7% respectively across all other open medical schemes[3]).
- Financial strength, with R30.4 billion in member funds, a 38.01% solvency level, and an AAA credit rating confirming the Scheme's ability to meet large, unexpected claim variations.
- Discovery Health Medical Scheme (DHMS) gross administration expenditure is the fourth lowest[4] out of 18 schemes in the open scheme market.

OTHER KEY STAKEHOLDER RELATIONSHIPS RELEVANT TO OUR FINANCIAL CAPITAL OUTCOMES:

- HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES
- FINANCIAL ADVISERS
- OUR EMPLOYEES
- DISCOVERY HEALTH
- REGULATORY BODIES

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, and rated us excellent at a score of 4.8 out of 5. The next evaluation is due in November 2022.

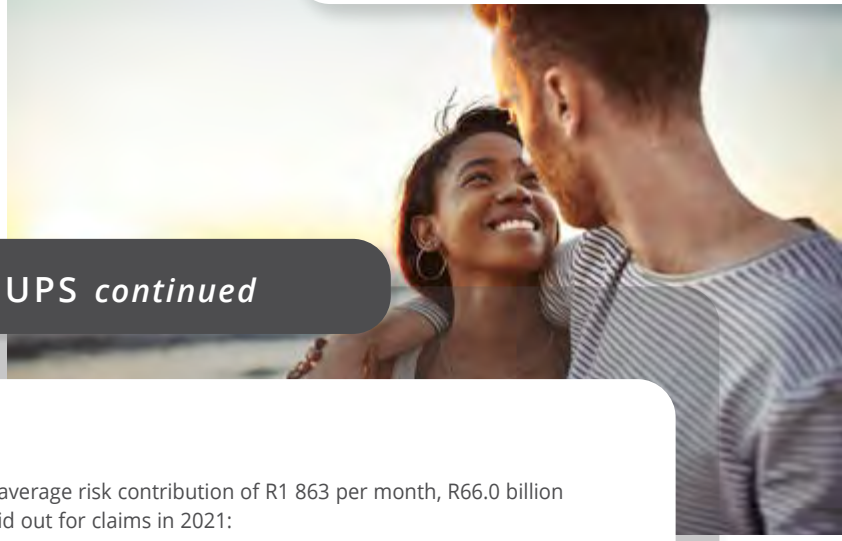
EMPLOYEES

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, including wellbeing strategies aimed at mitigating the impact of COVID-19 on employees and their families.

OTHER KEY STAKEHOLDER RELATIONSHIPS RELEVANT TO OUR HUMAN AND INTELLECTUAL CAPITAL OUTCOMES:

- HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES
- DISCOVERY HEALTH
- REGULATORY BODIES

1 *According to the latest available DHMS statutory returns submission from Q4 2021.*
2 *Latest available market share: based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2021 (https://www.medicalschemes.co.za/wpfd_file/quarterly-report-for-30-september-2021/).*
3 *Source for industry information: Annexures to the CMS Annual Report 2020–2021 (https://www.medicalschemes.co.za/cms-annual-report-2020-21/). Includes open and restricted schemes, and does not include data for 2021.*
4 *Based on the CMS Annual Report 2020–2021, as a percentage of gross contribution income.*



BUSINESS ACTIVITIES

OUTPUT

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 healthcare professionals, focused on efficiency and quality of care, the ongoing development of managed care programmes, innovation and integration.
- In 2020, DHMS led the market in responding to COVID-19, continuing this focus in 2021 with an extensive vaccination drive, resulting in approximately 80% of members over 60 being vaccinated.
- Benefits available to members related to COVID-19 include access to screening, testing, vaccinations and boosters, virtual consultations, home care including oxygen and pulse oximeters for high-risk members, and virtual support for non-COVID positive but at-risk members.
- Due to the exceptional utilisation patterns caused by the pandemic, and to assist members to deal with economic pressures, the Scheme was able to defer contribution increases in 2021 so that the average increase for the year was 2.95%. For 2022 the Scheme has deferred increases to 1 October 2022, meaning that members will only experience a 2.0% effective increase based on the annualised December 2021 rates.

VALUE OF BENEFITS[1]

- Members receive substantial value in terms of their healthcare benefits when they need to claim. The largest hospital claim made during 2021 would require 74 years of contributions by the member to cover it based on the plan that the member is on. Put another way, it would take 288 years of contributions based on the average risk contribution of R1 863 per month.
- For an average risk contribution of R1 863 per month, R66.0 billion was paid out for claims in 2021:
  - R5 254 per beneficiary with a chronic condition for out of hospital costs (740 488 beneficiaries)
  - R66 876 per admission (506 123 hospital admissions)
  - R103 528 per beneficiary undergoing oncology treatment (40 875 beneficiaries).
- 14.7% 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.
- 96.78% of members did not change their plan for 2021, reflecting member satisfaction, stability in benefit design and appropriate pricing.

AFFORDABILITY[2]

- Average contributions for our members in 2022 are 14.9% lower than the next six largest open medical schemes.
- The Scheme is more affordable than the next six largest open schemes across the majority of plan categories in 2022 (income-capitated: -4.3%; hospital: -0%; limited day-to-day: -16.3%; extensive day-to-day: -20.1%).

1 *All figures for the period October 2020 to September 2021, 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 2021.*

2 *Source: publicly available contribution information for DHMS and the next six largest open medical schemes.*

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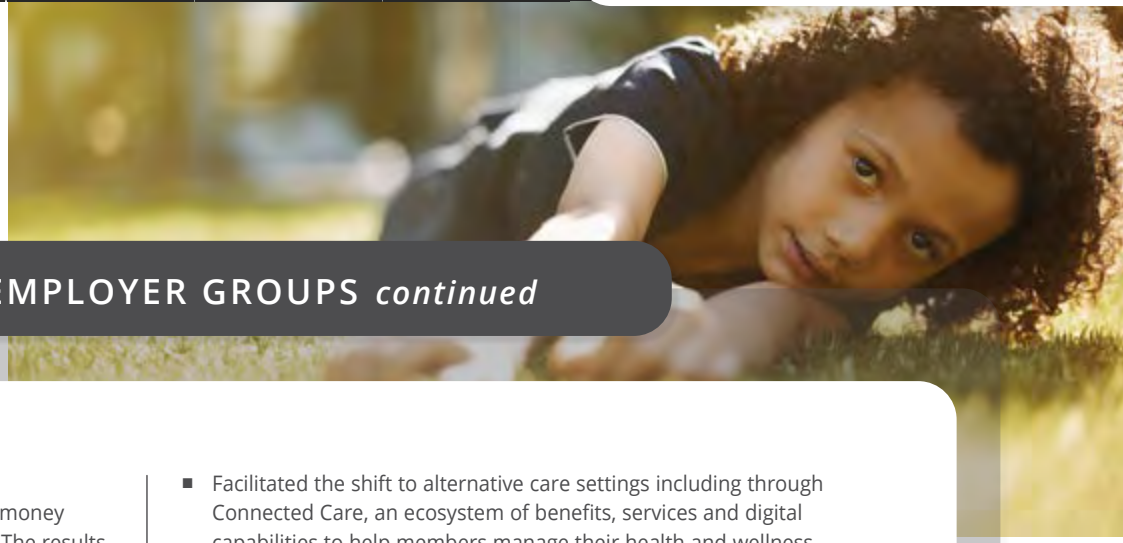


BUSINESS ACTIVITIES

OUTPUT

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 (DH) provides to the Scheme every year. The results are expressed as the value added by DH for each rand paid to it[1].

2020: R1.88 | 2019 R2.03 | 2018 R2.12 | 2017 R2.02 | 2016 R2.00 | 2015 R1.85 | 2014 R1.73

- 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. Deloitte have confirmed that the decrease in value for 2020 from 2019 is consistent with a decrease in utilisation experienced in 2020 as a result of the COVID-19 pandemic, while the administration and managed care fees have remained at similar levels in real terms.

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 2 401 doctors regularly used HealthID in treating our members during 2021, and 2.83 million members have given their doctors consent to access their records on HealthID[3].
- Facilitated the shift to digital care, with 23 400 virtual consultations conducted during 2021.
- 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 8.76 out of 10.
- Ask Afrika Top Icon Brands 2021/2022 - top 3 in medical aid category.
- READERS' CHOICE TOP for BRANDS 2021 - best medical aid.
- In 2020[4], the Sunday Times Top Brands retrospectively 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 system. The Scheme seeks to amplify these benefits by working towards an improved healthcare system.

OTHER KEY STAKEHOLDER RELATIONSHIPS RELEVANT TO OUR SOCIAL AND RELATIONSHIP CAPITAL OUTCOMES:

- HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES
- DISCOVERY HEALTH
- FINANCIAL ADVISERS
- REGULATORY BODIES

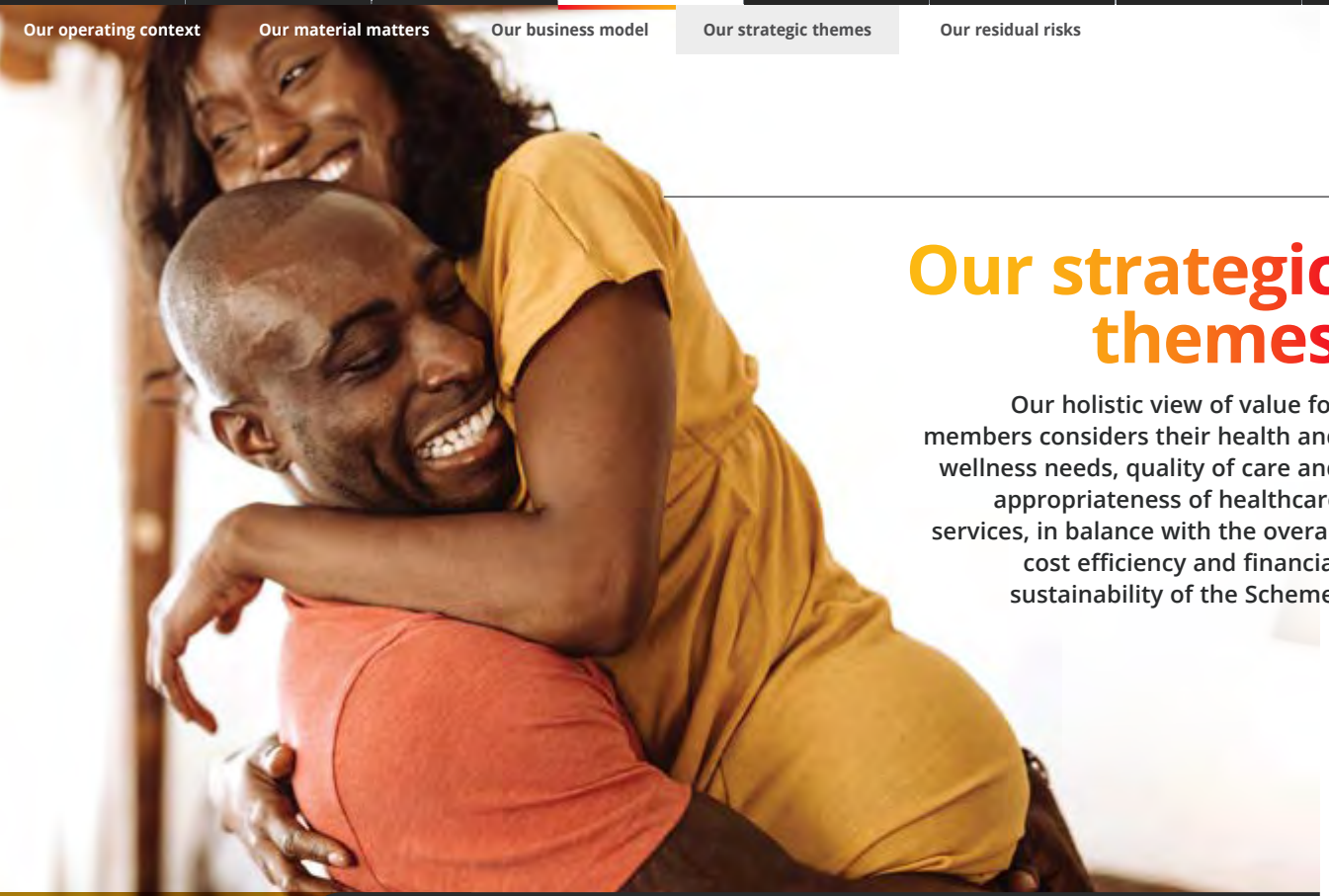
1 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2020, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R1.88 (2019: R2.03) in value from the activities of Discovery Health. As the assessment 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 to perform an actuarial review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2019 to 2020 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.*

4 *Top Brands was not updated in 2021.*



Our strategic themes

Our holistic view of value for members considers their health and wellness needs, 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. 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 mitigates 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. Both include a review of DH'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 lifespans of which 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.

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PERFORMANCE AGAINST OUR STRATEGIC THEMES IN 2021

01 Caring 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. Our funding policies aim to manage healthcare inflation while expanding appropriate interventions in response to our members' needs.

In 2021, we continued our focus on the management of diabetes, mental health, and oncology, among others. COVID-19 has had a particularly negative impact on mental health globally. The pandemic has also caused a deferral of screening and health checks, potentially resulting in delayed diagnosis, advanced disease at diagnosis and complications, with increased cost of treatment, reduced quality of life, and mortality. Additionally, we actively engaged with patient advocacy groups, doctor groups and other stakeholders to work together towards optimal care for our members.

MATERIAL MATTER

COVID-19 PANDEMIC

- Future pandemic preparedness and management.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- Protecting member funds.
- Access, delivery of quality healthcare, affordability and social solidarity for all.

MATERIAL MATTER

MEMBER NEEDS

- Member-centred, value-based, high-quality healthcare journeys.
- Active member participation in their health and wellness.
- Burden of disease and climate change.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- A stronger healthcare system.
- Approach to benefit design and funding models.
- Innovation, efficiency, excellence and value from Discovery Health.

RESOURCES, SUPPORT AND INFORMATION FOR OUR MEMBERS

Performance against our strategic themes in 2021 *continued*

02 Managing the implications of COVID-19

The unpredictable nature of the pandemic, as well as the extensive health, financial, economic and social impacts, continue to underpin much of the work of the Scheme.

In 2021, vaccinations were our key focus as we believe that it is essential for as many South Africans as possible to be vaccinated and ensure that they receive their booster doses in accordance with national guidelines. In leveraging DH's investment in vaccination site infrastructure and targeted campaigns to promote uptake, both Scheme members and non-members were afforded a highly positive and efficient vaccination experience. This resulted in notably higher vaccination rates among DHMS members than the national benchmark, especially in the older, higher-risk groups. At the end of 2021, approximately 80% of members above 60 were vaccinated compared with 69% of that age group as a whole[1].

In 2022, we will continue to promote vaccination, and we will also monitor the introduction of further evidence-based treatments, making these available to our members as need and affordability allows, in accordance with appropriate clinical and funding policies. We remain deeply concerned about deferred screening and healthcare utilisation during COVID-19 and will closely monitor any increased instances of more severe disease which we believe may result.

In 2021, we were the only open medical scheme to freeze contribution increases, thereby returning R2.2 billion of the improved reserves to members without affecting Scheme sustainability. Deferring the 2021 contribution increases to July reduced the increase by 50% to 2.95% on an annualised basis, substantially improving member affordability. We are again able to defer our increases, providing our members with much needed financial relief: we are deferring our increase to October which will mean that members will contribute approximately R5 billion less to the Scheme in 2022, providing them with much needed financial relief. DHMS members will experience an effective increase of under 2% in 2022 when compared to their December 2021 rates.

Looking forward, we believe that it is essential to learn from the COVID-19 experience and as a scheme, a country and a world, to develop improved pandemic preparedness and sound management frameworks for similar health events.

MATERIAL MATTER

COVID-19 PANDEMIC

- Impact of the COVID-19 pandemic.
- Advancements in COVID-19 disease management, treatments and vaccines.
- Shifts in healthcare delivery settings.
- Future pandemic preparedness and management.

1 *Source: https://sacoronavirus.co.za/latest-vaccine-statistics/).*

In 2021, we were the only open medical scheme to freeze contribution increases, thereby returning R2.2 billion of the improved reserves to members without affecting Scheme sustainability.

Performance against our strategic themes in 2021 *continued*

The Scheme's growth, demographics, financial strength, ability to pay claims, and sustainability over the long term are of critical importance to our members.

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.

In 2021, the Scheme successfully amalgamated with Quantum Medical Aid Society (QMAS), increasing our membership as a result, and developed a regional efficiency discount option (EDO) which we believe will fill a niche requirement for affordability and access in suitable parts of South Africa.

We also continue to advocate for the introduction of low-cost benefit options (LCBOs) in schemes, which will similarly assist access for new members in a highly affordable price range.

Our investment strategy received close attention in 2021 and will continue to do so in 2022 as we respond to the level of risk in the economic and scheme environment, driven by COVID-19 and global conflict, and with consideration of responsible investing practices. During 2021, the Trustees adopted an updated Responsible Investing Policy which includes the integration of environmental, social and governance factors in the investment strategy, active ownership activities and investment screening. Our investment managers have a mandate to not only earn excellent returns, but also to use the Scheme's assets to have a positive influence on the world.

In 2022, we will continue to ensure the Scheme's strength and sustainability by pursuing further growth opportunities, and continue to promote the Scheme's responsible corporate citizenship in the context of our society.

MATERIAL MATTER

MEMBER NEEDS
- Burden of disease and climate change.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS
- A stronger healthcare system.
- Approach to benefit design and funding models.
- Innovation, efficiency, excellence and value from Discovery Health.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY
- Protecting member funds.
- Access, delivery of quality healthcare, affordability and social solidarity for all.

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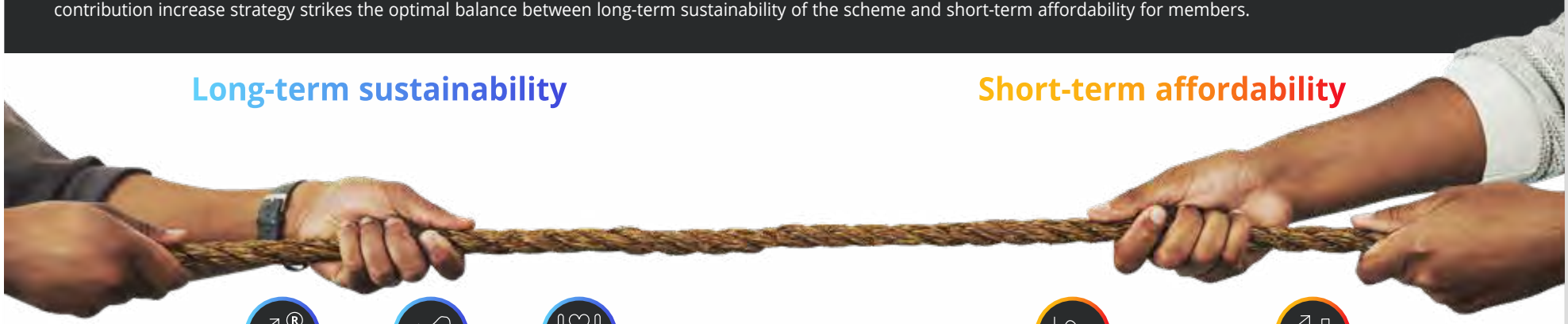
Medical scheme contribution increases must balance long-term sustainability and short-term affordability

When there is uncertainty regarding medical inflation, medical schemes must trade-off long-term sustainability against ongoing affordability when determining the optimal contribution increase strategy. Lower increases favour short-term affordability, but compromises the ability of the scheme to continually meet the costs of claims without high future contribution increases or benefit reductions. Higher increases mitigate the risk of the scheme making operating losses, but over time lead to unaffordable contributions. During a period of uncertain medical inflation, an effective contribution increase strategy strikes the optimal balance between long-term sustainability of the scheme and short-term affordability for members.

Long-term sustainability

Short-term affordability



Tariff | Demographic risk | Utilisation

COVID-19 economic effects | Gradual economic recovery

Medical schemes that are sustainable in the long term ensure that contributions continually meet the costs of healthcare claims without the need for future contribution increase "shocks", and that reserves remain above the regulated solvency levels. To remain sustainable in the long term, contributions must increase in line with the expected increase in healthcare claims. Healthcare claims increase each year based on medical inflation factors. The key components which determine medical inflation include tariff inflation, changes in demographic risk and utilisation trends.

The COVID-19 pandemic highlighted the importance of access to healthcare, but also significantly impacted the South African economy. DHMS provided its members with financial relief in 2021 by delaying contribution increases for six months. Although the South African economy showed gradual recovery in 2021, only 40% of employment losses from 2020 have been recovered by mid-2021 and providing financial relief to members remains critical.

The COVID-19 pandemic has created a new demand for COVID-19 healthcare and caused significant volatility in the demand for healthcare not related to COVID-19. This leads to greater uncertainty regarding future medical inflation in a difficult economic environment, and requires a contribution increase strategy for 2022 and beyond that effectively manages the tension between sustainability and affordability for the benefit of members in the short and long term.

DHMS CONTRIBUTIONS | CLAIMS AND INFLATION INFORMATION

Performance against our strategic themes in 2021 *continued*

04 Regulatory and policy developments

The Scheme continues to monitor the progress of work on the National Health Insurance Bill, the Medical Schemes Act Amendment Bill, and various other policies, and conducts extensive and detailed work in responding to them appropriately to promote the best outcomes for members. Industry engagements also take place through our industry body, the Health Funders Association. We believe that strong relationships between regulatory authorities and industry stakeholders is key to these developments, ensuring beneficial enhancements for all.

In 2021, the Scheme continued to engage actively with the CMS on several regulatory and policy matters, including an ongoing series of discussions regarding the Scheme's LCBOs and the Shariah' compliant arrangements. Working closely with the CMS also supported the successful holding of the Scheme's first virtual Annual General Meeting (AGM) in 2021.

The Scheme worked with DH on its response to the Section 59 Investigation Panel's interim report, which found no evidence of intentional, explicit racial bias in any of the processes or methodologies carried out on our behalf by DH, and confirmed that our FWA processes are necessary and justifiable given the significant risk and implications of losses to medical scheme members.

In 2022, the Scheme will continue to engage with regulatory developments and work to enhance stakeholder relationships to promote outcomes which support the success and sustainability of the industry.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Ethical leadership, fairness and social responsibility.
- A stronger healthcare system.
- Impact of inadequate governance, controls and capacity.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- Protecting member funds.
- Opportunities to innovate, compete and support the journey towards universal healthcare.
- Regulatory complexity and policy uncertainty.

05 Governance excellence

The Trustees closely monitor the work of the Scheme Office and DH 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.

Given the COVID-19 restrictions on public gatherings, the Scheme successfully held a virtual AGM and conducted Trustee elections in 2021. A virtual Special General Meeting (SGM) preceded the AGM, at which information regarding the proposed amalgamation with QMAS was presented. The majority of DHMS members present at the SGM voted in favour of the amalgamation. Additionally, the governance and compliance function instituted a comprehensive framework and auditing process for the ongoing management of accreditation for administration and managed care services provided to the Scheme.

Looking forward to 2022, the Scheme will apply frameworks and processes developed, as well as continue to consider and address risks related to governance and compliance.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Ethical leadership, fairness and social responsibility.
- Impact of inadequate governance, controls and capacity.
- Best practice governance and oversight.

Our residual risks

Discovery Health Medical Scheme (DHMS or the Scheme) closely monitors the highly regulated and ever-changing landscape of local and international healthcare industries, ensuring effective identification and mitigation of risks, and enabling 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. A Board-approved enterprise risk management framework, risk appetite framework and statement according to which risks are assessed are in place, and risks are rated according to impact and likelihood on a five-point scale, ranging from low to catastrophic. Through this process, we identify risks which may negatively impact organisational objectives as well as opportunities arising from effectively managing risks that affect the financial, operational and relational wellbeing of the Scheme.

This assessment specifically covers the Scheme's dependence on the resources and relationships represented by the various forms of capital, both those that pertain directly to our core service to our members and business activities, and also more broadly. This ensures that emerging risks are included in the scope of assessment, for instance the impact of climate change on disease vectors of climate change. Risk responses and mitigation plans are developed and monitored by Scheme management, who conduct regular reviews and report to the Risk Committee, to other Board Committees where relevant, and to the Board of Trustees (the Board or the Trustees).

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 into 2022 and beyond, negatively impacting the overall national healthcare system.

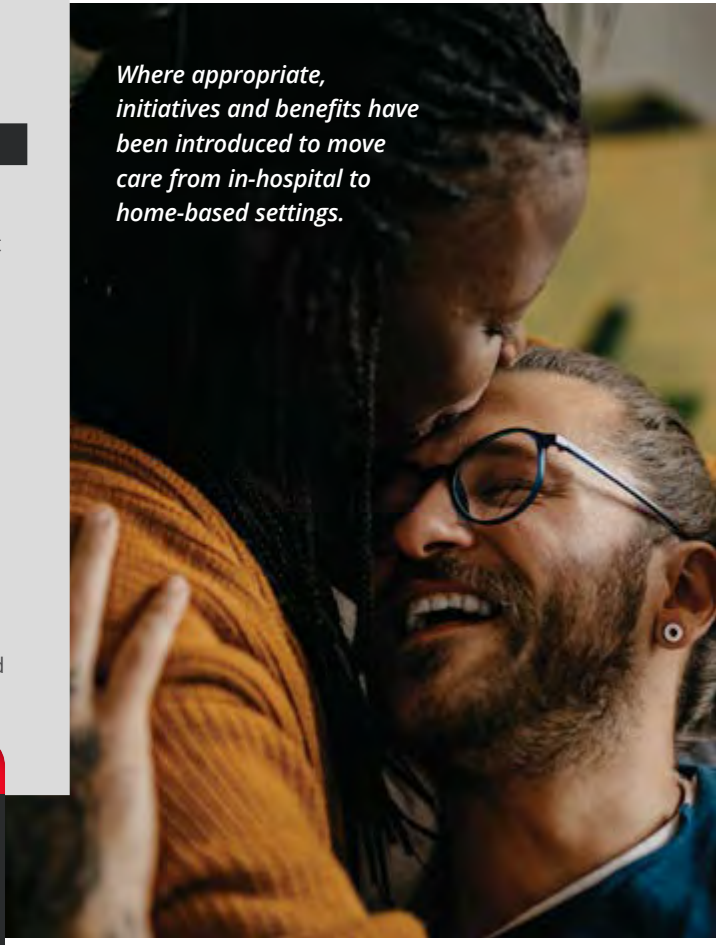
MITIGATING ACTIONS

- The Scheme consistently monitors COVID-19 related utilisation and healthcare trends to enable rapid and proactive responses, and to understand the potential impact of deferred screening and care.
- Through industry bodies and forums, close engagement is held with key stakeholders to formulate and implement response and mitigation plans.
- Where appropriate, initiatives and benefits have been introduced to move care from in-hospital to home-based settings, creating additional hospital capacity, while ensuring that our members receive care even in times of constrained hospital capacity.
- For 2022, the Trustees continue to consider the Scheme's budget and potential expenditure into the next two to three years, given the expected return of utilisation of care and benefits to prior levels and the possibility of more advanced and severe cases, as well as ongoing COVID-19 expenses and the impact of Long COVID.

MATERIAL MATTER

COVID-19 PANDEMIC

- Impact of the COVID-19 pandemic.
- Advancements in COVID-19 disease management, treatments and vaccines.
- Shifts in healthcare delivery settings.
- Future pandemic preparedness and management.



Where appropriate, initiatives and benefits have been introduced to move care from in-hospital to home-based settings.

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 supply-side factors (such as health technology, pricing and provider-driven increases in utilisation), as well as fraud, waste and abuse, driving 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, depending on the approved framework including a minimum benefit package and underwriting considerations amongst others, 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 and offer products currently only available through short-term insurance.

MITIGATING ACTIONS

- Each year, the Trustees critically assess the benefit plans offered by the Scheme to ensure the full spectrum of member needs are met within the bounds of affordability and sustainability. Due to the excess build-up of reserves in 2020, the Scheme was able to delay its contribution increases for 2021 and 2022 to provide relief to members, assisting them to maintain their scheme membership at affordable rates.
- 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 underpinned by a population health management approach, 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 (DH), along with other providers and suppliers, and that the Scheme's budget and expenditure is closely monitored and appropriately managed.
- Risk management interventions are implemented by DH on behalf of DHMS. These are guided by three strategic objectives, to ensure that care is accessed at the most appropriate level between secondary and primary level care, supported by quality health provider networks, and alternative reimbursement models.
- In keeping with the social solidarity principles on which the Scheme operates, active marketing and distribution strategies are developed and implemented to attract and retain members who enable effective cross-subsidisation.
- On behalf of the Scheme, DH actively monitors and negotiates prices of medicines, treatments and services offered to members. This includes evaluating supply chain dynamics and sourcing alternatives where appropriate.
- Engagement with regulators to address concerns and propose appropriate guardrails in regulatory amendments to help protect the sustainability of the Scheme.

MATERIAL MATTER

MEMBER NEEDS

- Member-centred, value-based, high-quality healthcare journeys.
- Active member participation in their health and wellness.
- Burden of disease and climate change.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- A stronger healthcare system.
- Approach to benefit design and funding models.
- Innovation, efficiency, excellence and value from Discovery Health.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- Protecting member funds.
- Regulatory complexity and policy uncertainty.
- Access, delivery of quality healthcare, affordability and social solidarity for all.

Discovery Health Medical Scheme registration number 1125

POLICY, REGULATORY AND COMPLIANCE

RISK DESCRIPTION

Changes in the regulatory environment may adversely impact the operations, strategy and sustainability of the Scheme, or may offer opportunities for improvements. Such changes may result in or exacerbate a potentially contradictory or incomplete regulatory environment. Reforms currently underway could change the structure and operating requirements of the industry, introducing the risk of being assessed as not or only partially compliant with 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 an exchange of information and views, and greater certainty on changes the Scheme must make. This enables the Scheme to develop and implement compliance strategies that are both comprehensive and pre-emptive in anticipation of regulatory changes.
- Proposed 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. Where appropriate, collaborative submissions are made with industry partners and/or representatives.
- The Scheme's views and positions are developed with input from independent advisers and DH'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 submission of considered and well-supported responses to support positive change for the industry.
- Operating in a highly regulated and complex environment requires extensive controls to ensure compliance; the Scheme safeguards compliance in all areas by utilising established and appropriate operational, oversight and assurance processes.
- Regulatory change is monitored closely, and plans are made well in advance of implementation dates to ensure requirements are addressed ahead of time.
- Existing processes are reviewed to ensure continued compliance and responsiveness to external change, with independent assessments commissioned as necessary.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Impact of inadequate governance, controls and capacity.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- Protecting member funds.
- Opportunities to innovate, compete and support the journey towards universal healthcare.
- Regulatory complexity and policy uncertainty.

New processes, systems and controls offering improved risk mitigation are continually assessed and implemented where appropriate.

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 increasing malicious attacks by third parties, is closely monitored by the Scheme's IT Governance Forum, consisting of representatives from the Scheme and DH.
- DH, which provides the Scheme's systems infrastructure and applications, reports extensively on the associated risks, controls and compliance with service levels.
- New processes, systems and controls offering improved risk mitigation are continually assessed and implemented where appropriate.

MATERIAL MATTER

MEMBER NEEDS

- Member-centred, value-based, high-quality healthcare journeys.
- Active member participation in their health and wellness.

MATERIAL MATTER

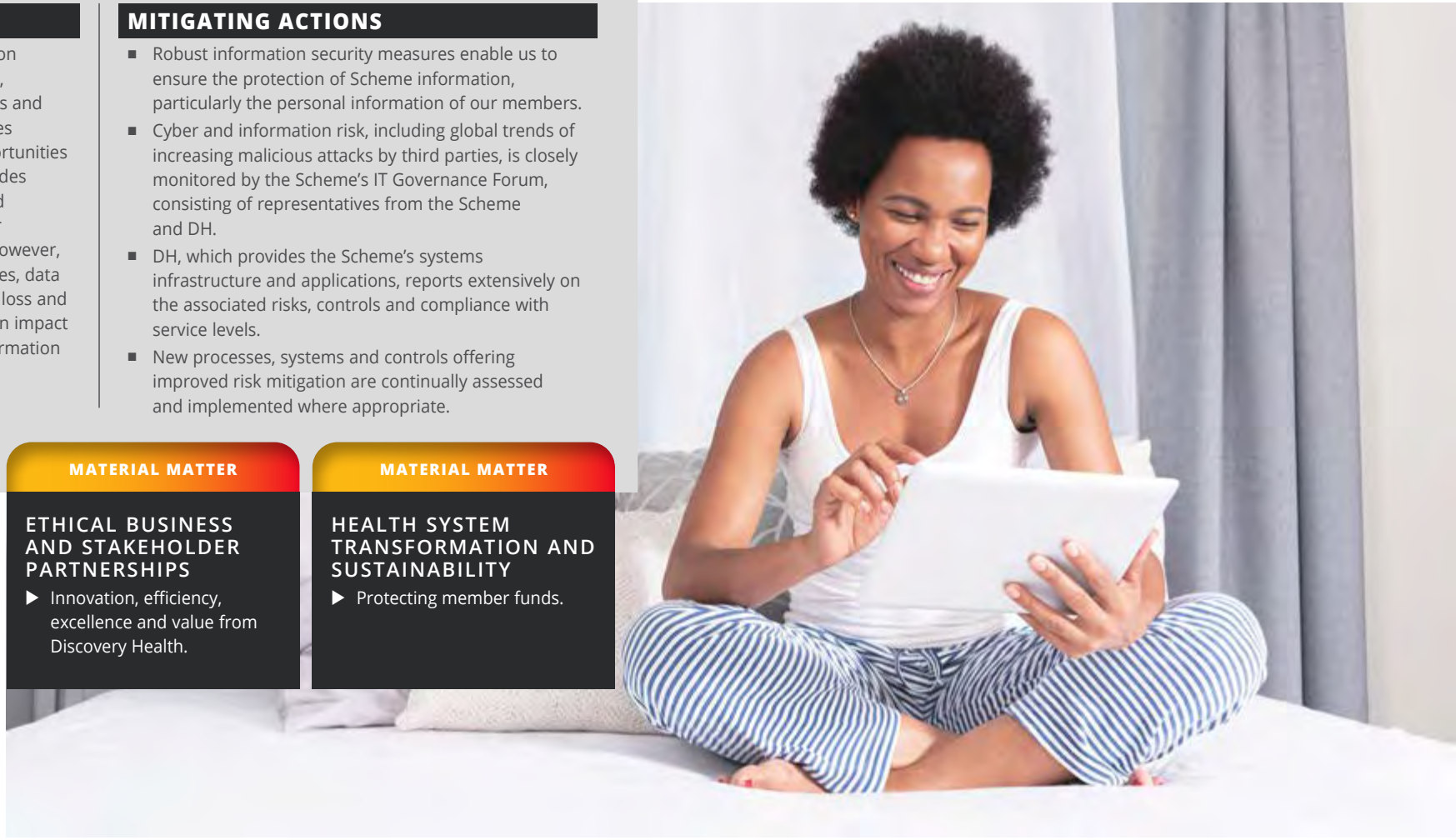
ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

- Innovation, efficiency, excellence and value from Discovery Health.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- Protecting member funds.



Discovery Health Medical Scheme registration number 1125

STAKEHOLDER MANAGEMENT

RISK DESCRIPTION

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

MITIGATING ACTIONS

- The Scheme engages proactively and frequently with all stakeholder groups to understand their needs, engender better understanding of the Scheme and promote alignment with its objectives.
- In principle, the Scheme's approach to stakeholder engagement and working relationships is to attempt to find solutions beneficial to or at minimum acceptable to all parties.
- The Trustees embrace the Treating Customers Fairly (TCF) principles and framework, and receive regular reports on the performance of DH on key TCF indicators, as well as other stakeholder engagements conducted on behalf of the Scheme.
- The Scheme conducts ongoing environmental scanning, and reviews regular reporting to identify possible risks related to our key stakeholders, which may affect business continuity, and develops or amends specific engagement strategies to deal effectively with these.
- The Scheme proactively shares evidence-based information with stakeholders to support their healthcare access and needs, awareness of quality outcomes, regulatory changes, and the non-profit status of the Scheme.
- The Scheme's use of the Vested contracting model in our engagement and working relationship with DH prioritises outcomes beneficial to both parties, which cascade into additional value and quality experienced by our members.

MATERIAL MATTER

COVID-19 PANDEMIC

- Shifts in healthcare delivery settings.

MATERIAL MATTER

MEMBER NEEDS

- Member-centred, value-based, high-quality healthcare journeys.
- Active member participation in their health and wellness.
- Burden of disease and climate change.

MATERIAL MATTER

ETHICAL BUSINESS AND STAKEHOLDER PARTNERSHIPS

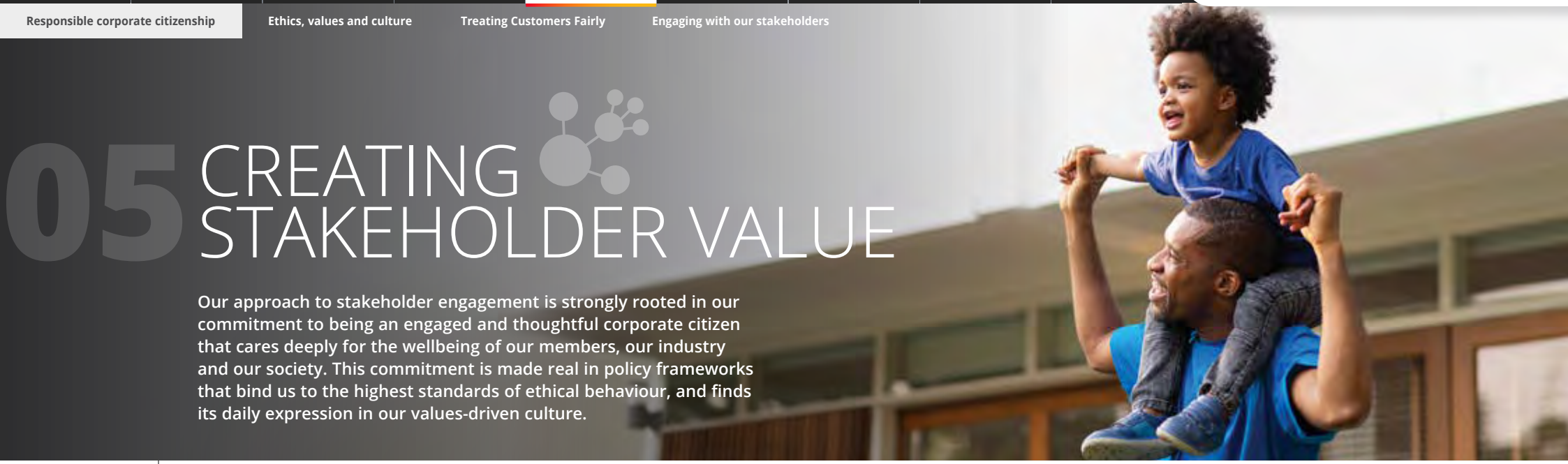
- Ethical leadership, fairness and social responsibility.
- A stronger healthcare system.
- Approach to benefit design and funding models.
- Innovation, efficiency, excellence and value from Discovery Health.

MATERIAL MATTER

HEALTH SYSTEM TRANSFORMATION AND SUSTAINABILITY

- Protecting member funds.
- Opportunities to innovate, compete and support the journey towards universal healthcare.

The Scheme proactively shares evidence-based information with stakeholders to support their healthcare access and needs.



05 CREATING STAKEHOLDER VALUE

Our approach to stakeholder engagement is strongly rooted in our commitment to being an engaged and thoughtful corporate citizen that cares deeply for the wellbeing of our members, our industry and our society. This commitment is made real in policy frameworks that bind us to the highest standards of ethical behaviour, and finds its daily expression in our values-driven culture.

Responsible corporate citizenship

Discovery Health Medical Scheme (DHMS or the Scheme) continuously and extensively engages with our stakeholders.

Our active engagement with them and our responses to their needs are situated within our strategic, long-term approach to responsible corporate citizenship. Over time, our responsible corporate citizenship framework guides us in aligning all our relationships, as well as our broader social investment activities, to our core intention of protecting our members while also contributing to positive reform and developments in society.

In line with the requirements of the King IV Report on Corporate Governance for South Africa 2016 (King IV), the Stakeholder Relations and Ethics Committee is mandated to oversee all aspects of the Scheme's responsibility as a corporate citizen. To help it fulfil its mandate, the responsible corporate citizenship framework includes relevant legislation and governance requirements, Scheme governance and management, ethics, stakeholder engagement, the Scheme's impact on society and vice versa, sustainability, and associated measuring and reporting requirements. The Committee receives regular reports, recommendations and presentations on areas covered by the framework, enabling it to monitor progress and provide input on related activities.

In 2021, the Scheme adopted a revised framework which defines and delineates the principles, parameters, operating requirements and environmental factors pertinent to the Scheme's responsible corporate citizenship approach. The framework serves as a guide for the Board of Trustees, Board Committees and Scheme Office management. The new framework incorporates and extends the Scheme's previous responsible corporate citizenship framework which was adapted from The Ethics Institute and incorporated King IV requirements[1].

1 *Sources: Crane, Matten & Spence (2008). Corporate social responsibility: Readings and cases in global context. London: Routledge. Groenewald & Dondé (2017). Ethics and compliance handbook. Pretoria: The Ethics Institute.*

Responsible corporate citizenship *continued*

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.

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.

During 2021, the Trustees adopted an updated Responsible Investing Policy which integrates ESG factors with the investment strategy, active ownership activities and investment screening. Our investment managers have a mandate to not only earn excellent returns, but also to use the Scheme's assets to have a positive influence on the world.

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

Our ethics, values and culture

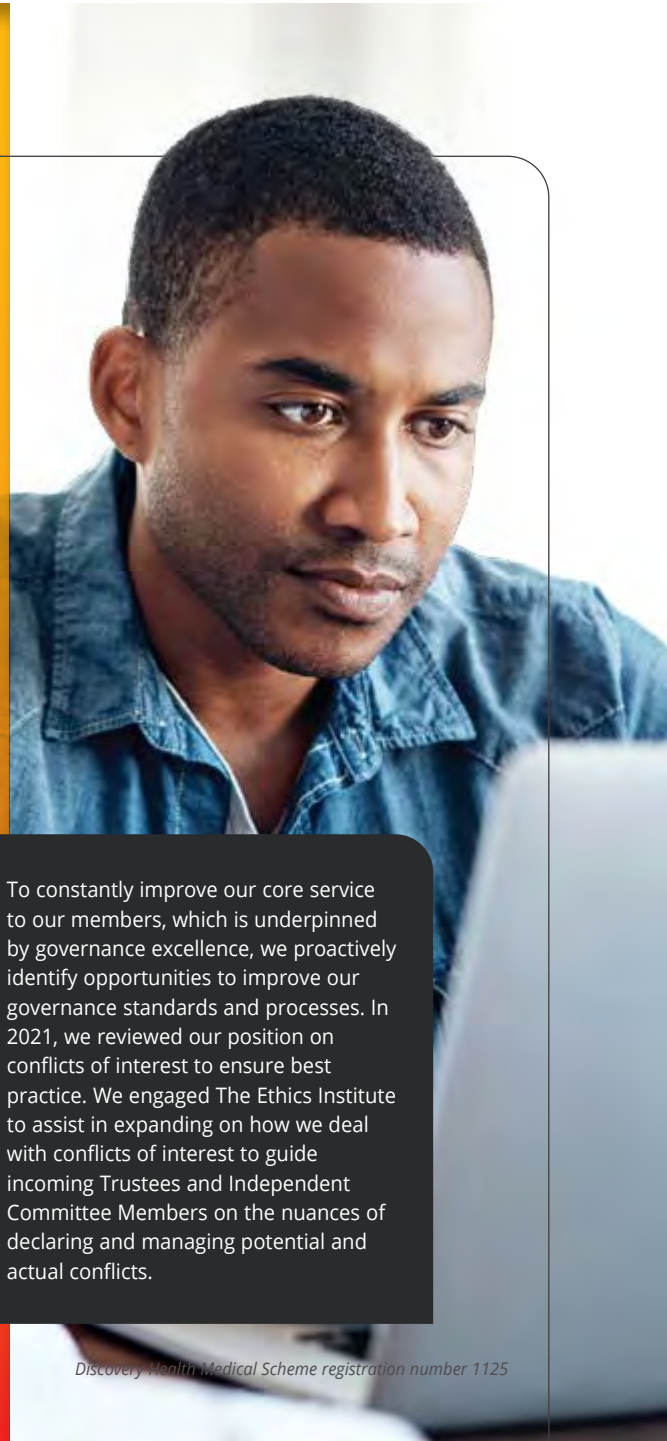
We operate according to the highest ethical standards with relevant policies that are binding on the Trustees and employees of the Scheme. Where appropriate, we also include ethics clauses in our contracts with third parties.

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 areas such as organisational ethics 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]. In 2021, an ethics risk and opportunity assessment of the Scheme's recruitment function was carried out, and the processes were found to be fair, ethical and well communicated.

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.

REPORTING UNETHICAL BEHAVIOUR



To constantly improve our core service to our members, which is underpinned by governance excellence, we proactively identify opportunities to improve our governance standards and processes. In 2021, we reviewed our position on conflicts of interest to ensure best practice. We engaged The Ethics Institute to assist in expanding on how we deal with conflicts of interest to guide incoming Trustees and Independent Committee Members on the nuances of declaring and managing potential and actual conflicts.

MORAL DUTIES AND ETHICAL VALUES

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

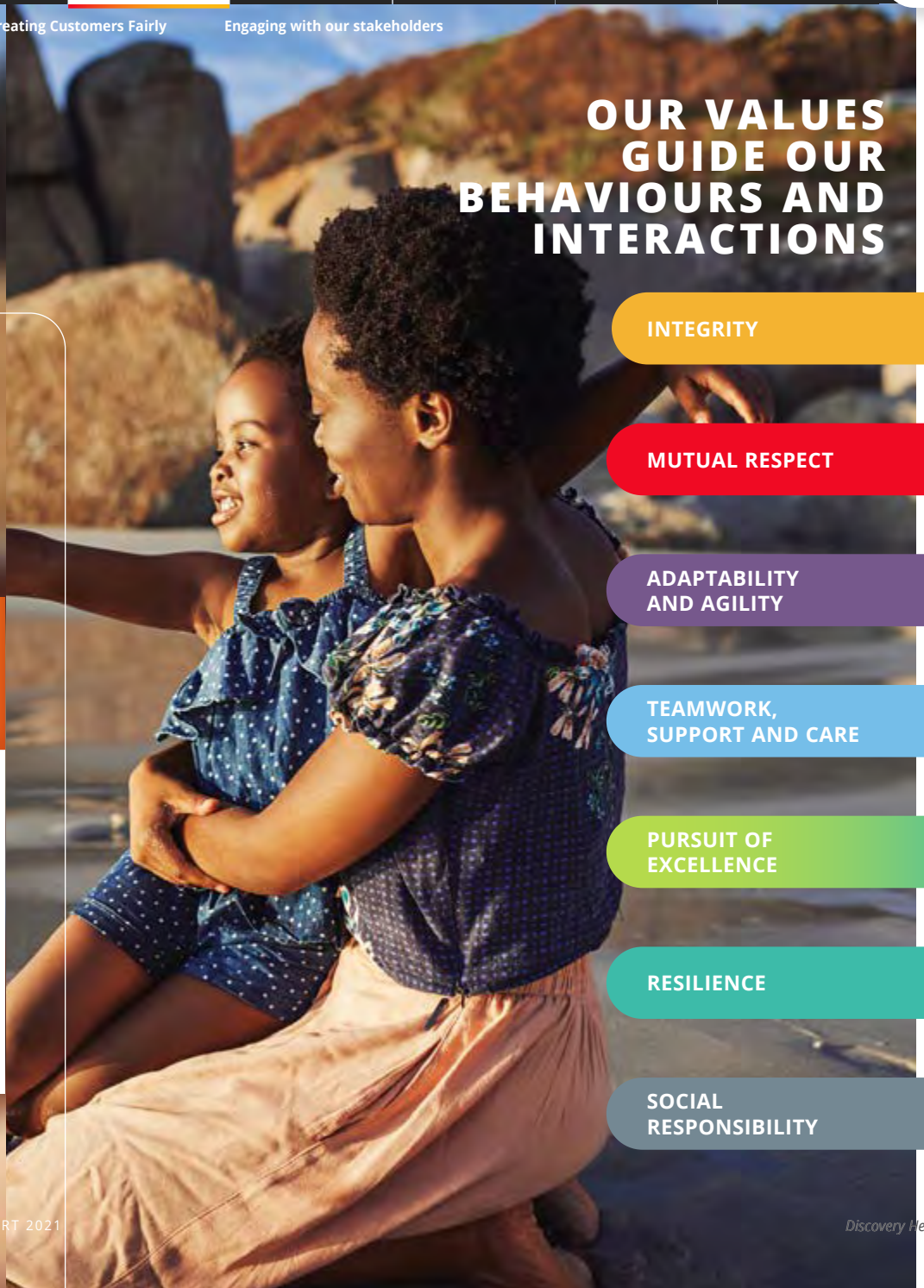
These are articulated in our Governance Framework:

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.

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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 (DH) has implemented a framework to support the following TCF desired outcomes:

- *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 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 for the customer's circumstances.*
- *Service is of an acceptable standard and products perform as expected.*
- *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, DH monitors:

- *Plan movements;*
- *Opportunities for process improvement;*
- *Communication and completion of interactions with members;*
- *Consistency of decisions and delivery;*
- *Correction of errors made;*
- *Embedding of TCF culture;*
- *The total number and content of complaints received; and*
- *The perception scores of members, financial advisers, healthcare professionals and employer groups.*

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

MORE ABOUT TCF

Engaging with our Stakeholders

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

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

The inclusion of a trust rating is in line with key principles of the Vested® outsourcing model which is formally applied in our contractual arrangement with DH and informs our interaction with our other stakeholders. The results of the assessment are reported to the Committee, informing 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.

MORE ABOUT VESTED

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

DH has extensive stakeholder engagement capacity and experience; specialised teams respond either to requests and queries received, or engage proactively according to the Scheme's initiatives and industry activity. Material items are presented to executive-level forums on a weekly basis or escalated to the appropriate executives, including the 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 professionals and their societies to increase quality of care, decrease fragmentation and control costs for our members and the Scheme.
- Supporting the Scheme's regulatory and policy engagement through gathering information and working with stakeholders.
- Providing training and support to financial advisers on the Scheme's products.

OUR MEMBERS

We exist for our members, who entrust us with their healthcare funding needs and with facilitating their access to beneficial programmes and treatments. Keeping this top-of-mind, the Scheme aims to manage contribution affordability in a challenging economic context characterised by high healthcare inflation, 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 driving value-based healthcare that places members at the centre of care. In this delivery model, health results are prioritised over the volume of services delivered by reimbursing healthcare professionals based on health outcomes rather than inputs, giving our members access to facilities, programmes and professionals that are committed to continuous improvement in quality healthcare. This approach also encourages healthcare professionals to collaborate in providing holistic, high-quality patient care to our members.

BETTER HEALTHCARE AT LOWER COST? HERE'S HOW IT'S HAPPENING FOR YOU

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

DH'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 the call centre, a chat platform, or the member app. On admission, members have access to benefit specialists in many hospitals throughout the country who facilitate their healthcare journeys and support and advise them on their plan entitlements. Additionally, members can contact the Principal Officer directly if required.

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

Information is also made available on an ad hoc basis in response to specific healthcare concerns. In 2020 and 2021, substantial information on COVID-19, related support available, vaccines, screening and testing procedures was made available on the website. This is updated as new information becomes available.

Various customer satisfaction and operational metrics are monitored to assess whether our members' service expectations are being met. Dissatisfied members can access a complaints and disputes process and, in the case of escalation, these members can elect to have a hearing before an independent Disputes Committee in terms of the Scheme's Rule 27. Alternatively, members may choose to take a complaint to the Council for Medical Schemes (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 2021: 8.76 out of 10 (2020: 8.74). We track members' perceptions of service received at multiple points and locations, including after-claims processes and the call centre. Follow-up surveys are also frequently conducted with members after their interactions with us.

For our members

COVID-19 SUPPORT AND INFORMATION

- BENEFITS AND COVER
- YOUR COVID-19 VACCINATION JOURNEY
- ADDRESSING VACCINE MISINFORMATION AND FEARS
- COVID-19 RECOVERY GUIDE

CARE AT HOME

- CONNECTED CARE SERVICES, INFORMATION AND BENEFITS
- CONNECTED CARE INFORMATION VIDEO
- HOSPITAL AT HOME VIDEO

NEED MORE SUPPORT AND INFORMATION WITH YOUR COVID-19, DIABETES OR HEART DISEASE CONDITION? JOIN OUR PATIENT COMMUNITIES

- ARTICLE
- VIDEO

Continued below

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For our members *continued*

INFORMATION ON SOME SPECIFIC CONDITIONS, BENEFITS AND PROGRAMMES

DIABETES

- THE DIABETES CARE PROGRAMME
- DIABETIC RETINOPATHY SCREENING BENEFIT
- *HEAR FROM A MEMBER*: TREATING DIABETES MEANS TREATING THE WHOLE PERSON

MENTAL HEALTH

- THE MENTAL HEALTHCARE PROGRAMME
- MENTAL HEALTHCARE HUB – TO SUPPORT PARENTS AND TEENS

ONCOLOGY

- ONCOLOGY PROGRAMME INFORMATION
- DISCOVERY'S 10-PART PODCAST SERIES, UNDERSTANDING CANCER, FEATURES SA'S TOP ONCOLOGY EXPERTS, WHO SHARE FASCINATING INSIGHTS TO INFORM AND CHANGE YOUR PERSPECTIVE ON CANCER
- RAISING AWARENESS ON WORLD CANCER DAY

KIDNEY CARE

- KIDNEY DISEASE INFORMATION
- CHRONIC DIALYSIS PATHOLOGY BASKET OF CARE AND CALENDAR
- *HEAR FROM A MEMBER*: TEVIN CELEBRATES ADULT LIFE AFTER A LIFE-SAVING KIDNEY TRANSPLANT AT AGE 12

ASSISTED REPRODUCTIVE THERAPY

- ASSISTED REPRODUCTIVE THERAPY BENEFIT INFORMATION
- *HEAR FROM A MEMBER*: MEET BABY JAXON: BROUGHT INTO THE WORLD WITH A LITTLE HELP FROM THE ASSISTED REPRODUCTIVE THERAPY BENEFIT

HEAR FROM SOME OF OUR MEMBERS:

- JESSICA'S JOURNEY 'LEARNING FROM LUKE'
- CANCER SURVIVOR MARK LOCKWOOD REFLECTS ON THE PANDEMIC'S IMPACT ON MENTAL HEALTH
- BABY MIGHTY MACK'S FIGHT AGAINST ACUTE MYELOID LEUKAEMIA
- HANNAH (5) DEFIES THE ODDS OF FINGER, TOE AND LOWER-LEG AMPUTATIONS CAUSED IN WOMB
- PRINCESS NAKEDI IS A TRIPLE NEGATIVE BREAST CANCER SURVIVOR

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.
- Getting 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 Health Medical Scheme registration number 1125

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 2021, employers were faced with complex challenges in navigating their employees through various COVID-19 outbreaks, ensuring their employees remained safe and protected at all times. 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

During 2021, Discovery Health offered DHMS employers and their employee members a fully integrated corporate health and wellness solution. This 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.
- Facilitation of vaccination for employees, with the launch of five key vaccination sites across the country, accessible to both DHMS and non-DHMS employers supporting the national effort to get South Africans vaccinated against COVID-19. DHMS employers were able to schedule, track and incentivise their employees to get vaccinated using Discovery Health's vaccination sites.
- Digital and physical solutions for wellness screening for various health metrics, allowing wellness specialists to identify members at risk and refer them to appropriate care in a safe environment.
- Discovery Healthy Company, a proactive, digitally enabled employee assistance programme.
- Integrated servicing and reporting for all Discovery Health employer products for improved service experience.

In addition, Discovery Health Medical Scheme offered employers:

- Financial support for members through Discovery Health Medical Scheme's unique contribution freeze for 2021, allowing members and employees to maintain their cover at 2020 rates for the first 6 months of 2021.
- Extended financial support for 2022 through an additional contribution freeze until October, meaning that members will contribute approximately R5 billion less to the Scheme in 2022. DHMS members will experience an effective increase of under 2% in 2022 when compared to their December 2021 rates.
- Thought leadership and guidance around pertinent issues faced by employers, including emerging COVID-19 and non-COVID-19 healthcare trends, protection of vulnerable employees and mandatory vaccination considerations.
- National training on product and benefit enhancements for 2022 to key decision makers of employer groups, supported by comprehensive employee training sessions.

1 *Based on annual Global Credit Ratings reports for the six largest medical schemes that subscribed in 2018.*

Discovery Health offers DHMS employers and their employee members a fully integrated corporate health and wellness solution.

HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES

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

Healthcare professionals (HPs) are central to the healthcare system and therefore a key stakeholder of the Scheme. This group was again severely affected by the COVID-19 pandemic during 2021, with these effects magnified by political and economic uncertainty and the emergence of transformational technologies challenging entrenched care delivery norms. Tragically, several HPs have succumbed to the pandemic while others, including senior leaders in the profession, have either partly or fully retired. Despite these challenges, the Scheme together with DH are acknowledged to have played an important role in supporting the profession to navigate structural change and has provided supportive benefits since the first COVID-19 case in March 2020.

Stakeholder engagement is crucial to understanding the profession and forming close relationships with medical societies and management groups that will enable us to co-create and implement programmes that keep pace with healthcare innovation, and assure the sustainability of medical practice and funding resources. DH provides DHMS with an avenue to engage the HPs on administrative, reimbursement and clinical matters, and for extensive engagement with umbrella organisations and medical societies to address both macro healthcare issues and those unique to individual disciplines.

During 2021 HP engagement included the following associations, as well as engagement with individual professionals:

South African Orthopaedic Association
Paediatric Management Group
SASA
Faculty of Consulting Physicians of South Africa
SASOG
SASCI
Society of Neurosurgeons of South Africa
SASES
South African Urological Association
ENT
Ophthalmology Management Group Ltd
SA Heart

Healthcare professionals (HPs) are central to the healthcare system and therefore a key stakeholder of the Scheme.

LOOKING BACK AT 2021

During 2021, the atypical environmental conditions of COVID-19 saw the team focusing on supporting patients and practices with COVID-19 care while also considering needs for access to non-COVID-19 related essential services. The overburdening of traditional facilities with COVID-19 patients necessitated the adoption of new approaches and settings of care.

For specialist disciplines, in-rooms initiatives were launched for certain minor surgical procedures that are considered safe and appropriate to be performed in an in-rooms setting. Specialists are reimbursed for the defined list of procedures at an enhanced professional fee funded from the Scheme in lieu of the more cost-effective setting of care; the choice of setting remains strictly at the discretion of the treating doctor, in consultation with their patient, and there is no change to the existing acute hospital benefits where that setting is more appropriate.

Despite some hospitals reaching capacity during the third wave of infections, HPs were able to treat COVID-19 positive patients through the Connected Care for members at home benefit. For qualifying members presenting with COVID-19 infection, Connected Care at Home offers hospital-level care at home or early hospital discharge, instead of hospitalisation. The benefit is available on all DHMS plans.

It is evident that a group of early adopter practices have adjusted to the current environment conditions and thrived despite prevailing challenges. We express our deep appreciation to the profession for leading the pandemic response.

Healthcare professionals and professional societies *continued*

LOOKING FORWARD TO 2022

Building on progress made in 2021, we will offer participation in new initiatives focused on strengthening the relationship between doctors and patients, and providing access to new care delivery approaches that have become increasingly prevalent through the pandemic.

Primary healthcare professionals' role in managing members' chronic conditions

Global data demonstrate that a strong relationship between patients and primary healthcare doctors improves both continuity and co-ordination of care. The World Health Organisation reports that patients who consistently saw the same doctor had 13% fewer hospital admissions and 27% fewer visits to emergency departments. This is particularly important for those living with chronic or complex conditions.

In recent years general practitioners have taken active steps to promote stronger ties between primary care practices and patients to unlock similar healthcare gains. In 2022, we will begin aligning with this global best practice. All DHMS members with registered chronic conditions will be required to nominate a primary care doctor in the relevant DH General Practitioner (GP) Network for their chosen plan type to create a consistent doctor-patient relationship and to empower GPs to deliver outstanding first-line healthcare.

During 2022, the Scheme will embark on extensive communication with the primary care doctor community and Scheme members, and provide automated means to facilitate the GP nomination process. For instance:

- KeyCare members must nominate a primary GP from the KeyCare GP Network.
- Smart Plan members must nominate a GP from the Smart GP Network.

Healthcare at home

COVID-19 has accelerated adoption of digital and online healthcare services and technologies by patients and HPs, both globally and in South Africa. Following the endorsement of telemedicine and the implementation of related guidelines by the Health Professions Council of South Africa, virtual consultations increased substantially, allowing essential medical services to continue even when regional healthcare systems were overwhelmed by COVID-19 patients. Virtual consultations helped to keep patients and healthcare professionals safe, while the rapid expansion into acute in-home care ensured there was continuity of care for members living with chronic diseases.

MORE ABOUT CARE AT HOME

Accelerated digitisation enables the healthcare system to deliver hospital level of care at home

Leveraging technology and multiple global learnings, we have extended virtual care capabilities, enabling local doctors to be at the forefront of another strongly emerging global trend: offering care at home. Doctor partnerships, in conjunction with sophisticated remote home monitoring and support by skilled homecare clinical staff, enable care in the comfort of a patient's own home. This is available for a subset of eligible patients and conditions, in addition to COVID-19 care, where the attending doctor is comfortable with the safety and appropriateness of remote care.

Healthcare professionals and professional societies *continued*

SHOWCASING OUR CARE PROGRAMMES

Discovery Health Arthroplasty Network (DHAN)

Since its inception in 2018, the DHAN serves over 96% of arthroplasty procedures within DHMS. The network is remunerated under a global fee which includes hospital, surgeon, anaesthetist, physiotherapist, and prosthesis fees, with all other costs billed on a fee for service basis.

Data shows that while the rate of arthroplasty undertaken is increasing in the DHMS membership base, there have been reductions in length of stay, the need for acute care and close monitoring and re-admission rates. The programme has provided insights into new metrics like early revision rates, which appear to be higher than international benchmarks and hence a good area of focus for society peer discussions in this area.

While patient-reported outcome measures (PROMs) data is increasing in volume, it remains difficult to include and assess at a surgeon level due to the response rates tailing off at each milestone. There is work underway to improve response rates from patients to enhance data utility.

Same-day arthoplasty

A pilot of same-day discharge surgery (SDDS) arthroplasty was successfully undertaken in 2021 with Surge, a group of orthopaedic surgeons, with promising results:

The move to same-day discharge surgery (SDDS) is well established around the world. SDDS is no longer a pathway only suitable for the more minor procedures like cataracts and hernias, but also for major procedures like arthroplasty or spinal surgery. For arthroplasty, it is estimated that up to 60% of elective cases can be safely discharged on the same day.

Surge has developed a multi-disciplinary team to enable a same-day discharge patient pathway for elective hip and knee replacement.

Results of the pilot are very encouraging. Surge doctors allocated 70% of DHMS arthroplasty procedures to the SDDS pathway and all these patients were successfully discharged on the same day. These patients had a 90-day re-admission rate of only 3.6%, comparing favourably to the overall arthroplasty network rate of 4.5% at 30 days.

Early PROMs data demonstrate encouraging results, including improvements in hip disability and osteoarthritis outcome scores, knee injury and osteoarthritis outcome scores, and early return to function. More than 90% of patients indicated that the treatment met their expectations at six and 12 months and 86% stated they would opt for SDDS if they needed arthroplasty again.

Length of stay (LOS) (days)

2020: **4.01**

2009: **6.73**

2.7 days

% of procedures with LOS ≤1 days

2020: **4.83%**

2009: **0.0%**

4.8%

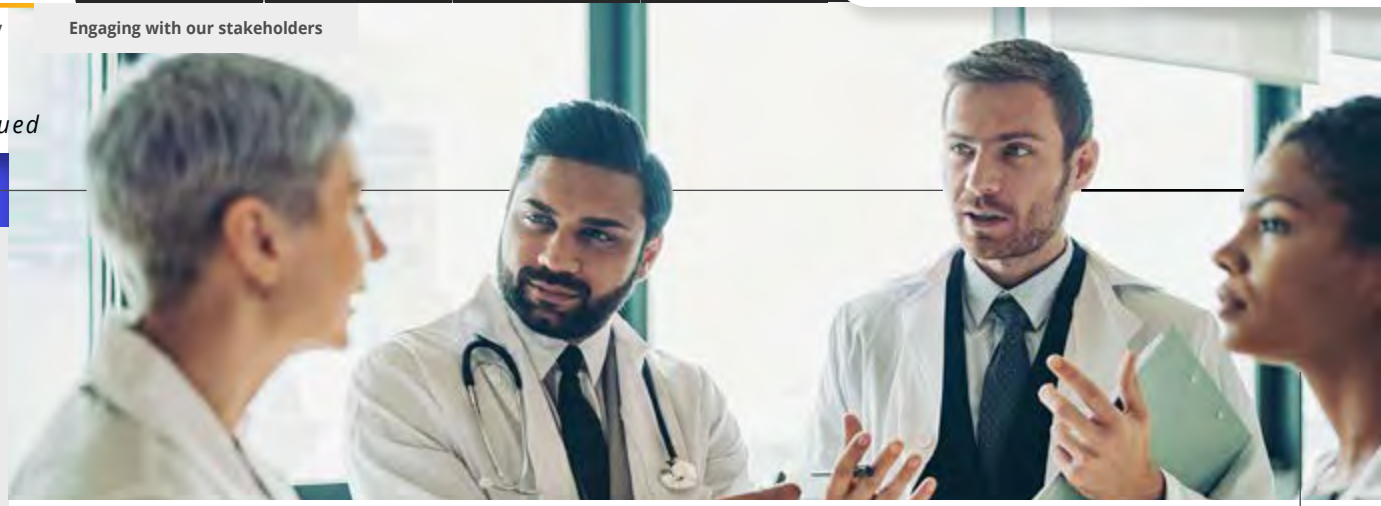
30-day readmission rate

2020: **4.5%**

2009: **7.11%**

37%

Healthcare professionals and professional societies *continued*



For healthcare professionals

RESOURCES

THE HEALTHCARE PROFESSIONAL ZONE

The Healthcare Professional Zone (HP Zone) is for healthcare professionals. It provides 24/7 access to tools to help you manage your practice as well as access to important patient information to facilitate co-ordination of patient care.

DISCOVERY HEALTH INSIGHTS

Research data and actuarial expertise across COVID-19 and other trends in healthcare.

SUPPORT FOR YOUR PATIENTS: GET AN ONLINE SECOND OPINION ABOUT THEIR CONDITION AND TREATMENT FROM GLOBAL MEDICAL EXPERTS

INTERNATIONAL SECOND OPINION SERVICES

DOCTORS CAN ACCESS REWARDS THROUGH THE DISCOVERY DOCTOR RESILIENCE SUITE

COVID-19

CLINICAL GUIDELINES AND RESOURCE DOCUMENTS

WEBINARS AND PODCASTS

HEAR FROM A DOCTOR:
GP EXPLAINS VALUE OF VIRTUAL CONSULTATIONS IN MANAGING COVID-19

HEAR FROM A DOCTOR:
COVID-19 VACCINE BRINGS HOPE TO GROOTE SCHUUR HOSPITAL - DR KHATIJA KADWA

SHOWCASING INNOVATIONS IN HEALTHCARE DURING THE PANDEMIC

SOUTH AFRICA'S SCIENTISTS BOOST GLOBAL FIGHT AGAINST COVID-19

OxERA - A SOUTH AFRICAN INVENTION

MEET QUINTIN, A BOT THAT GIVES COVID-19 PATIENTS IN ICU HOPE

SUPPORTING YOUR PATIENTS: THEY CAN JOIN PATIENT COMMUNITIES FOR THEIR COVID-19, DIABETES OR HEART DISEASE CONDITION

ARTICLE

VIDEO

CARE AT HOME

CONNECTED CARE SERVICES, INFORMATION AND BENEFITS

CONNECTED CARE INFORMATION VIDEO

HOSPITAL AT HOME VIDEO

HOW ARE CUTTING-EDGE MEDICAL DEVICES LIKE TYTOHOME REVOLUTIONISING THE FUTURE OF ONLINE DOCTOR CONSULTATIONS?

WHAT DOCTORS SAY ABOUT TYTOHOME

TYTOHOME DEVICE VIDEO

HEAR FROM A DOCTOR:
DR SUDESHAN GOVENDER: NOW, TELEHEALTH IS SAVING LIVES

Continued below

INFORMATION ON SOME SPECIFIC CONDITIONS, BENEFITS AND PROGRAMMES

DIABETES

THE DIABETES CARE PROGRAMME

DIABETIC RETINOPATHY SCREENING BENEFIT

HEAR FROM A MEMBER:
TREATING DIABETES MEANS TREATING THE WHOLE PERSON

MENTAL HEALTH

THE MENTAL HEALTHCARE PROGRAMME

ONCOLOGY

ONCOLOGY PROGRAMME INFORMATION

DISCOVERY'S 10-PART PODCAST SERIES, UNDERSTANDING CANCER, FEATURES SA'S TOP ONCOLOGY EXPERTS, WHO SHARE FASCINATING INSIGHTS TO INFORM AND CHANGE YOUR PERSPECTIVE ON CANCER

KIDNEY CARE

KIDNEY DISEASE INFORMATION

CHRONIC DIALYSIS PATHOLOGY BASKET OF CARE AND CALENDAR

ASSISTED REPRODUCTIVE THERAPY

ASSISTED REPRODUCTIVE THERAPY BENEFIT INFORMATION

Discovery Health Medical Scheme registration number 1125

Healthcare professionals and professional societies *continued*

For healthcare professionals *continued*

HealthID and HealthID 2.0

By placing important patient information at the health professional's fingertips, HealthID provides a more complete view of a patient's health history and test results. This improves patient care and reduces the likelihood of serious medical errors and duplication or unnecessary pathology tests. In addition, HealthID also reduces the administrative burden by making it quick and easy to fill in Chronic Illness Benefit applications and obtain the relevant scheme formulary list.

HealthID 2.0 gives a holistic view of a patient's health information which facilitates effective and efficient patient care, enabling better patient outcome. The platform reduces administration by assisting with electronic scripting and referrals.

FIND OUT MORE ABOUT HealthID AND ACCESS IT HERE

AND FIND OUT MORE ABOUT HealthID 2.0 HERE

DISCOVERY PAY
A NEW APPROACH TO PAYING FOR HEALTHCARE[1]

For DHMS members and healthcare professionals, Discovery has introduced a new, sophisticated, and integrated payments platform that makes direct payments to a provider's practice faster, smarter, and more convenient. Discovery Pay integrates medical scheme reimbursement with the payment infrastructure of Discovery Bank, allowing clients to transact seamlessly across the healthcare system.

In 2022, all DHMS members, whether existing Discovery Bank customers or not, can get access to a Discovery Pay account with no regular monthly fees by downloading the Discovery Bank app. Discovery Pay allows patients to transact across the healthcare system, integrating payments for medical bills across all sources of funding through a simple, intuitive system that consolidates payment sources into an effortless transactional experience for practices and patients.

1 *Discovery Pay is not part of the benefits and services offered by Discovery Health Medical Scheme. Discovery Pay is made available by Discovery Bank Limited, registration number 2015/408745/06. Discovery Bank is an authorised financial services provider (FSP48657) and registered credit provider (NCRCP9997).*

Discovery Health Medical Scheme registration number 1125

FINANCIAL ADVISERS (BROKERS)

The private healthcare industry in South Africa is complex, encompassing different types of healthcare professionals, 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. COVID-19 has created large reserves and divergent pricing strategies between medical schemes. The role of financial advisers has become even more crucial to navigate the additional complexity of the medical scheme environment caused by COVID-19.

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 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 Sector Conduct Authority 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.

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 advisers of Discovery Health for the year was 8.99 out of 10, slightly down from 9.06 for 2020.

ENGAGEMENTS IN 2021

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 financial advisers had access to year-end marketing collateral, including training videos, brochures, articles, FAQs and thought leadership insights informing financial advisers and their clients of updates and benefit changes for 2022.

In addition, national webinars to corporate brokerages at two different times during the year provided further insights on the Scheme's strategies, industry position, financial results, and risk management initiatives.

A COVID-19 information hub and various webinars focused around COVID-19 thought leadership 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.

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

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.

Discovery Health Medical Scheme registration number 1125

DISCOVERY HEALTH (PTY) LTD

DH 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, DH provides administration and managed care services to DHMS, as well as 18 other restricted schemes. Our relationship with DH has enabled the Scheme to become the largest open medical scheme in South Africa.

The Scheme and DH have an arm's length contractual relationship that governs all activities outsourced by the Scheme to DH. During 2022, the managed care and administration agreements with DH will be renewed, subject to final terms being agreed.

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.

DH 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 DH meets agreed strategic and operational requirements.

The agreement between the Scheme and DH contains extensive service level requirements against which the Trustees monitor and measure DH'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 DH 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.

HOW DISCOVERY HEALTH SUPPORTS THE SCHEME'S VALUE CREATION

ADMINISTRATION AND MANAGED CARE SERVICES RENEWAL

OUR EMPLOYEES

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

Employees have access to the Scheme's human resource policies which are also embedded in the Scheme's daily operations. The Principal Officer is accountable for all employee-related matters.

The Scheme employs a small and specialised team which 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. Emphasis is placed on managerial leadership practices to ensure employee engagement and the delivery of their best efforts in alignment with the Scheme's strategic objectives.

Training and development opportunities are regularly identified, and a development plan is in place for all employees, who attend training relevant to their work and their potential within the Scheme.

In the context of a small team offering limited scope for promotion, periodic assessments of the Scheme's value proposition to employees enables interventions to promote staff satisfaction and retention. Additionally, regular performance discussions help employees to maintain focus on the Scheme's strategic objectives, their role objectives and career development.

During 2021, the Scheme continued to focus on supporting the wellbeing of employees and their families. All employees and their dependants[1] have access to Discovery Healthy Company, a comprehensive employee assistance programme, incorporating physical, emotional and financial wellbeing and legal support. Seminars covering key health and wellbeing topics were held for employees, and improvements identified in the 2020 culture survey were implemented.

In 2022, the focus on employee wellbeing will continue, with particular reference to an intended (COVID-19 risk-dependent) hybrid workplace model and employee salaries will be benchmarked to ensure that the Scheme continues to attract and retain appropriate skills and experience.

1 *Dependants are spouses, children, parents, or anyone living in the same household as the main member who are financially dependent on the main member. An employee's dependents can access advice and assistance with episode management, including telephonic support and counselling with a Discovery Healthy Company Coach, legal adviser, debt counsellors or trauma counsellors, and face-to-face consultations with registered psychologists or social workers.*

REGULATORY BODIES

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

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

The Scheme and DH 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 broad-based access to private healthcare, access to more affordable health technology, managing fraud, waste and abuse, and in promoting positive regulatory change. The Scheme also engages in industry-related matters with regulators through our industry representative body, the Health Funders Association (HFA).

COUNCIL FOR MEDICAL SCHEMES

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

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

The Scheme engages actively with the CMS on matters of health policy, application and interpretation of rules, benefit design, Scheme finances and resolution of disputes with members. In 2021, the CMS published 74 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.

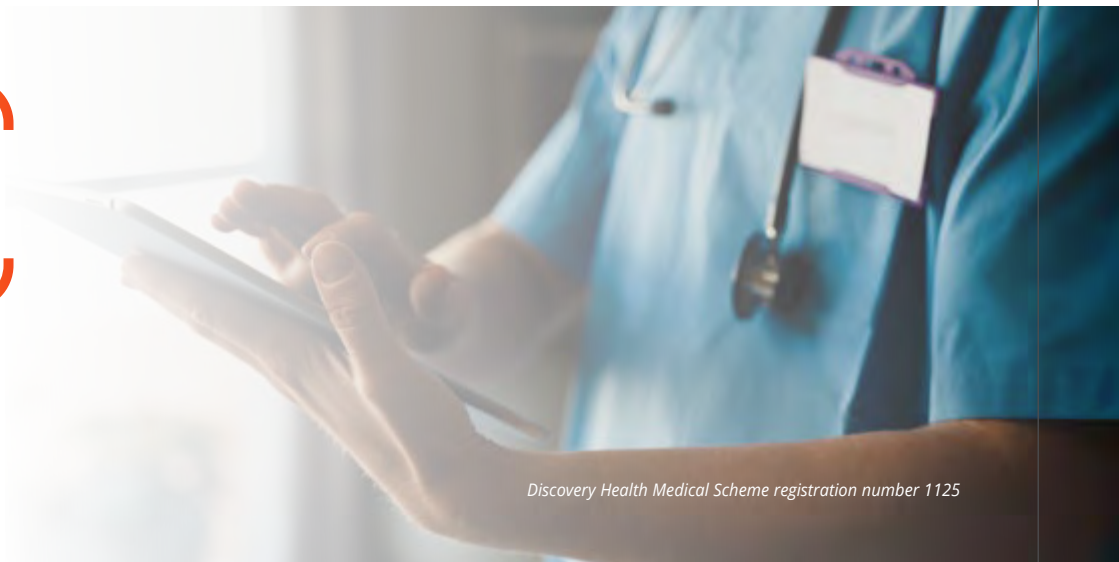
CMS PUBLICATIONS

THE NATIONAL DEPARTMENT OF HEALTH AND THE PARLIAMENTARY COMMITTEE ON HEALTH

The Scheme interacts with the National Department of Health whenever required, either directly or through the HFA. DHMS supports the objectives of universal health coverage as well as the need for the healthcare industry to respond to the needs of its patients within our social, economic and demographic context.

The Parliamentary Committee on Health (PCH) has conducted extensive stakeholder engagements regarding the National Health Insurance Bill, and has received over 100 000 written submissions on the Bill. In late 2021 and early 2022, DH and various other stakeholders made verbal presentations to the PCH, raising a variety of shared concerns including possible Constitutional challenges, the potential impact on the right of access to healthcare, alternative funding models, and inadequate governance structures in the Bill.

Maintaining constructive relationships with our industry regulators is critical to the Scheme's ability to create value.

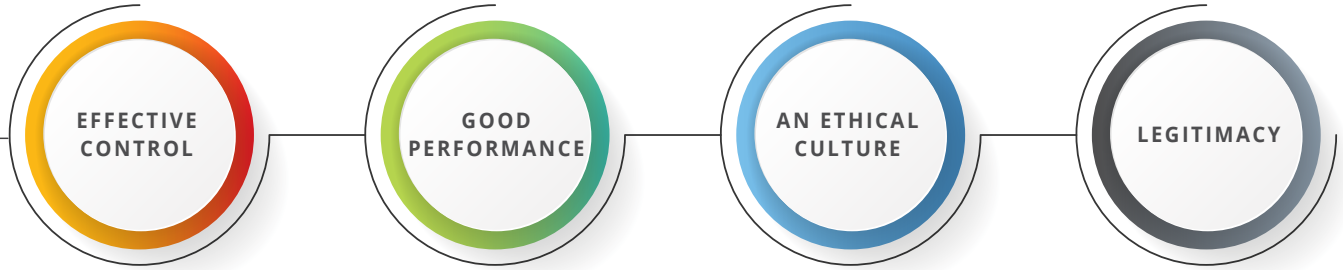


06 GOVERNANCE AND LEADERSHIP

How we are governed

All medical schemes in South Africa are governed by the Medical Schemes Act (the Act). Discovery Health Medical Scheme (DHMS or the Scheme) Rules are developed in accordance with the Act and 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 Board of Trustees (the Trustees or the Board) embrace the principles of King IV in achieving optimal governance outcomes for the Scheme and within the Scheme environment. 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 and policies.

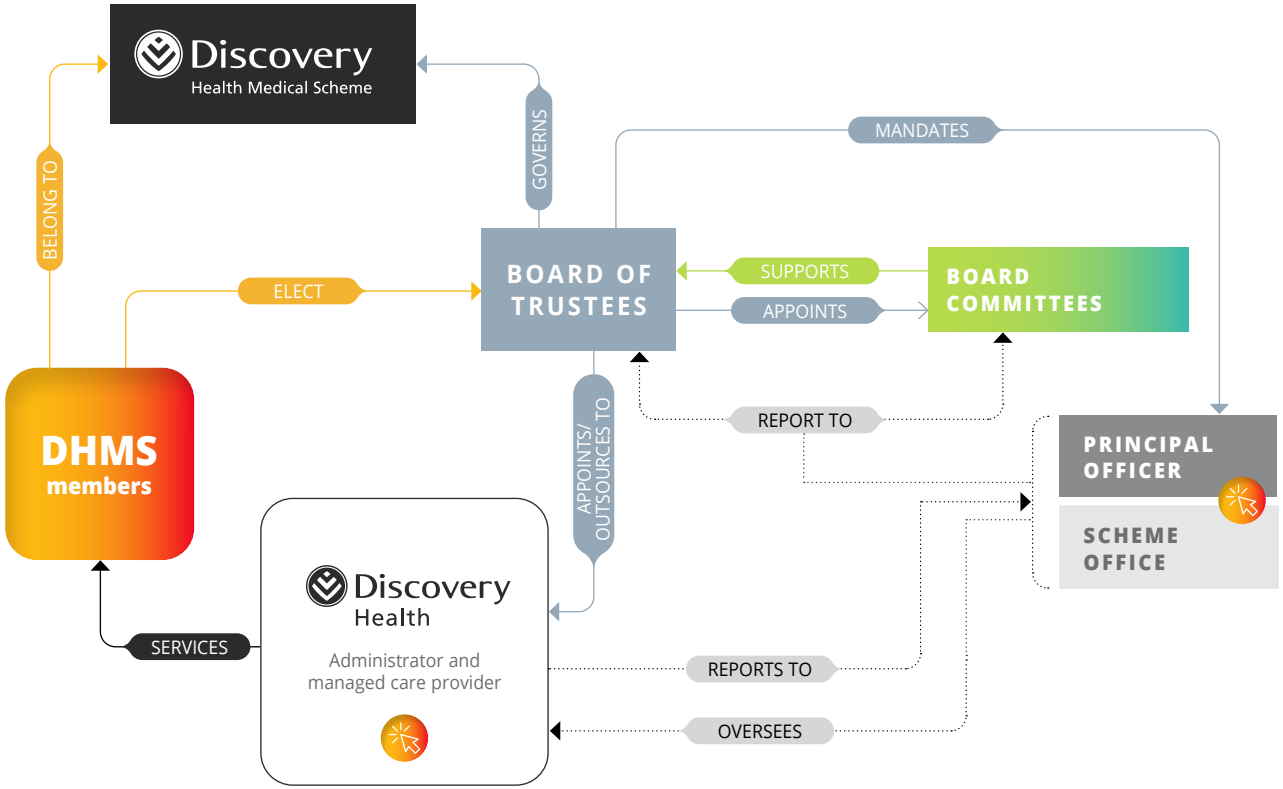
The Trustees' overriding objective is to ensure that the best interests of Scheme members are served equitably, while safeguarding the sustainability of the Scheme. The Trustees are accountable to the Scheme's members.

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

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

The Trustees dedicate a significant amount of time and effort to their fiduciary duties, well beyond meeting attendance, to ensure effective leadership.

Our governance structures



COMPOSITION AND FUNCTIONING

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

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

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

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 their impact on the Scheme's reputation.

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

OUR APPROACH TO REMUNERATION

BOARD EVALUATIONS

As of 2022 the Board is assessed annually, 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 to develop a plan and recommend actions for the Board. All applicable recommendations have been implemented, with the next evaluation to be conducted in November 2022.

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

TRUSTEE TERMS

Name of Trustee or Board Committee Member	Designation	Appointed/Elected	Start of Term	End of Term
Mr David King	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Dr Dhesan Moodley	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Mr Neil Morrison[1]	Trustee	Elected	23 Jun 16	22 Jun 19
	Trustee	Elected	20 Jun 19	22 Jun 22
Ms Joan Adams SC[2]	Trustee	Elected	22 Jun 17	21 Jun 20
Mr Johan Human	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
Mr John Butler SC[1]	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 Jun 23
Dr Susette Brynard[2]	Trustee	Elected	22 Jun 17	21 Jun 20
	Trustee	Elected	01 Sep 21	31 Aug 24
Mrs Lalita Harie	Trustee	Elected	01 Sep 21	31 Aug 24

1 Mr Morrison resigned as Chairperson of the Board of Trustees effective 31 December 2021, and Mr Butler was appointed Chairperson effective 1 January 2022.

2 The terms of Ms Adams and Dr Brynard were extended until such time that the joint 2020/2021 AGM was held on 30 August 2021. The 2020 AGM and Trustee elections due to be held at it were postponed due to COVID-19.

2021 MEETING ATTENDANCE RECORD

Board Meetings attendance in 2021

		28 Jan[A]	22 Feb	23 Feb	14 Apr	11 Jun	18 Aug[A]	26 Aug	21 Sep[A]	02 Nov[A]	18 Nov	08 Dec[A]
Trustees	Mr Neil Morrison (Chair) *	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Dave King	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
	Dr Dhesan Moodley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ms Joan Adams SC ▫	✓	✓	✓	✓	✓	✓	✓	–	–	–	–
	Mr Johan Human	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr John Butler SC %	✓	✓	✓	✓	✓	✓	✓	✓	–	x	✓
	Mrs Lalita (Gita) Harie ◊	–	–	–	–	–	–	–	✓	–	✓	✓
	Dr Susette Brynard ~	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
Chairperson: Audit Committee	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
Independent Members	Dr Alewyn Burger # ∞	–	✓	–	–	–	–	–	✓	–	–	–
	Mr Ndumiso Luthuli #	–	✓	–	–	–	–	–	–	–	–	–
	Dr Nonkululeko Mlaba #	–	✓	–	–	–	–	–	–	–	–	–
	Dr Selma Smith #	–	✓	–	–	–	–	–	–	–	–	–
	Mrs Sue Ludolph # ∞	–	✓	–	–	–	–	–	✓	–	–	–

A - Ad hoc meetings:

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

- *A meeting was convened on 28 January 2021 to discuss the Scheme's COVID-19 vaccination strategy.*
- *A meeting was convened on 18 August 2021 to discuss the 2021 Annual General Meeting (AGM) motions.*
- *A joint Board, Audit and Product Committee meeting was convened on 21 September 2021 to discuss the proposed Scheme Rule amendments for 2022.*
- *A Board task team was convened on 02 November 2021 to discuss the 2022 operating budget.*
- *A meeting was convened on 08 December 2021 to discuss the renewal of service agreements in place with Discovery Health.*

* *Mr Morrison resigned as Chairperson of the Board of Trustees effective 31 December 2021.*

% *Mr Butler appointed as Chairperson of the Board of Trustees effective 01 January 2022.*

▫ *Initial term of 3 years ended on 21 June 2020; however due to Covid-19 and lockdown restrictions at the time, an exemption was received from the CMS to have the term extended until such time that the joint 2020/2021 AGM was held on the 30th of August 2021. Ms Joan Adams was not re-elected to serve as a trustee.*

◊ *Elected as a Trustee effective 01 September 2021.*

~ *Term ended on 21 June 2020; however due to COVID-19 and lockdown restrictions at the time, an exemption was received from the CMS to have the term extended until such time that the joint 2020/2021 AGM was held on the 30th of August 2021. Re-elected as a Trustee effective 01 September 2021.*

\# *Invited to attend the Board of Trustees Strategy Session on 22 February 2021.*

∞ *Requested to attend the joint Board, Audit and Product Committee meeting held on 21 September 2021.*

– *Not required to attend.*

x *Apology tendered.*

Our Trustees[1]

MR JOHN BUTLER SC (55)

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

Chairperson (from 1 January 2022)

Mr Butler SC is a practising advocate and 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 chaired the Stakeholder Relations and Ethics Committee during 2021 but resigned as Chairperson effective 31 December 2021, to allow for his responsibilities as Board Chairperson. He also serves on the Remuneration Committee and previously served on the Audit Committee.

Mr Butler was elected Chairperson of the Board effective 1 January 2022.

MS JOAN ADAMS SC (58)[2]

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

Ms Adams SC has been an advocate for 34 years. She was previously a Senior State Advocate and Senior Family Advocate and served for five years on two presidentially elected Commissions of Inquiry addressing fraud and corruption. She was appointed Senior Counsel in early 2018. She is an accredited forensic practitioner[4] and a member of the Gauteng Society of Advocates and the IoDSA. Ms Adams SC has considerable experience in medical law and ethics, has chaired numerous professional conduct inquiries, and presented various ethics seminars. She is currently in the process of completing the Certified Director qualification at the IoDSA.

She was elected as a Trustee in 2017 and served on the Clinical Governance, Risk, and Stakeholder Relations and Ethics Committees in 2021.

DR SUSETTE BRYNARD (65)

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, and is currently a director of SAMBA, a co-operative buy-aid. She has also been elected to the National Executive Council of Down Syndrome South Africa. She attained her postgraduate degrees cum laude and is doing ground-breaking work on the education and development of learners with Down syndrome internationally, and currently assists the London Down Syndrome Consortium in their research on Alzheimer's disease. She also serves as vice chair of the National Executive Council of Down Syndrome South Africa.

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

MRS LALITA (GITA) HARIE (63)

BA (Social Work), BA (Hons) Social Science (Psychology), Certified Director (IoDSA)

Mrs Harie has more than 40 years' experience in the mental health field, 19 years of which was as executive director of one of the largest mental health non-governmental organisations (NGOs) in the country. She is currently serving as a non-executive director on the Boards and Standing Committees of the Health and Welfare Sector Education and Training Authority, Health Systems Trust and Professional Board for Psychology of the Health Professions Council of South Africa. She has received numerous awards in recognition of her leadership, governance, and innovative services and was selected on two occasions for the International Visitors Leadership Programme (IVLP) by the United States Department of State to visit the USA for mental health programmes, the second visit being as an IVLP Gold Star Alumni participant.

Mrs Harie was elected as a Trustee on 31 August 2021 and serves on the Clinical Governance, Risk, and Stakeholder Relations and Ethics Committees.

1 All ages are at 31 December 2021.
2 Ms Adams' term ended in August 2021.
3 Forensic Practitioner, South Africa.
4 Institute for Commercial Forensic Practitioners, South Africa.

MR JOHAN HUMAN (51)

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

Mr Human has more than 25 years' experience in actuarial and healthcare consulting to large corporate organisations and medical schemes. He is 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 on 5 September 2016. He currently chairs the Product Committee and serves on the Investment and Audit Committees.

MR DAVID KING (58)

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 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 (59)

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 children with conditions such as cleft palate or burns. Previously, he was president of Alexander Proudfoot North America and Africa, CEO of Bluepeter Consulting, partner of Ethos Private Equity Technology Fund, associate partner at Accenture, and principal at Gemini Consulting. He has deep expertise in health insurance and healthcare. His past and present affiliations include the Health Professionals Council of South Africa, South African Medical Association, American Academy of Anti-aging Medicine, Young Presidents' Organisation, World Presidents' Organisation, Black Management Forum of South Africa, and American Chamber of Commerce.

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

MR NEIL MORRISON (65)

BSc (Hons) Physics; MA (Economics)

Chairperson (until 31 December 2021)

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 Audit, Investment and Remuneration Committees, having previously served on the Stakeholder Relations and Ethics Committee. He was elected Chairperson of the Board on 14 August 2017.

As his second term as a Trustee ends in 2022, Mr Morrison resigned as Chairperson effective 31 December 2021 to allow for a handover period and succession planning for the position. Mr Butler was elected Chairperson of the Board effective 1 January 2022.

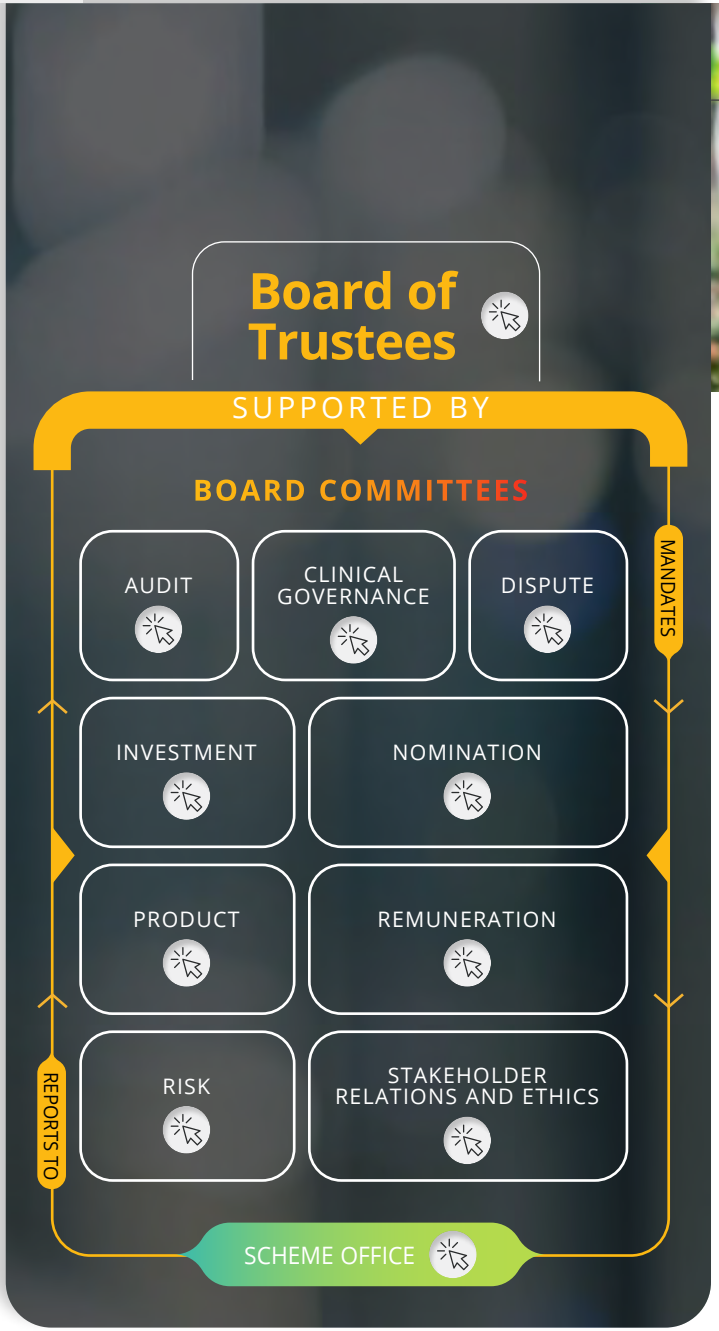
1 Fellow of the Institute of Actuaries UK.
2 Fellow of the Actuarial Society of South Africa.

Board Committees

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

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

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



BOARD COMMITTEE EVALUATIONS

The evaluation of the Board Committees contributes to the effectiveness of the Committees and the Board as a whole, is part of their accountability duties, and allows a greater granularity of governance scrutiny within the Scheme.

On 14 December 2020, DHMS appointed the IoDSA to independently facilitate the Board Committee evaluation. Self-evaluations were conducted by individual Committee Members to assess the performance of the specific DHMS Committees they serve on. Each Committee received an overall score tallied from the individual self-evaluations of its members. These results indicate that our Committees are operating exceptionally well:

Audit Committee 4.7/5.0	**Clinical Governance Committee** 4.7/5.0	**Investment Committee** 4.9/5.0	**Product Committee** 4.5/5.0
Remuneration Committee 4.8/5.0	**Risk Committee** 4.7/5.0	**Stakeholder Relations and Ethics Committee** 4.7/5.0	

All Committees deliberated on the feedback received from the IoDSA and the findings were reported to the Board, together with recommendations for how to enhance performance where necessary.

The Nominations and Dispute Committees were not evaluated by the IoDSA as these two Committees are independent and exclude Trustee representation to maintain impartiality and independence in fulfilling their duties.

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 Medical Schemes Act (the Act). Chaired by an Independent Committee Member, it comprises at least five highly skilled and experienced members with extensive financial, actuarial, governance, legal, and IT governance expertise and knowledge. At least two members of the Committee are Trustees and the majority are Independent Committee Members. The Committee assists the Board in discharging its responsibilities relating to safeguarding assets, operating adequate and effective internal control systems, and preparing fairly presented financial statements in compliance with all applicable legal and regulatory requirements and accounting standards.

The responsibilities of the Committee include:

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

COMBINED ASSURANCE

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

First line	Scheme management (Principal Officer and executives)
Second line	Risk, Compliance, Quality Assurance and Forensics functions
Third line	Internal Audit, appointed external auditors, appointed independent actuaries and other independent assurance providers

The combined assurance assessment showed that adequate assurance was provided and received in respect of all significant risks for the 2021 benefit year. The Trustees are comfortable with the level and type of assurance the Scheme obtains.

ACTIVITIES DURING 2021

The Committee considered the results of the committee effectiveness review conducted by the Institute of Directors South Africa (IoDSA), making changes where required, and 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 2021 have fulfilled its responsibilities in accordance with its terms of reference.

REPORT OF THE AUDIT COMMITTEE

COMPOSITION AND MEETINGS IN 2021

At the end of 2021, the Committee comprised two Trustees and three Independent Committee Members, one of whom chaired the Committee.

During 2021, the Committee met four times and held additional ad hoc meetings. The Audit and Product Committees jointly considered the actuarial valuation and contribution increases for the 2021 and 2022 benefit years; PricewaterhouseCoopers Inc (PwC) and Insight Actuaries, the Scheme's external auditors and independent actuaries, were invited to attend. 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, Scheme management and heads of the outsourced administration functions attend all Committee meetings by invitation, to provide information and insight into their areas of responsibility. They also have unrestricted access to the Chairperson of the Audit Committee.

The Committee may consult any expert or specialist to assist in performing its duties. The Independent Actuarial function is regularly invited to Committee meetings to provide information and assurance in accordance with the applicable agreements in place.

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

Audit Committee attendance in 2021		25 Mar	06 Apr[A]	12 Aug	19 Aug	16 Sep[A]	21 Sep[A]	21 Oct
Independent member/ Chairperson	Mr Eric Mackeown	✓	✓	✓	✓	✓	✓	✓
Committee members	Mr Johan Human (Trustee)	✓	✓	✓	✓	✓	✓	✓
	Mr John Butler SC (Trustee)	✓	✓	✓	✓	✓	✓	✓
	Dr Alewyn Burger (Independent Member)	✓	✓	✓	✓	✓	✓	✓
	Mrs Sue Ludolph (Independent Member) *	✓	✓	✓	✓	✓	✓	✓

A - Ad hoc meetings:

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

- *A meeting was convened on 06 April 2021 to discuss the Actuarial Valuation Report and 2021 Scheme Rule changes.*
- *A meeting was convened on 16 September 2021 to discuss the 2021 audit plan.*
- *A joint Board, Audit and Product Committee meeting was convened on 21 September 2021 to discuss the proposed Scheme Rule amendments for 2022.*

* *Term ended on 31 December 2021.*

FUTURE FOCUS AREAS

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. This includes continuous careful consideration of how the Scheme should balance its solvency requirements against the provision of future COVID-19 and other benefits, managing higher utilisation and keeping contributions affordable.

CLINICAL GOVERNANCE COMMITTEE

While there is no statutory requirement for this Committee, it was established in terms of Scheme Rule 19.3, which gives power to the Board to appoint and delegate authority to a subcommittee consisting of Board members and other experts it may deem necessary. 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 to oversee 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 (DH) in terms of the managed care agreement and therefore has insight into clinical and utilisation risk management, management of clinical exceptions and ex-gratia funding, funding pilot projects, member complaints, appeals and disputes, and health benefit formulation.

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

Additionally, the Committee engages with Health Quality Assessment (HQA), an independent industry body that measures and reports on quality of care in the private medical industry. The Scheme is represented in the HQA Board of Directors and its Clinical Advisory Committee by the Scheme's Chief Medical Officer, and indirectly through DH representatives.

ACTIVITIES DURING 2021

In accordance with its annual work plan, the Committee held four meetings over the course of 2021, through which it provided oversight on key strategic risk management initiatives implemented by DH during the year. To do this, the Committee considered relevant risk intelligence and risk management reports, including key indicators on scheme demographic and claims utilisation risk, and programme-specific reports.

The Committee continued its focus on monitoring the evolution of the COVID-19 pandemic and reviewing the Scheme's response to mitigate COVID-19's impact on members, including access to and funding of vaccines and other appropriate healthcare interventions.

The Committee also sought expert insights to enhance its capability to fulfil its mandate; this included hosting external guest speakers from the National Institute of Communicable Diseases and the Groote Schuur Long COVID clinic to share emerging scientific insights on Long COVID, and an international expert in value-based oncology care.

As per its terms of reference, in support of the Product Committee, the Committee also considered proposed benefits for implementation in 2022 and evaluated these from a medical and health systems perspective.

The Committee considered the results of the committee effectiveness review conducted by the IoDSA and is satisfied that its activities, recommendations and reporting to the Trustees during 2021 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

At the end of 2021, 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 DH's clinical and risk management teams.

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

Clinical Governance Committee attendance in 2021		04 Mar	03 Jun	02 Sep	04 Nov
Trustee/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓
Committee members	Ms Joan Adams SC (Trustee) ▫	✓	✓	–	–
	Mrs Lalita (Gita) Harie (Trustee) ◊	–	–	–	✓
	Ms Nonkululeko Mlaba (Independent Member) ~	✓	✓	✓	✓
	Prof Selma Smith (Independent Member) *	✓	✓	✓	✓
	Dr Unati Mahlati (Chief Medical Officer) %	✓	✓	✓	✓

▫ *Term ended on 31 August 2021 after the Annual General Meeting.*
◊ *Appointed as a Committee Member effective 21 September 2021.*
~ *First term as an Independent Member ended on 27 August 2021. Re-appointed effective 01 September 2021.*
* *Term ended on 31 December 2021.*
% *Scheme Executive. All other Committee members are non-executive.*
– *Not required to attend*

FUTURE FOCUS AREAS

The Committee remains focused on partnering with healthcare professionals to progressively scale up value-based care (VBC) to improve members' health outcomes, while ensuring the sustainability of healthcare professionals and the healthcare system broadly. The Committee monitors and evaluates the impact of benefits, funding policies, and risk management initiatives on members, healthcare professionals and other healthcare professionals. Key focus areas in 2022 will include benefit enhancements and VBC programmes for chronic conditions that impact the Scheme's disease burden and cost drivers such as 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 healthcare delivery models and 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.

DISPUTE COMMITTEE

The independent Dispute Committee hears and adjudicates on all formally lodged member and forensic-related healthcare professional 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 Council for Medical Schemes (CMS) in terms of Section 47 of the Act.

The responsibilities of the Committee include:

- Receiving submissions from members or healthcare professional 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 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.

Access to the Committee is available both to members and to healthcare professionals in respect of forensic (fraud, waste and abuse-related) disputes; the Committee heard its first

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

healthcare professionals' matters in early 2021. Professionals who wish to lodge a dispute about forensic processes and investigations are encouraged to utilise this channel for independent, expeditious and cost-effective resolution of such disputes.

ACTIVITIES DURING 2021[1]

The dispute statistics for the 2021 year were encouraging with the total number of disputes dropping from 757 in 2020 to 699 in 2021, a 7.5% decrease. Of the 699 disputes, two were forensic disputes with the remainder being lodged by members. Of those 697 member-related disputes, 333 were either withdrawn by the member or settled by DH without a hearing being required. During 2021, 23 hearings took place with 27 rulings being issued, the additional four being residual from 2020. Of the 27 rulings, 22 were in favour of the Scheme, two in favour of members and three partially in favour of both parties. Only one dispute ruling was further challenged by the member in the form of a complaint to the CMS, lodged in terms of Section 47 of the Act. Of the two forensic dispute hearings, one resulted in a ruling in favour of the Scheme, and one remains partly heard, requiring further input from the provider.

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 considered the results of the self-evaluations of its effectiveness and is satisfied that it has fulfilled its responsibilities in accordance with its operating framework.

1 *Unlike the other Committees, the Nominations and Dispute Committees do not undergo the IODSA committee effectiveness review as these two Committees are independent and exclude Trustee representation to maintain impartiality and independence in fulfilling their duties.*

COMPOSITION AND MEETINGS IN 2021

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 expertise regardless of the outcome of the hearings. All hearings during 2021 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.

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;

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

- 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;
- Monitoring the Scheme's responsible investing initiatives for compliance with the Responsible Investing Policy; and
- Assisting the Trustees in preparing their annual report on investment performance and compliance.

ACTIVITIES DURING 2021

- 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 overall and ongoing impact of the COVID-19 pandemic on the Scheme 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.
- Monitored the equity benchmark considering the concentration risk arising from Naspers and Prosus and ongoing changes to related equity indices.
- Made additional allocations to the new flexible fixed-income, equity and offshore mandates.
- Transferred assets from the Ninety One Target Return Bond Fund to the Ninety One Multi Asset Credit Fund.
- Given prevailing market conditions and the Scheme's risk appetite, removed the Scheme's equity and foreign currency hedges.
- Adopted a roadmap for the Scheme's responsible investing strategy and recommended an updated Responsible Investing Policy to the Board for approval.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included virtual 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.
- Considered the results of the committee effectiveness review conducted by the IoDSA, making changes where required.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2021 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

At the end of 2021, 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 2021

		18 Feb	06 May	21 Jun[A]	05 Aug	14 Oct
Trustee/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓	✓
Committee members	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓	✓

A - Ad hoc meetings:

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

- *A meeting was convened on 21 June 2021 to review the offshore investments allocation.*

FUTURE FOCUS AREAS

During 2022, 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 and/or appoint suitably fit and proper persons as Trustees or Independent Committee Members. 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 2021 AGM and Trustee election, the Trustees approved the appointment of Deloitte and the independent third-party service provider to assist the Nomination Committee.

ACTIVITIES DURING 2021[1]

The joint 2020-2021 AGM and Trustee elections were held on 30 August 2021. The Nomination Committee oversaw this process from a governance perspective in terms of its mandate. The following activities and this process will continue into 2022, with Deloitte 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 adequate vetting process and procedures are adhered to, ensuring that candidates standing for election are fit and proper. During the process, each nominee is subject to stringent vetting criteria;
- Manage the proxy appointment and vetting processes;
- 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; and
- Overseeing any other aspects that members need to vote on; either via ballot or show of hands.

The Committee reported to the Board on its activities for the 2021 election and fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

The Committees Members' second term came to an end on 30 September 2021. The Board have since appointed new members to the Nomination Committee to serve for a period of three years, effective 1 January 2022, for the purposes of the 2022 - 2024 nominations and elections processes. The Committee comprises three Members who are independent of the Board and Board Committees. Committee meetings are attended by the IEB and its representatives.

FUTURE FOCUS AREAS

The 2022 AGM and Trustee election is scheduled to take place on 23 June 2022. The Nomination Committee will oversee the process, supported by the Scheme's IEB partner, Deloitte, to ensure the independence of the Nominations and election process.

Nomination Committee attendance in 2021		25 Jan	03 Feb	05 Feb	15 Feb	19 Feb	26 Feb	12 Mar	26 Mar	01 Apr	09 Apr	16 Apr	30 Apr	07 May	21 May	27 May	03 Jun	04 Jun	11 Jun	17 Jun	21 Jun	22 Jun	23 Jun	24 Jun	25 Jun	28 Jun	02 Jul	06 Jul	07 Jul	09 Jul	21 Jul	30 Jul	13 Aug	20 Aug	27 Aug	30 Aug	31 Aug	16 Sep
Independent Member/ Chairperson	Mr Peter Goss ▫	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee members	Mr Roy Shough (Independent Member) ▫	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Tom Wixley (Independent Member) ▫	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	x

▫ *Term ended on 30 June 2020, but was extended to end on 30 September 2021 in order to cater for the Scheme's 2020/2021 joint AGM held on 31 August 2021. The deferment of the 2020 AGM was approved through an exemption process by the CMS.*

x *Apology tendered.*

1 *Unlike the other Committees, the Nomination and Dispute Committees do not undergo the IODSA committee effectiveness review as these two Committees are independent and exclude Trustee representation to maintain impartiality and independence in fulfilling their duties.*

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

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 both the legislative and regulatory requirements of the Act, and best practice governance principles pertaining to benefit and product development. The Committee comprises members with the requisite skills including actuarial and medical expertise.

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

ACTIVITIES DURING 2021

The Committee held five Product Committee meetings during 2021. In accordance with the Committee's annual work plan, the Committee considered matters pertaining to the Scheme's research and design strategy, marketing strategy and plan, financial experience and current benefits utilisation. The Committee considered the proposals and actuarial valuation report for 2022 product, benefit and proposed Scheme Rule changes, and having taken cognisance of relevant Clinical Governance Committee and Audit Committee inputs, recommended these to the Board for approval. The Committee continuously monitors developments in the policy and regulatory space, including the proposed National Health Insurance (NHI), and Low-Cost Benefit Options framework development.

The Committee considered the results of the committee effectiveness review conducted by the IoDSA and is satisfied that it has fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

At the end of 2021 the Committee comprised three Trustees, one of whom chaired the Committee and 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 obtains regular reports and presentations from DH, 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 2021		18 Mar	06 Apr[A]	22 Jul	19 Aug	21 Sep[A]
Trustee/ Chairperson	Mr Johan Human	✓	✓	✓	✓	✓
Committee members	Dr Dhesan Moodley (Trustee)	✓	✓	✓	✓	✓
	Dr Susette Brynard (Trustee) ◊	✓	✓	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	✓	✓	✓	✓	✓

A - Ad hoc meetings:

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

- *A meeting was convened on 06 April 2021 to discuss the interim contribution Increase.*
- *A joint Board, Audit and Product Committee meeting was convened on 21 September 2021 to discuss the proposed Scheme Rule amendments for 2022.*

◊ *Re-elected as a Trustee effective 01 September 2021 and re-appointed as a Committee Member effective 21 September 2021.*

% *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 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 has been the case with COVID-19.

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

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. Such recommendations must also be tabled at the Scheme's AGM for approval by Scheme membership. 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 2021

- 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 and Scheme members for approval.
- 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.
- Considered the results of the committee effectiveness review conducted by the IoDSA, making changes where required.
- Considered and recommended the filling of Board Committee vacancies.

As part of the Scheme's 2021 AGM, the Remuneration Committee presented the Scheme's Trustee Remuneration Policy and remuneration consideration for the years 2020 and 2021. The 2020 remuneration considerations were tabled at this AGM due to the national lockdown regulations for COVID-19 preventing the 2020 AGM from being held.

Results of the member vote may be accessed through the below link:

AGM, ELECTIONS AND VOTING RESULTS INFORMATION

The Committee is satisfied its activities, recommendations and reporting to the Board during 2021 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

At the end of 2021, the Committee comprised four Trustees and an Independent Committee Member. The Principal Officer attends Committee meetings by invitation.

Remuneration Committee attendance in 2021

		20 May	11 Nov
Trustee/ Chairperson	Mr Dave King	✓	✓
Committee members	Mr John Butler SC (Trustee)	✓	✓
	Mr Ndumiso Luthuli (Independent Member) ▫	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓
	Dr Susette Brynard (Trustee) ◊	✓	✓

▫ *First term as an Independent Member ended on 17 April 2021. Re-appointed effective 18 April 2021.*

◊ *Re-elected as a Trustee effective 01 September 2021 and re-appointed as a Committee Member effective 21 September 2021.*

FUTURE FOCUS AREAS

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

- Benchmarking to ensure that employee remuneration is commensurate with industry norms and practices.
- Continuing to engage with the Principal Officer and Board on the Scheme's Remuneration Policy and ensuring the appropriateness of remuneration and reward arrangements and/or systems;
- Reviewing the Scheme's remuneration practices where appropriate, and ensuring these comply with changing legislative and regulatory requirements, including those relating to King IV; and
- Continuing to review the Scheme's succession planning processes to ensure that the Scheme can adequately respond to vacancies.

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

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

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 DH to monitor and oversee the outsourced operations, and a compliance monitoring plan is approved on an annual basis.

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

RISK MANAGEMENT

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

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

ACTIVITIES DURING 2021

- Participated in the annual risk assessment, which included representatives of the Committee, the Scheme Office, and the administrator and managed care provider.
- Regularly considered risk management reports and key risk indicators, and reviewed the risk appetite which was recommended to the Trustees for approval.
- Regularly reviewed compliance reports and monitored exposure and actions taken to mitigate compliance risks.
- Received reports to assist in managing the Scheme's IT governance obligations. This included a focus on cybersecurity and business continuity.
- Considered specific compliance and risks related to privacy laws.
- Reviewed the Enterprise Risk Management, IT Governance and Compliance Frameworks and the Financial Crimes Risk Management Policy which were recommended to the Board for approval.
- Reviewed and monitored reports on the service levels delivered by DH.
- Assessed the value added to the Scheme by DH.
- Reviewed the Scheme's non-healthcare expenses against budget.
- Recommended a revised Procurement Policy to the Board for approval.
- Reviewed the Committee's terms of reference.
- Considered the results of the Committee Effectiveness review conducted by the IoDSA, making changes where required.

The Committee is satisfied its activities, recommendations and reporting to the Board during 2021 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

At the end of 2021, 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 DH also attend to provide detailed operational insight.

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

Risk Committee attendance in 2021		11 Mar	29 Jul	12 Aug	21 Oct
Trustee/ Chairperson	Mr Dave King (Trustee)	✓	✓	✓	✓
Committee members	Dr Alewyn Burger (Independent Member)	✓	✓	✓	✓
	Mr Eric Mackeown (Independent Member)	✓	✓	✓	✓
	Ms Joan Adams SC (Trustee) ▫	✓	✓	✓	–
	Mrs Lalita (Gita) Harie (Trustee) ◊	–	–	–	✓
	Mr Neil Morrison (Trustee) *	–	✓	✓	–
	Ms Charlotte Mbewu (Principal Officer) %	✓	✓	✓	x
	Mr Selwyn Kahlberg (Chief Risk Officer) %	✓	✓	✓	✓

▫ *Term ended on 31 August 2021 after the AGM.*
◊ *Appointed as a Committee Member effective 21 September 2021.*
* *Mr Morrison attended the meetings of 29 July 2021 and 12 August 2021 as a Committee Member until the Committee was reconstituted after the 2021 Trustee elections.*
% *Scheme Executive. All other Committee members are non-executive.*
– *Not required to attend.*
x *Apology tendered.*

FUTURE FOCUS AREAS

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

STAKEHOLDER RELATIONS AND ETHICS COMMITTEE

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

Ethics and society:

- Oversee, monitor and evaluate the ethics of the Scheme in a way that supports an ethical culture.
- Oversee, monitor and evaluate the corporate citizenship of the Scheme such that the Scheme is, and is 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, monitor and evaluate engagement with the Scheme's material stakeholders.
- Provide feedback and updates to the Board regarding stakeholder interactions, risks identified, or opportunities for new channels of engagement.

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

ACTIVITIES DURING 2021

- Closely considered the interim report of the Section 59 Investigation Panel and its implications for the Scheme and our stakeholders, and deliberated the Scheme's position on key areas of the report.
- Oversaw engagements with stakeholder groups emanating from the Section 59 investigation process, and reviewed the establishment of an industry group to advise on fraud, waste and abuse countering measures conducted by DH on the Scheme's behalf.
- Considered the impact of COVID-19, specifically vaccine hesitancy, and measures to counter it to the benefit of Scheme members and society as a whole.
- 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 and high-risk medical cases.
- Reviewed the Scheme's plans to conduct a virtual AGM, including impact on stakeholders.
- Reviewed the activities of the Dispute, Relationship Management and Research Governance Committees.
- Adopted a responsible corporate citizenship framework as a guide for the Trustees, Board Committees and Scheme Office management to engage with the governing principles of responsible corporate citizenship.
- Considered a position paper on conflicts of interest, to inform policy and process improvements.
- Discussed legal and regulatory matters which may affect the Scheme's members, other stakeholders, and the operations of the Scheme.
- Considered the results of the committee effectiveness review conducted by the IoDSA, making changes where required.

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

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2021 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2021

At the end of 2021, 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 DH, which engages in some stakeholder relations activity on the Scheme's behalf. Individuals from DH 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 2021		25 Feb[A]	02 Mar	31 Mar[A]	28 Jul	09 Nov
Trustee/ Chairperson	Mr John Butler SC ▫	✓	✓	✓	✓	✓
Committee members	Mr Dave King (Trustee)	✓	✓	✓	✓	✓
	Dr Dhesan Moodley (Trustee)	✓	✓	✓	✓	✓
	Ms Joan Adams SC ◊	✓	✓	✓	✓	–
	Mrs Lalita (Gita) Harie (Trustee) ~	–	–	–	–	✓
	Dr Susette Brynard (Trustee) ∞	✓	✓	✓	✓	✓
	Ms Charlotte Mbewu (Principal Officer) %	✓	✓	✓	✓	✓
Attendees	Mr Neil Morrison (Trustee) *	–	–	–	–	✓

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee members are remunerated according to the duration of such meetings.
- *A meeting was convened on 25 February 2021 to discuss the Section 59 Interim Report.*
- *A meeting was convened on 31 March 2021 to discuss the Section 59 Interim Report.*

▫ *Mr Butler resigned as Chairperson of the Stakeholder Relations and Ethics Committee effective 31 December 2021.*
◊ *Term ended on 31 August 2021 after the AGM.*
∞ *Re-elected as a Trustee effective 01 September 2021 and re-appointed as a Committee Member effective 21 September 2021. Appointed Chairperson of the Committee effective 01 January 2022.*
% *Scheme Executive. All other Committee members are non-executive.*
* *Mr Morrison attended the meeting of 09 November 2021 at 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 closely monitor the longer-term effects of the COVID-19 pandemic on stakeholders and society.

ACCREDITATION COMMITTEE

The Accreditation Committee is an ad hoc committee, established by the Trustees on 30 January 2020 in terms of Scheme Rule 19.3, which gives power to the Board to appoint and delegate authority to a subcommittee consisting of Board members and other experts it may deem necessary. Its purpose is to deliberate on matters raised by the CMS with regards to the accreditation of Discovery Health (Pty) Ltd, and provide feedback to the Trustees.

ACTIVITIES DURING 2021:

The Committee was not required to meet during 2021, but remains constituted pending the finalisation of accreditation matters.

COMPOSITION AND MEETINGS IN 2021

The Committee comprises four Trustees.

FUTURE FOCUS AREAS

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

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

SERVICES RENEWAL COMMITTEE

The Services Renewal Committee, an ad hoc subcommittee of the Board, was established during 2021 to oversee the potential renewal of the administration and managed care agreements currently in place with DH, provide recommendations to the Board and, if renewed, the terms of such renewal. The agreements currently in place between DH and Discovery Health Medical Scheme (DHMS) have an initial duration of five years, to the end of 2022. The Scheme was required to notify DH by 31 December 2021 whether the agreements will be renewed or terminated.

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 Board members and other experts it may deem necessary 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 2021

The Services Renewal Committee assessed extensive reports covering the services provided by DH, including the objectives that the Scheme agrees with DH each year, value added by DH, innovation, operational elements, marketing and distribution and compliance, as well as the Health Market Inquiry's (HMI's) recommendations and the CMS' requirements.

The Committee appointed Deloitte to conduct a review of the administration and managed healthcare service provider landscape across three areas being baseline criteria for service providers; benchmarking of top performing schemes; and innovation and competitive advantage against global best practice.

The Committee recommended that the Board elects to renew the agreements with DH for a period of five years, commencing on 01 January 2023. The renewal is subject to DHMS and DH reviewing and agreeing on the terms and commercial elements of the agreements for the forthcoming contractual period.

COMPOSITION AND MEETINGS IN 2021

In 2021, the Committee comprised four Trustees for the first meeting, and three Trustees with one alternate member thereafter.

Services Renewal Committee attendance in 2021		03 Nov[A]	11 Nov[A]	23 Nov[A]	07 Dec[A]
Trustee/ Chairperson	Mr Johan Human	✓	✓	✓	✓
Committee members	Mr Neil Morrison *	✓	–	–	–
	Mr Dave King	x	✓	✓	✓
	Mr John Butler SC	✓	✓	✓	✓

* *Attended the first meeting as a full Committee member, after which he was appointed an alternate member to attend only in the absence of other members.*
– *Not required to attend.*
x *Apology tendered.*

FUTURE FOCUS AREAS

During 2022 the Committee will attend to the terms and commercial elements of the agreements for the forthcoming contractual period.

Discovery Health Medical Scheme registration number 1125

INDEPENDENT MEMBER TERMS[1]

Independent Committee Member	Designation	Appointments	Start of Term	End of Term
Mr Eric Mackeown	Chair of the Audit Committee; Risk and Investment Committee member	Appointed	01 Sep 19	31 Aug 22
Dr Alewyn Burger	Audit and Risk Committees member	Appointed	01 Jan 20	31 Dec 22
Mr Ndumiso Luthuli	Remuneration Committee memberv	Appointed	18 Apr 18	17 Apr 21
	Remuneration Committee member	Reappointed	18 Apr 21	31 Mar 24
Dr Nonkululeko Mlaba	Clinical Governance Committee member	Appointed	28 Aug 18	27 Aug 21
	Clinical Governance Committee member	Reappointed	01 Sep 21	31 Aug 24
Dr Selma Smith	Clinical Governance Committee member	Appointed	01 Jan 16	31 Dec 18
	Clinical Governance Committee member	Reappointed	01 Jan 19	31 Dec 21
Mrs Sue Ludolph	Audit and Risk Committees member	Appointed	19 Jan 16	19 Jan 19
	Audit and Risk Committees member	Reappointed	20 Jan 19	19 Jan 22
Dr Peter Goss	Chair of the Nomination Committee	Appointed	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	26 Jun 20
	Chair of the Nomination Committee	Term extended[2]		30 Sep 21
Mr Tom Wixley	Nomination Committee member	Appointed	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	26 Jun 20
	Nomination Committee member	Term extended[2]		30 Sep 21
Mr Roy Shough	Nomination Committee member	Appointed	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	26 Jun 20
	Nomination Committee member	Term extended[2]		30 Sep 21
Mrs Alexandra Muller	Nomination Committee member	Appointed	01 Jan 22	31 Dec 24
Mr Andrew Bryce	Chair of the Nomination Committee	Appointed	01 Jan 22	31 Dec 24
Ms Berenice Marais	Nomination Committee member	Appointed	01 Jan 22	31 Dec 24
Ms Melanie Bosman	Audit Committee member	Appointed	01 Jan 22	31 Dec 24
Ms Henda van Deventer	Investment Committee member	Appointed	01 Jan 22	31 Dec 24
Prof Laurel Baldwin-Ragaven	Clinical Governance Committee member	Appointed	01 Feb 22	31 Jan 25

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

2 *Term ended on 30 June 2020, but was extended to end on 30 September 2021 in order to cater for the Scheme's 2020/2021 joint AGM held on 31 August 2021. The deferment of the 2020 AGM was approved through an exemption process by the CMS.*

INDEPENDENT COMMITTEE MEMBERS[1]

PROF LAUREL BALDWIN-RAGAVEN

65

AB (Smith College), MDCM (McGill), FCFP (Canada), FCFP (SA)

Member of the Clinical Governance Committee

Internationally experienced academic family physician, health and human rights advocate and medical ethics teacher and researcher. Vast clinical expertise in primary care, knowledge of public health systems and passion for interventions into the social determinants of health and disease.

MS MELANIE BOSMAN

50

CA(SA)

Member of the Audit Committee

Experienced non-executive director in the financial services industry, notably short-term and life insurance. Formerly an audit partner at a large accounting firm. In-depth knowledge of governance, IFRS and financial sector regulation.

MR ANDREW BRYCE

66

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

Member of the Nomination Committee

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

DR ALEWYN BURGER

70

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

Member of the Audit and Risk Committees

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

MS HENDA VAN DEVENTER

45

CA(SA); BA Law

Member of the Investment Committee

Independent consultant with over 19 years' financial services experience in credit and investment, including in development finance, investment banking, alternative assets and credit risk policy development and implementation. Track record as non-executive member or chair of various investment and credit committees and similar governance forums.

DR PETER GOSS

54

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

58

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. Experienced independent non-executive director and member of Audit, Risk and Social, Ethics and Sustainability Committees.

MR NDUMISO LUTHULI

46

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

Member of the Remuneration Committee

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

1 *Note: all ages as at 31 December 2021.*
2 *BCL: Bachelor of Civil Law.*

Independent Committee Members *continued*

MR ERIC MACKEOWN
64

CA(SA)

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

More than 40 years' experience in the accounting and auditing profession. Was lead audit partner for numerous major multinational and JSE-listed companies. Non-executive director and chairperson of the audit committee of Assore Holdings. Thorough and deep understanding of the health and medical aid industries.

MS BERENICE LUE MARAIS
57

MBA (International Business); BA Economics

Member of the Nomination Committee

Extensive leadership, governance, strategic business development, and international co-operation experience. Multiple senior executive leadership and non-executive director positions, including the Board of Directors and HR & Remuneration Committee for The Ethics Institute and Chair of the Governance, HR and Remuneration Committee, and Member of the Board of Directors for Save the Children South Africa.

DR NONKULULEKO MLABA
50

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

Member of the Clinical Governance Committee

Seasoned healthcare professional with a medical degree and post graduate 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.

MRS ALEXANDRA MULLER
45

CA(SA)

Member of the Nomination Committee

20 years spent at a professional services firm, ten of which were as a partner specialising in governance, risk and internal audit. Significant knowledge of medical schemes having provided services to such organisations in addition to other financial services businesses, both listed and unlisted. Currently serving as an independent non-executive director on various companies.

MR ROY SHOUGH
71

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
60

MBChB; M Prax Med[1]; FCFP(SA)[2]

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
81

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 *M Prax Med: Masters in Family Medicine.*
2 *FCFP(SA): Fellow of the College of Family Physicians of South Africa.*

Discovery Health Medical Scheme registration number 1125

Our approach to remuneration

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

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

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.

OUR FULL REMUNERATION POLICY

Managing the Scheme Office

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

The Principal Officer must be fit and proper to hold this office and may appoint any staff, in accordance with the approved human capital plan, required for the proper execution of the business of the Scheme.

The Board delegates 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, and the Scheme Rules along with any other applicable laws, codes and standards, the Board's delegation of authority to the Principal Officer is supported by an executive management team to execute 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 Scheme Office oversees the work done by Discovery Health on the Scheme's behalf.

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

REMUNERATION AND HUMAN RESOURCES PLANNING

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

The Scheme must attract and retain high-calibre staff to manage and oversee its complex operations. In 2021, the Scheme Office consisted of 13 staff members, including a team of six executives who report to the Principal Officer and are supported by the Scheme Secretariat and administration departments. This lean employee complement makes succession planning challenging; to mitigate this risk, the Scheme employs a mature knowledge management and retention strategy, including a notice period sufficient to allow for transition and recruitment of scarce skills.

DELEGATION OF AUTHORITY

A formal delegation of authority, implemented by the Board, provides a framework for achieving strategic priorities and effectively managing the Scheme within compliance requirements, while also balancing the interests of the Scheme's stakeholders, minimising and avoiding conflicts of interest, and practicing good corporate behaviour. The delegation of authority supports the effective exercise of authority and responsibility required for optimal operation of the Scheme, promoting independent judgement, and ensuring appropriate checks and balances. 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.

SCHEME SECRETARIAT

The Scheme has an experienced secretariat function within its operational structure that provides the Board and its Committees with support regarding their duties, responsibilities and powers. The secretariat team is responsible for ensuring sound corporate governance practice. In addition, the secretariat function assists to develop and educate the Trustees and Independent Committee Members, ensuring they are equipped to fulfil fiduciary and other governance responsibilities. The function also ensures that the Board and its Committees adhere to all rules and legislation applicable to the Scheme during meetings, and that Board decisions are adequately documented and implemented.

EXECUTIVE TEAM

PRINCIPAL OFFICER
MS CHARLOTTE MBEWU

BCom (Hons) Accounting; CA (SA)

Council member of iFHP[1], and a member of SAICA[2] Medical Schemes Project Group.

Chief Executive Officer of the Scheme.

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]; (EP)SA[4]; Certified Ethics Officer; Certified Fraud Examiner

Board member of the Marketing Code Authority, member of the Independent Regulatory Board for Auditor's (IRBA) Committee for Auditor Ethics, member of the Fraud, Waste Abuse and Errors Committee of the iFHP[5].

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.

HEAD: COMPLIANCE AND GOVERNANCE (HCG)
MRS LUSANI NELUFULE-MUGIVHI

LLB; Postgraduate Diploma in Compliance Management; Postgraduate Certificate in Data Protection and Privacy; Certified Ethics Officer

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.

CHIEF FINANCIAL OFFICER (CFO)
MRS JOY MALETE

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

Member of SAICA[2] Medical Schemes Project Group

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

CHIEF MEDICAL OFFICER (CMO)
DR UNATI MAHLATI

MBChB; FCPHM[6]; MMed; MBA (in progress)

Member of the Board and Clinical Advisory Committee of HQA[7].

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

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.

HEAD: SPECIAL PROJECTS AND STAKEHOLDER RELATIONS (HSPSR)
MS MICHELLE CULVERWELL

BA (Hons); MBA in Executive Management

Member of the HFA[8] Technical Advisory Committee.

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

1 *iFHP: International Federation of Health Plans.*
2 *SAICA: South African Institute of Chartered Accountants.*
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 *Ethics Practitioner SA.*
5 *iFHP: International Federation of Health Plans.*
6 *FCPHM: Fellow of the College of Public Health Medicine of South Africa.*
7 *HQA: Health Quality Assessment.*
8 *HFA: Health Funders Association.*

Regulatory and industry matters dealt with in 2021

FRAUD, WASTE AND ABUSE

In recognition of the severe impact of fraud, waste and abuse (FWA) on medical schemes and their members, the Council for Medical Schemes (CMS) held its inaugural annual FWA Summit in early 2019. Discovery Health Medical Scheme (DHMS or the Scheme) 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 Health Funders Association (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 Medical Schemes Act (the Act) which confers medical schemes the power to recover funds unduly paid to either members or healthcare professionals. Various healthcare professionals, facilities, medical schemes and medical scheme administrators testified at the inquiry, as did Discovery Health (DH) and DHMS. The Scheme and DH explained the processes and principles of its activities to combat FWA, demonstrated that they are legal and ethical, and made written submissions in support of this testimony.

Although the publication of the investigation report was delayed during 2020, an interim report was published for stakeholder comments in early 2021 and DH made a submission to the Panel on 5 April 2021 in this regard. The Scheme and DH 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. At the time of writing the Scheme awaits the publication of the final report, as well as the code of good practice.

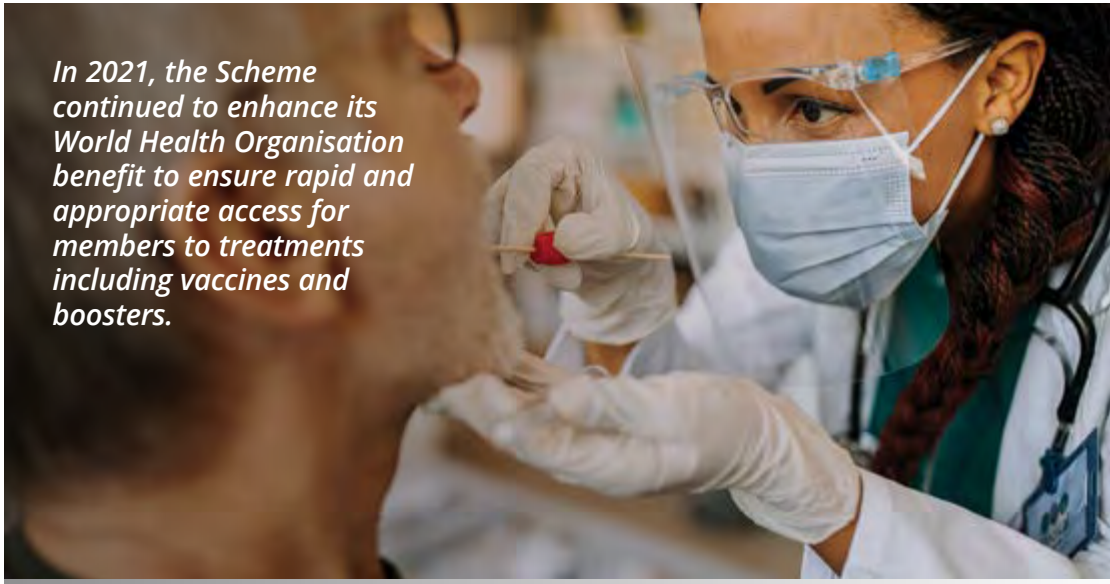
MORE ON HOW WE ARE IMPROVING OUR FORENSICS PROCESSES

COVID-19

The pandemic has continued to drive significant industry activity, characterised by high levels of co-operation, with proactive steps taken to support all South African citizens, including Scheme members and other stakeholders. In 2021, the Scheme continued to enhance its WHO Global Outbreak Benefit to ensure rapid and appropriate access for members to treatments including vaccines and boosters in alignment with the COVID-19 Prescribed Minimum Benefits (PMBs), and what we have considered best practice to ensure best possible health outcomes for our members.

Through the HFA, administrators and medical schemes engaged with pathology services providers and the Competition Commission regarding the pricing of polymerase chain reaction (PCR) and antigen tests for COVID-19. In late 2021, subsequent to a complaint laid by the CMS, the Competition Commission obtained significant reductions in these prices from the laboratories. The three largest pathology laboratories in South Africa (Ampath, Lancet and PathCare) had been charging R850 per PCR test since April 2020; this has since been reduced to R500 due to a settlement agreement with the Competition Commission which also specified the maximum pricing of antigen tests at R150 (down from R350).

COMPETITION TRIBUNAL ANNOUNCEMENT



In 2021, the Scheme continued to enhance its World Health Organisation benefit to ensure rapid and appropriate access for members to treatments including vaccines and boosters.

Regulatory and industry matters dealt with in 2021 *continued*

CMS MATTERS

In 2016, the Scheme sought to register an amendment to Rule 11, regarding preventing members from re-joining the Scheme immediately after committing fraud or intentional non-disclosure against it. To protect its greater membership, the Scheme believes that such members should be prohibited from re-joining for a certain period. During 2016, the Scheme lodged two unsuccessful appeals and, following legal advice, on 17 May 2017 the Scheme lodged a High Court Application for Review of the non-registration of this Rule in terms of the Promotion of Administrative Justice Act. The High Court Review has yet to be set down.

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

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

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. Since the draft Primary Healthcare Package was published for review and costing, there has not been any material movement during 2021.

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 stakeholder engagements and has established two advisory committees that incorporate 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, and in Circular 9 of 2022, further extended it to 31 March 2024. To our knowledge, as of early 2021, most of the work to draft the LCBO framework is complete. The next steps include finalisation of a report on the work done by the advisory committees for consideration by the CMS. The CMS has also indicated that it will establish a third workstream including policyholders, consumers, unions and other key stakeholders. DHMS will continue to engage with and support the expansion of access to quality and appropriate care for low-income and uninsured households, which will also expand and improve the risk pools of medical schemes and reduce pressure on public sector resources and infrastructure.

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

In Circular 52 of 2021, the CMS requires medical schemes to report on income received from investments as investing cash flows (not as operating cash flows) in their Statement of Cash Flows in their financial statements of the year ended 31 December 2021 onwards. In our assessment, the circular may conflict with International Financial Reporting Standards (IFRS), which are a set of principle-based - not rules-based – standards requiring interpretation and judgement to best depict information for users. Auditors are required to provide an opinion on the presentation of the financial statements in accordance with IFRS, and the Audit Committee and Board of Trustees are also required to attest to the fair presentation of the financial statements; the inability to do so may lead to a modification of the audit opinion by the auditors. The South African Institute of Chartered Accountants (SAICA) Medical Schemes Project Group is engaging with CMS on this matter. The CMS has since deferred the implementation of the classification of investment income as investing cash flows, not as operating cash flows, in the Statement of Cash Flows as required in terms of Circular 52 of 2021 until the matter has been deliberated on by the SAICA Accounting Practices Committee.

A notice was published by the Department of Health in 2017 regarding an intention to declare certain practices regarding designated services provider networks and co-payments undesirable, and submissions were made to the CMS in response. In April 2021 the Department of Health Notice 214 of 2021 was published, declaring certain practices pertaining to the selection of Designated Service Providers (DSPs) and imposition of excessive co-payments undesirable. The notice indicated that the CMS would publish guidelines on the selection of DSPs and imposition of co-payments within 180 days of the publication date. On behalf of its members, the HFA lodged a Promotion of Administrative Justice Act request to the Registrar and Council at both CMS and the Department of Health to understand how the declaration was arrived at, and has also lodged a Section 50 Appeal regarding the declaration. The CMS has indicated that the development of guidelines has been put on hold, pending the outcome of the appeal.

During 2021, CMS notified DHMS that the Scheme was not compliant with Explanatory Note 2 of Annexure B as the Scheme's assets in category 1 (a) (i) and 1 (a) (ii) of Annexure B

Regulatory and industry matters dealt with in 2021 *continued*

fell below 20% of the Scheme's Regulation 30 assets. This assessment by CMS was conducted using the aggregate fair value of liabilities and total accumulated funds rather than "minimum accumulated funds" as stated in Regulation 29.

In demonstrating compliance with Regulation 30 and Annexure B, the Scheme measures the assets against the aggregate fair value of liabilities and "minimum accumulated funds", namely 25% of gross annual contributions as stated in Regulation 29, on which basis the Scheme is compliant.

The Scheme further obtained a legal opinion from Knowles Husain Lindsay Inc. on 25 February 2022 to confirm the application of the Act and its Regulations, which demonstrated that the Scheme is compliant with Explanatory Note 2 of Annexure B. At the date of this report, the matter had not been concluded and DHMS will continue to engage CMS on the matter.

MORE INFORMATION ON THE LIMITATION OF ASSETS MATTER

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 DH to perform administration services for a further two-year period, extending this to 31 December 2021. This accreditation was subject to conditions which DH 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 and 2021, DH submitted evidence of compliance to the CMS. DH has received feedback on some of these submissions, resulting in amendment to these conditions, with some being fulfilled by DH.

In December 2021, CMS granted accreditation to DH for two years to 31 December 2023 subject to compliance with the conditions stipulated.

NATIONAL HEALTH INSURANCE (NHI)

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, 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 DH made joint submissions on both Bills and engaged in other consultative forums including the HFA and Business Unity South Africa, both of 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 written submissions. In late 2021 and early 2022, various stakeholders, including DH, made verbal presentations to the PCH raising a variety of shared concerns including possible Constitutional challenges, the potential impact on the right of access to healthcare, alternative funding models, and inadequate governance structures in the Bill.

07 OUR PERFORMANCE

Scheme performance for the 2021 financial year

Discovery Health Medical Scheme's (DHMS or the Scheme) 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 in caring for our members, ensuring Scheme stability and sustainability, and meeting the regulatory solvency requirements set out in the Medical Schemes Act.

The Scheme has a fiduciary obligation to maximise investment returns with due regard for related risks, requiring that we consider issues that can impact longer-term investment performance.

BUSINESS MODEL | KEY PERFORMANCE INFORMATION | FINANCIAL STATEMENTS

OVERVIEW

For the year ended 31 December 2021, DHMS delivered a planned negative net healthcare result of R1 165 million (2020: R7 451 million positive); a decline attributable to the delayed contribution increase for the 2021 benefit year. Despite this, results are significantly better than expected (likely due to members continuing to defer their healthcare needs during COVID-19 waves in 2021) and the Scheme generated investment income of R1 772 million (2020: R1 690 million), contributing to the net surplus of R2 044 million (2020: R9 006 million) for the year.

This better-than-expected financial performance increased members' funds to R30.4 billion (2020: R28.2 billion) with a solvency level of 38.01% (2020: 36.9%), exceeding the regulatory requirement of 25%. Receiving a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co, the Scheme has achieved the highest possible rating for a medical scheme in South Africa for the 22nd consecutive year, confirming the Scheme's financial strength and ability to pay claims. It is the Trustees' view that DHMS ended 2021 in a strong financial position despite challenging and unusual market conditions, and remains well placed to meet members' needs in the event of the anticipated increases in utilisation resulting from postponement of care over 2020 and 2021 and consequently worsened states of health of our members.

Investment income
R1 772 million
(2020: R1 690 million)

Net surplus
R2 044 million
(2020: R9 006 million)

Members' funds
R30.4 billion
(2020: R28.2 billion)

Solvency level
38.01%
(2020: 36.9%)

Credit rating
AAA
The Scheme has achieved the highest possible rating for a medical scheme in South Africa for the
22ST CONSECUTIVE YEAR

Discovery Health Medical Scheme registration number 1125

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 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.

- Net membership increase
  1.69%
  (2020: 1.57% decrease)
- Net beneficiary increase
  0.96%
  (2020: 1.77% decrease)
- Average age at year-end[1]
  36.17
  (2020: 35.86)
- Pensioner ratio[2]
  11.25%
  (2020: 10.98%)
- Annualised lapse rate
  5.13%
  (2020: 5.19%)

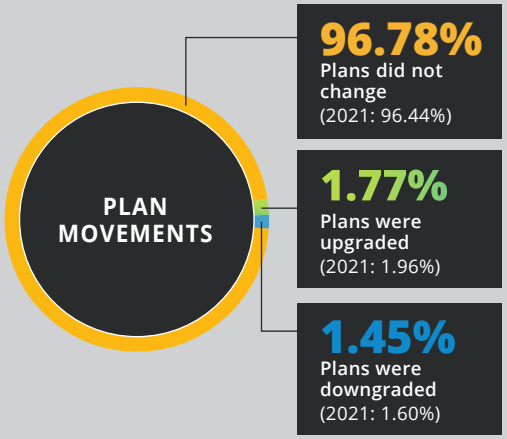
MEMBERSHIP SIZE

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

- **1 353 012**
  Principal members
  at 31 December 2021
  (2020: 1 330 513)
- **2 784 793**
  Beneficiaries
  at 31 December 2021
  (2020: 2 758 340)
- **57.5%[3]**
  Share of open scheme market
  (2019: 57.0%)

PLAN MOVEMENTS

Low movement between plans indicates member satisfaction and appropriate benefit design and pricing. For 2022:



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 2022
  14.9%
  lower than the next six largest open schemes[4]
  (2021: 16.1%[5])

1 *An increase of less than one year per annum is favourable as it indicates that young people are joining the Scheme.*
2 *Based on beneficiaries' dates of birth.*
3 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2021 (https://www.medicalschemes.co.za/wpfd_file/quarterly-report-for-30-september-2021/).*
4 *Source: publicly available contribution information for DHMS and the next six largest open medical schemes. 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 six 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.*
5 *The 2021 contribution differential previously reported (17.3%) differs from this figure due to a change in methodology. The Scheme's contributions were compared to the next eight largest schemes, however, we have now amended the calculation to include the next six largest open schemes as the contribution information of the smaller two schemes was not available at the time of calculation.*

In 2021, the Scheme deferred the contribution increase to 1 July, providing relief to its members and passing on the benefit of excess reserves.

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
  38.01%
  (2020: 36.9%)
  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. In 2021, the Scheme deferred the contribution increase to 1 July, providing relief to its members and passing on the benefit of excess reserves. The deferral of the increase resulted in the Scheme generating a negative net healthcare result for the year.

- Net healthcare result for the year of
  R1 165 million negative
  (2020: R7 451 million positive)
- Net surplus for the year of
  R2 044 million
  (2020: R9 006 million surplus)[2]

PRUDENT INVESTMENT MANAGEMENT

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

- Gross return on investments
  10.31%
  (2020: 5.77%)

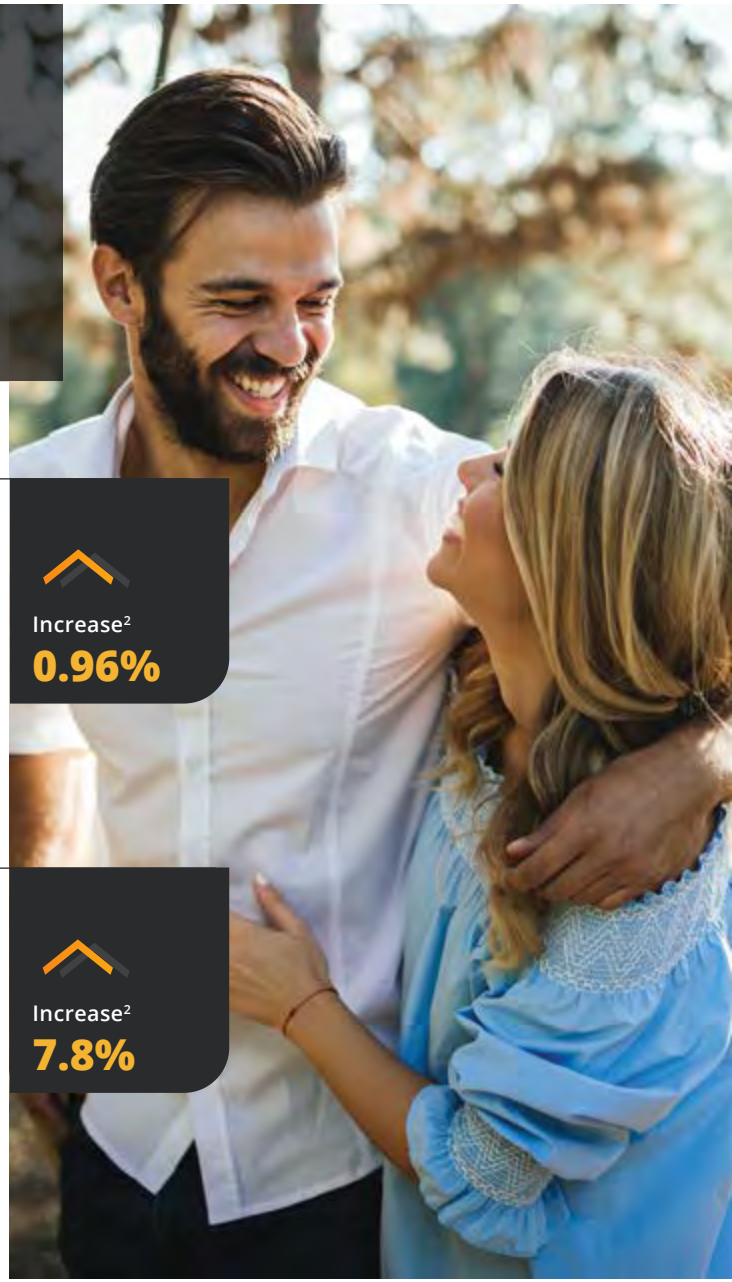
VALUE-ADDED ADMINISTRATION AND MANAGED CARE

- For every R1.00 Spent by DHMS on administration and managed care fees in 2020[3], our members received
  R1.88
  (2019: R2.03)
  in value from the activities of Discovery Health. This is equivalent to nominal added value of R6.40 billion in 2020 (2019: R7.09 billion).
- Administration fees
  7.33%
  of gross contributions
  (2020: 7.23%)
- Managed care fees
  2.56%
  of gross contributions
  (2020: 2.54%)

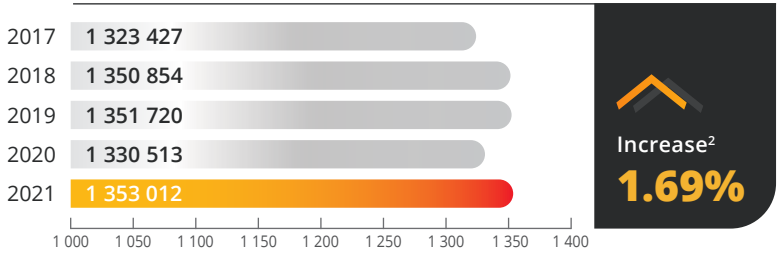
1 *Rating affirmed in April 2021; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*
2 *Claims experience in 2020 was substantially reduced due to deferred healthcare seeking during the COVID-19 pandemic.*
3 *As the assessment uses industry information reported by the Council for Medical Schemes (CMS), 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 recovered from prior year levels, indicating that membership of a trusted scheme such as DHMS remains a priority for our members. Members' funds are sufficient to assure members that the Scheme is able to take care of their healthcare needs.

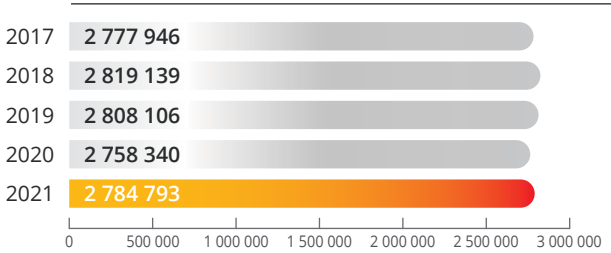


SCHEME PRINCIPAL MEMBERS



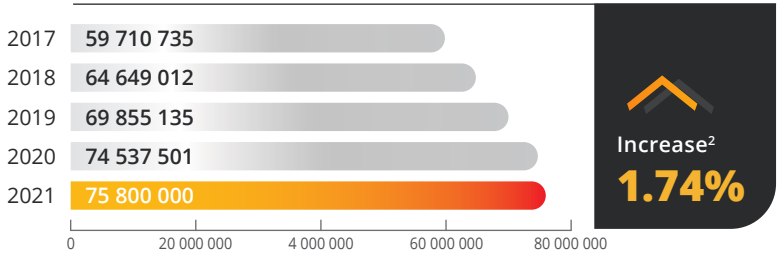
Increase[2] **1.69%**

SCHEME LIVES



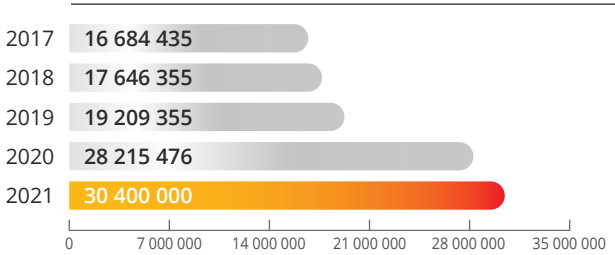
Increase[2] **0.96%**

GROSS CONTRIBUTIONS (R'000)



Increase[2] **1.74%**

MEMBERS' FUNDS (R'000)



Increase[2] **7.8%**

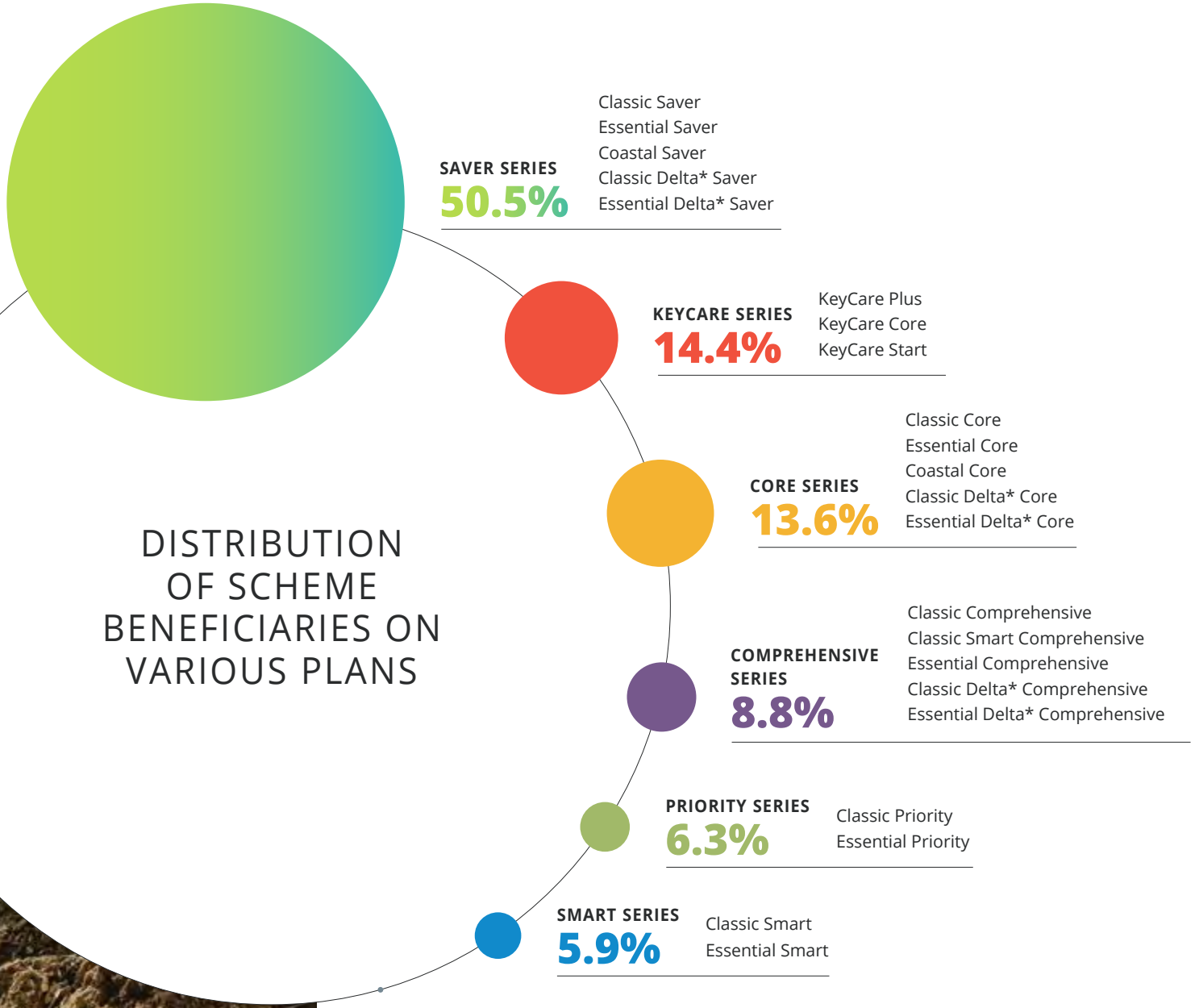
1 *According to the Q3 2020 CMS report, at the end of September 2020, a total of 8 901 342 beneficiaries were covered, down from 8 953 000 at the end of 2019.*
2 *Year-on-year change (2019 – 2020).*

DHMS plans and beneficiary distribution

17
Benefit options
(2020: 17)

6
Network efficiency discount options*
(2020: 6)

DISTRIBUTION OF SCHEME BENEFICIARIES ON VARIOUS PLANS



SAVER SERIES 50.5%
Classic Saver
Essential Saver
Coastal Saver
Classic Delta* Saver
Essential Delta* Saver

KEYCARE SERIES 14.4%
KeyCare Plus
KeyCare Core
KeyCare Start

CORE SERIES 13.6%
Classic Core
Essential Core
Coastal Core
Classic Delta* Core
Essential Delta* Core

COMPREHENSIVE SERIES 8.8%
Classic Comprehensive
Classic Smart Comprehensive
Essential Comprehensive
Classic Delta* Comprehensive
Essential Delta* Comprehensive

PRIORITY SERIES 6.3%
Classic Priority
Essential Priority

SMART SERIES 5.9%
Classic Smart
Essential Smart

EXECUTIVE SERIES 0.6%
Executive

Discovery Health Medical Scheme registration number 1125

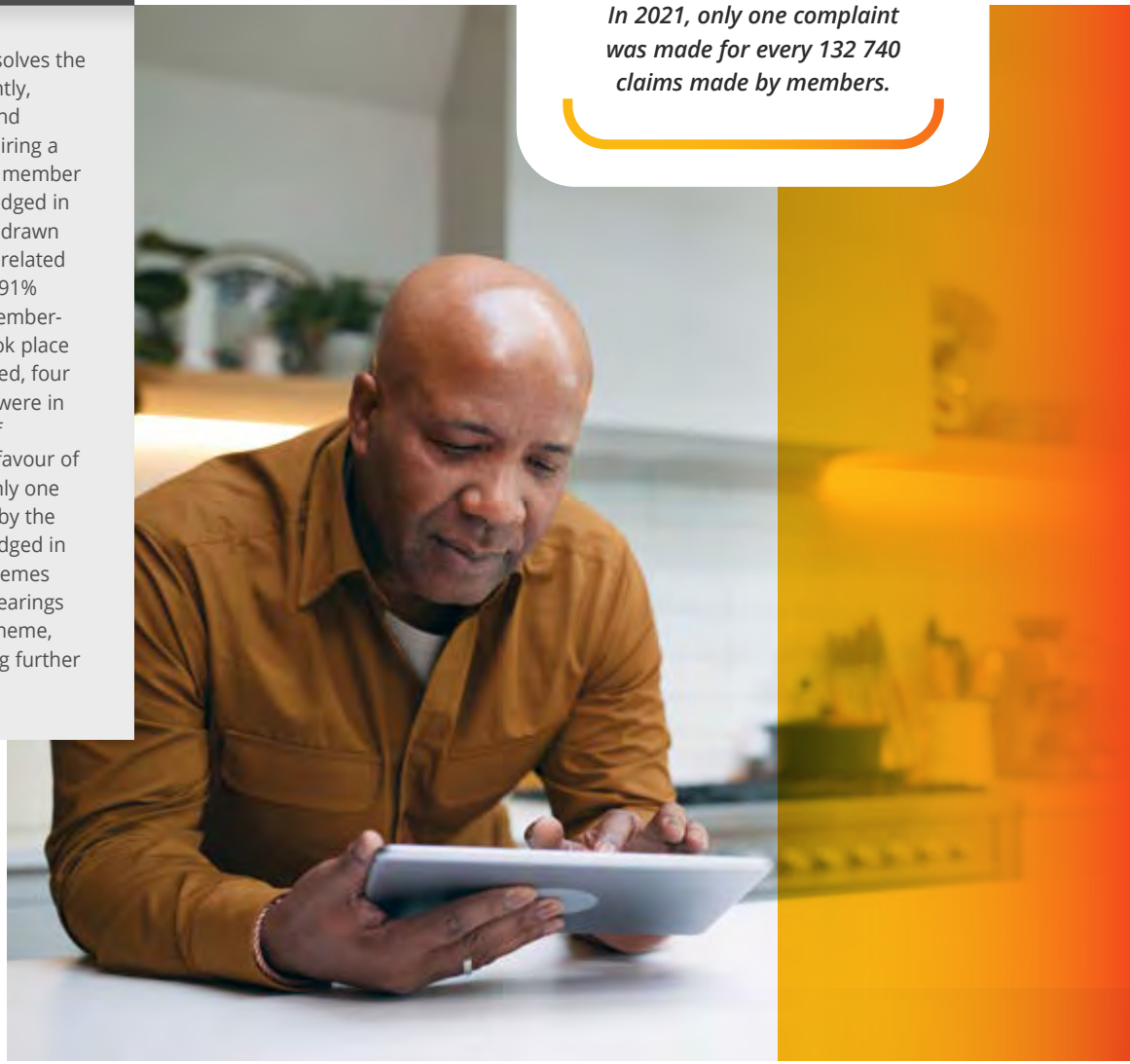
MEMBER DISPUTES AND CMS COMPLAINTS

We thoroughly investigate and review all disputes formally lodged by Scheme members, aiming to resolve as many as possible internally which means that members do not need to lay complaints with the CMS. The Dispute Committee process is also available to healthcare professionals wishing to escalate disputes regarding billing practices and forensic investigations with the Scheme. The first hearings of this nature were held in early 2021.

Relative to the 54 556 179 claims made in 2021, the number of CMS complaints made by DHMS members totalled 411 in 2021[1] (2020: 401 complaints to 47 675 525 claims). While this reflects a 2.5% increase in complaints from 2020, the ratio of complaints to the number of claims has decreased. The ratio of internal disputes to CMS complaints has continued to improve from 39% in 2015, to 170% in 2021 (ie. for every 1.7 internal disputes lodged, there is one CMS complaint made).

The Scheme's disputes mechanism resolves the majority of cases amicably and efficiently, achieving a high rate of withdrawals and settlements without the member requiring a hearing. In 2021, 627 (90%) of the 697 member disputes and two forensics disputes lodged in terms of Rule 27[2], were settled or withdrawn prior to a hearing (2020: 757 member related disputes, no forensic disputes, 692 or 91% settled or withdrawn). In respect of member-lodged disputes, some 23 hearings took place during 2021 with 27 rulings being issued, four of which were residual from 2020; 22 were in favour of the Scheme, two in favour of members, and three were partially in favour of both the member and the Scheme. Only one dispute ruling was challenged further by the member in a complaint to the CMS, lodged in terms of section 47 of the Medical Schemes Act. One of the two forensic dispute hearings resulted in a ruling in favour of the Scheme, and one remains partly heard, awaiting further input from the provider.

In 2021, only one complaint was made for every 132 740 claims made by members.



1 *This equates to 1 complaint to every 132 740 claims (2020: 1 complaint to every 118 892 claims).*
2 *Rule 27 of the DHMS Rules deals with complaints and disputes. The Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.*

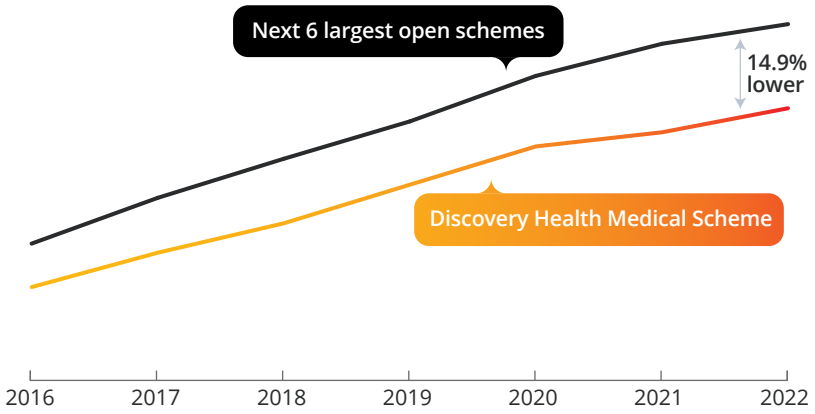
GROSS CONTRIBUTION INCOME

The Scheme remained highly competitive, with average contributions for 2022 being 14.9% lower[1] on a plan-for-plan basis (2021: 16.1%[2]) than the next six largest open schemes; this is predominantly due to our ability to contain the impact of healthcare inflation.

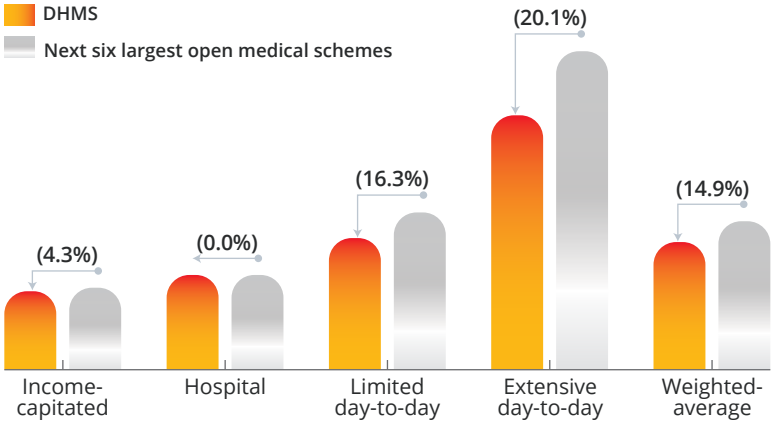
Due to the exceptional utilisation patterns[3] caused by the pandemic, the Scheme has been able to adopt a contribution freeze for the second year in a row, assisting our members to manage economic pressures. DHMS was the first and only medical scheme in South Africa to implement a freeze on contribution increases effective from January to July 2021. This year, we are freezing contributions for nine months, with a monthly contribution increase of 7.9% for all DHMS members effective 1 October 2022. The delayed implementation of the 2022 contribution increases will result in a 2.0% effective increase for members, based on the annualised December 2021 rates.

Driven by contribution increases required to match healthcare inflation, gross contribution income rose 1.72% to R75.8 billion (2020: R74.5 billion). The most significant net membership growth contributing to the increase in GCI was recorded in mid- to low-tier options, where the Smart series grew by 36 221 net members (2020: 16 512). At a net principal membership decline of 17 685 (2020: 14 452), the Comprehensive series of plans experienced the largest reduction.

DHMS CONTRIBUTIONS ARE 14.9% LOWER THAN THE NEXT SIX LARGEST OPEN MEDICAL SCHEMES IN 2022



DHMS IS MORE AFFORDABLE ACROSS MAJORITY OF PLAN CATEGORIES IN 2022



1 *Source: publicly available contribution information for DHMS and the next six largest open medical schemes. 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 six 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.*

2 *The 2021 contribution differential previously reported (17.3%) differs from this figure due to a change in methodology. The Scheme's contributions were compared to the next eight largest schemes, however, we have now amended the calculation to include the next six largest open schemes as the contribution information of the smaller two schemes was not available at the time of calculation.*

3 *2020 marked a radical shift in healthcare seeking behaviour, with stringent COVID-19 lockdown measures set in place by government and concerns about the risk of infection at places of care, resulting in 3.5 million fewer member claims than in 2019 and 76.5% of Scheme income funding claims (vs 87.3% in 2019). In 2021, members began utilising healthcare again, increasing the number of claims made to 54 556 179 (vs 47 675 525 in 2020) and the percentage of Scheme income spent on funding claims to 89.1%. The Scheme's deferral of the 2021 contribution increase to 1 July 2021, providing relief to its members and passing on the benefit of excess reserves, resulted in the Scheme generating a negative net healthcare result for the year.*

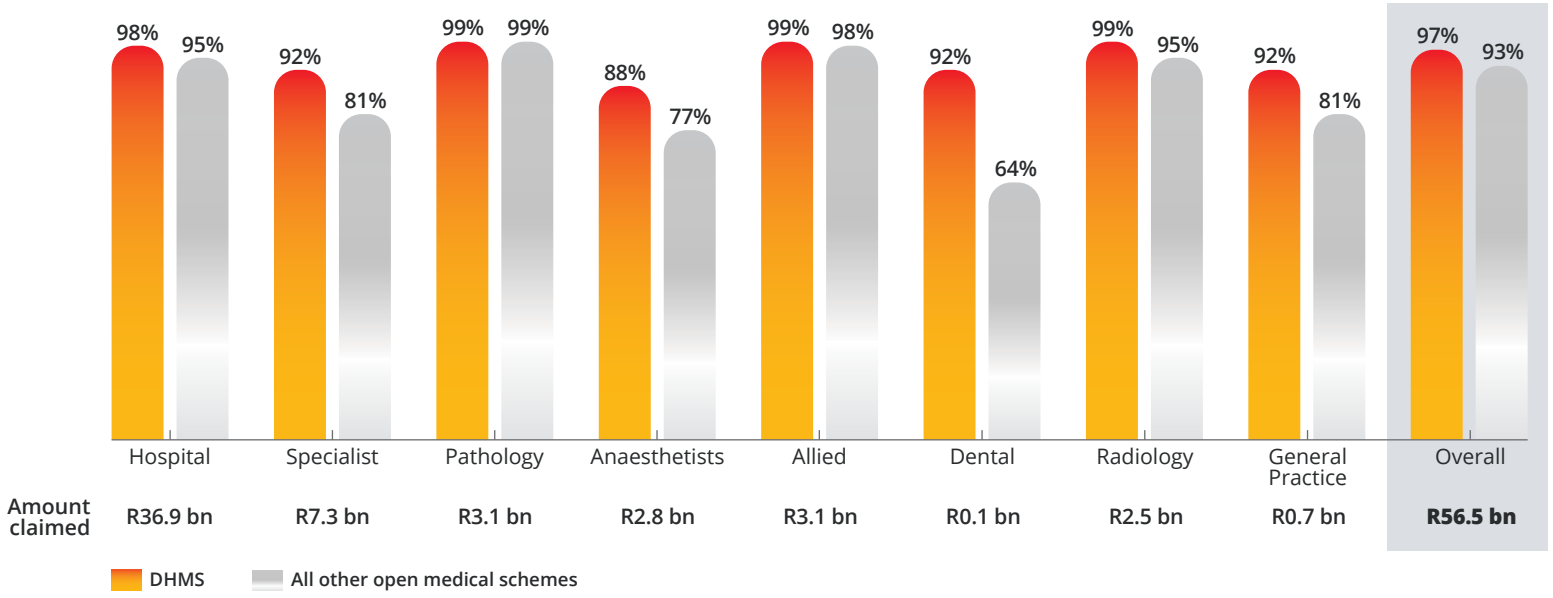
BALANCING SUSTAINABILITY AND AFFORDABILITY

Continued below

Gross contribution income *continued*

In return for their contributions, DHMS continues to provide exceptional claims cover for members.

*In 2020, we paid **97%** of in-hospital claims, vs 93% for all other open schemes[1]:*



1 *Source: CMS Annual Report 2020-2021; gynaecologists, neurosurgeons, radiation oncologists and medical specialists are excluded from the analysis, as these healthcare professionals were not included in the CMS Annual Report annexures. Comparative data not yet available for the 2021 year.*

NET CLAIMS INCURRED

Net claims incurred increased by 21.39% to R54.4 billion (2020: -7.63% and R44.8 billion), a reversal from the previous year where the decrease was attributable to the stringent lockdown measures set in place by government during 2020 in response to COVID-19, and concerns about the risk of infection at places of care, both of which significantly impacted healthcare-seeking behaviour. The Scheme expects a continued increase in claims between 2022 and 2023, likely with a more severe disease case mix, as members' postponed healthcare needs return to the system and drive increased utilisation.

The gross claims ratio[1] increased to 90.09% (2020: 76.5 %) due to the deferral of the 2021 contribution increases to July 2021. The impact of the deferral was however offset by the robust risk management interventions implemented by the Scheme's administrator and managed care provider, Discovery Health.

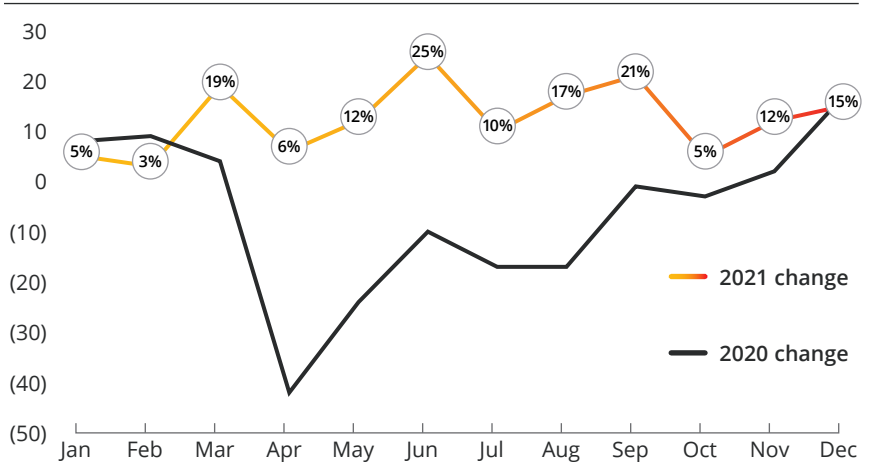
Healthcare inflation continues to be a concern for medical schemes, with inflation consistently above consumer price index (CPI) inflation. The primary driver of healthcare inflation is the extent of healthcare services utilisation due to demand- and supply-side effects.

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.

In 2021, COVID-19 continued to have a material impact on the healthcare system, dampening the expected influence of demand- and supply-side effects due to:

- Government regulations issued under the Disaster Management Act limiting 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, especially during the COVID-19 waves.
- 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 15.8% compared to 2019), despite a lower total number of hospital admissions.
- Additional costs incurred for Personal Protective Equipment (PPE) used by healthcare professionals when treating patients.

Unprecendented claim patterns in 2020 and 2021, from a 2019 base
RISK COST PER LIFE PER MONTH (PLPM), YEAR-ON-YEAR CHANGE

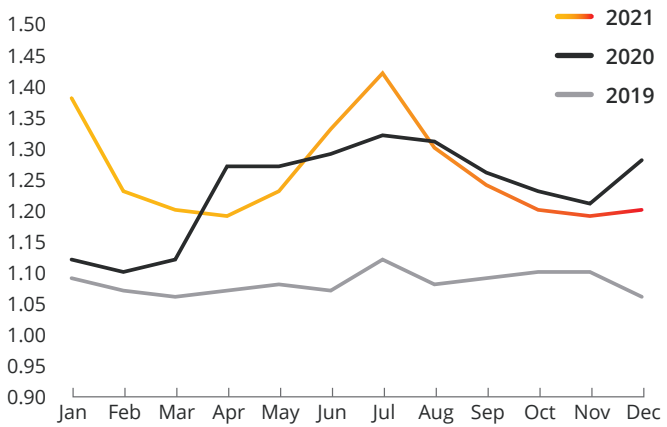


1 *The percentage of risk contributions utilised to fund relevant healthcare expenditure (net claims incurred, accredited managed healthcare services fees and net income/(loss) on risk transfer arrangements).*

Continued below

Net claims incurred *continued*

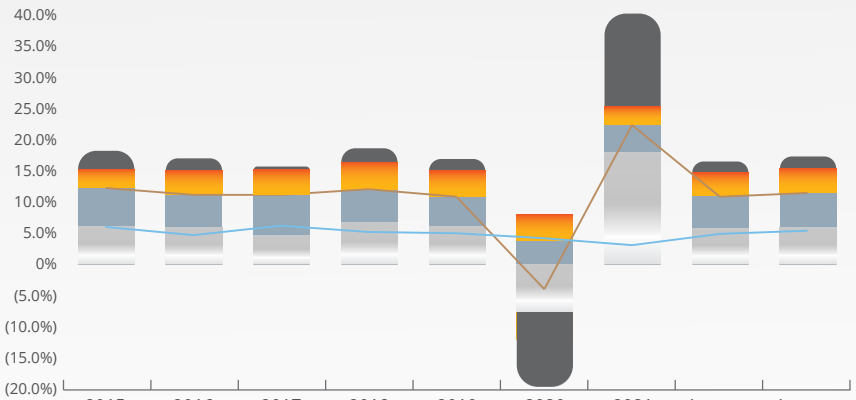
HIGHER SEVERITY ADMISSIONS IN 2020 AND 2021



In 2020, COVID-19 had a material impact on the entire healthcare system, dampening the expected influence of demand- and supply-side effects, whereas 2021 saw an increase in supply-side demand. This was largely driven by COVID-19 related benefits such as vaccines, PPE and polymerase chain reaction (PCR) testing, bolstered by healthcare seeking behaviour returning to more normal levels compared to 2020.

A summary of the composition of healthcare inflation (annualised over the period 2015 to 2021) is illustrated in the diagram below.

ANNUALISED INFLATION



	2015	2016	2017	2018	2019	2020	2021	Average age '15 – '21	Average age '15 – '19
Supply side impact	2.9%	1.9%	0.5%	2.2%	1.9%	(11.9%)	14.8%	1.8%	1.9%
Demand side impact	3.1%	3.9%	4.0%	4.4%	4.1%	4.3%	2.9%	3.8%	3.9%
Tariff increase	6.0%	5.2%	6.5%	5.2%	4.7%	3.6%	4.4%	5.1%	5.5%
Total utilisation	6.0%	5.8%	4.5%	6.6%	6.0%	(7.6%)	17.7%	5.6%	5.8%
CPI at Sep of prior year	5.9%	4.6%	6.1%	5.1%	4.9%	4.1%	3.0%	4.8%	5.3%
Total plan mix adjusted increase	12.1%	11.0%	11.0%	11.9%	10.7%	(4.0%)	22.1%	10.7%	11.3%

GROSS ADMINISTRATION EXPENDITURE

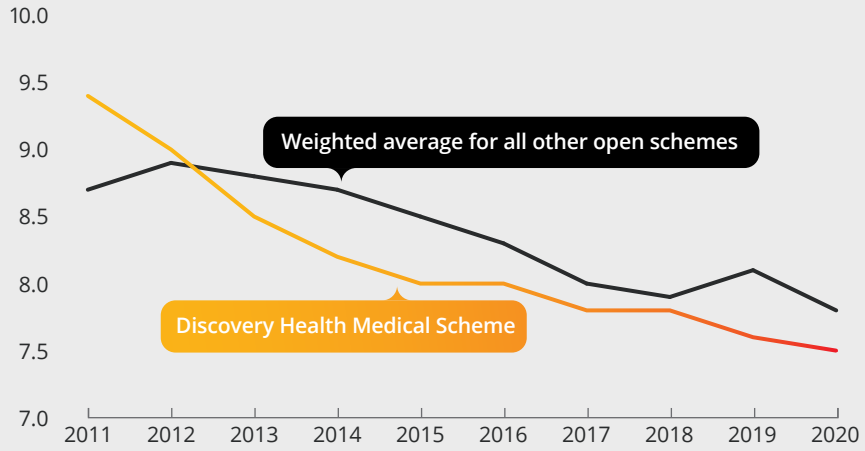
Gross administration expenditure comprises administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's administrator, Discovery Health. During 2021, gross administration fees increased by 3.07% to R5.6 billion (2020: R5.4 billion), driven by an increase in the average administration fee per member of 2.57% to R345.49 (2020: R336.84), largely due to an annual CPI-linked increase.

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

The Scheme's analysis of the CMS Annual Report 2020–2021 shows that, at 7.5% for 2020, DHMS continued to rank below the weighted average gross administration expenditure for open schemes when considered as a proportion of gross contribution income, which was 7.8% excluding the Scheme. This means that the Scheme's gross administration expenditure is the fourth lowest out of 18 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



ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 4.11% to R1.96 billion (2020: R1.88 billion) is predominantly attributable to the increase of 3.6% from R117.70 to R121.93, in accredited average managed care costs per member per month. This reflects the annual CPI-linked increase. Managed care costs as a percentage of gross contribution income increased slightly from 2.53% in 2020 to 2.59% in 2021. An analysis of the CMS Annual Report 2020 – 2021 demonstrates that the Scheme's managed care cost as a proportion of gross contribution income was 2.5%, compared to the weighted average for open schemes, excluding DHMS, of 2.2%[1].

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

In 2020, claims cost savings of R203.06 (2019: R213.84) per average beneficiary per month were realised through claims review processes, protocols implemented, price negotiations and drug utilisation reviews[2]. This equates to a saving of R2.58 (2019: R3.06) for every Rand paid in managed care costs, an exceptional return on investment of 258% (2019: 306%).

1 *In last year's Integrated Report, we indicated that that the weighted average managed care cost for the industry (excluding DHMS) was 3.0%. This year we have updated the methodology used to exclude costs for managed care with risk transfer arrangements as only one scheme in the industry reports their managed care fees inclusive of these costs. Utilising the amended methodology, last year's weighted average managed care cost for the industry would have been 2.1%, excluding the Scheme.*

2 *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 they fall due. Given the short-term nature of Scheme liabilities, a significant portion of our assets are invested in cash and money market instruments and short duration bonds. Allocations are also made to bonds (local and foreign) and equities.

The Scheme earned a gross investment return of 10.31% for 2021 (2020: 5.77%).

SOLVENCY

The Medical Schemes Act 131 of 1998, as amended (the Act) requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29 (2).

At 31 December 2021, the Scheme's solvency level of 38.01% (2020: 36.9%) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R9.9 billion (2020: R8.9 billion).

R'000	2021	2020
Total members' funds per Statement of Financial Position	**30 418 845**	28 215 475
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(1 603 656)**	(686 683)
Accumulated funds per Regulation 29	**28 815 189**	27 528 792
Gross annual contribution income	**75 816 287**	74 537 501
Solvency margin = Accumulated funds/gross annual contribution income x 100	**38 01%**	36 93%

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 11.18 for 2021 (10.63[1] in 2020). At year-end, only a very small proportion of contributions had not yet been collected.

Year ended	2021	2020
Gross contributions	**75 816 287**	74 537 501
Total outstanding - excluding December contributions	**58 747**	52 343
% Outstanding	**0.08**	0.07

1 *Corrected from last year's report, which indicated 11.95 days in 2020.*

RESERVE ACCOUNTS

STATEMENT OF CHANGES IN FUNDS AND RESERVES

OUTSTANDING CLAIMS

NOTE 7 IN THE FINANCIAL STATEMENTS

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2021

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

During 2021, 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 2021 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/ surplus (R'000)
Executive	**(218 517)**	**(200 506)**
Classic Comprehensive	**(970 676)**	**(728 148)**
Classic Priority	**(116 613)**	**54 327**
Essential Comprehensive	**(30 278)**	**(2 564)**
Coastal Core	**(164 519)**	**30 778**
Coastal Saver	**(249 999)**	**133 760**
KeyCare Plus	**(910 471)**	**(356 593)**

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.

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2021 *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 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 that they are correctly paid.

CLAIMS PAID IN EXCESS OF 30 DAYS

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

During the year, there were instances were claims were not paid within 30 days. These 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 2021 *continued*

DIRECT OR INDIRECT BORROWING OF MONEY

In terms of Section 35 (6) (c) of the Act a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were instances during the year where the Scheme inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of this re-occurring.

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, exemption 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. Regulation 10 (3) of the Act states that funds deposited in a member's personal medical savings account shall be available or the exclusive benefit of the member and his or her dependants but may not be used to offset contributions. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R93k resulting from late applications. 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.

MID-YEAR CONTRIBUTIONS COMMUNICATION ERROR AND FAILURE

The Medical Schemes Act, Section 57 (4) (d), requires that members must be informed of their rights, benefits, contributions, and duties in terms of the rules of the medical scheme. DHMS Rule 15.2 stipulates those members must be informed of changes in benefits or contributions at least 30 days before such change is affected.

DHMS mid-year contribution increase notifications were e-mailed on 28 May 2021. The link in the notification e-mail, to opening the increase letter, displayed an error message, resulting in some members not being able to view the content of the letter.

Apology notifications were sent to the affected members on 17 June 2021 with a new link.

The affected members received updated contribution letters and additional processes have been implemented to mitigate the risk of this re-occurring.

INCORRECT SUSPENSION OF DHMS MEMBERS

The Medical Schemes Act, Section 29 (2), states that a medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependents, except on certain grounds.

Electronic Funds Transfer (EFT) payments received in December 2021 did not reflect on the payor transaction query, due to a system error, which resulted in 722 members being incorrectly suspended. Members who were incorrectly suspended were unsuspended. Apology calls were made to the affected members, and they were provided with confirmation that the allocation was corrected.

OPERATIONAL STATISTICS PER BENEFIT PLAN

for the year ended 31 December 2021

2021	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	7 927	105 496	46 937	316 368	74 947	12 235	154 565	50 719	5 075	169 966	73 193	211 492	16 903	6 026	454	55 372	45 337	**1 353 012**
Number of beneficiaries at the end of the accounting period	16 027	223 204	101 414	694 333	164 791	22 121	330 891	111 202	10 129	380 185	165 129	365 033	28 462	7 812	874	110 256	52 930	**2 784 793**
Average number of members for the accounting period	7 998	108 031	47 114	315 143	76 126	12 338	148 344	49 211	5 051	170 788	73 919	209 431	16 153	5 815	446	52 524	41 391	**1 339 822**
Average number of beneficiaries for the accounting period	16 306	229 611	102 019	692 010	167 543	22 400	317 558	107 799	10 151	382 386	166 860	362 434	26 949	7 527	883	104 546	48 119	**2 765 100**
Average risk contributions per member per month (R')	9 455.29	7 606.24	4 337.87	4 092.64	5 129.41	6 489.40	3 372.66	3 428.50	4 626.75	3 716.18	3 681.13	2 211.90	1 842.82	1 411.87	7 653.41	3 204.54	1 710.20	**3 884.80**
Average risk contributions per beneficiary per month (R')	4 638.05	3 578.70	2 003.31	1 863.80	2 330.63	3 574.32	1 575.51	1 565.12	2 302.38	1 659.78	1 630.74	1 278.14	1 104.59	1 090.74	3 863.53	1 609.95	1 471.07	**1 882.37**
Average net claims incurred per member per month (R')	11 106.92	7 726.02	3 497.81	3 386.06	4 631.16	6 062.97	2 371.16	2 646.87	3 289.29	3 219.97	3 259.92	2 196.63	1 471.40	843.38	4 314.71	2 439.80	1 021.70	**3 383.53**
Average net claims incurred per beneficiary per month (R')	5 448.22	3 635.06	1 615.35	1 542.02	2 104.24	3 339.45	1 107.67	1 208.30	1 636.83	1 438.16	1 444.15	1 269.31	881.96	651.55	2 178.12	1 225.75	878.84	**1 639.48**
Average administration costs per member per month (R')	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	203.98	109.47	203.98	376.41	376.41	376.41	**345.49**
Average administration costs per beneficiary per month (R')	184.64	177.10	173.83	171.42	171.03	207.32	175.84	171.83	187.31	168.12	166.75	117.87	65.62	157.58	190.02	189.11	323.78	**167.41**
Average managed care: Management services per member per month (R')	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.13	120.13	120.13	120.87	120.87	120.88	**120.75**
Average managed care: Management services per beneficiary per month (R')	59.29	56.87	55.82	55.05	54.92	66.58	56.47	55.18	60.15	53.99	53.55	69.42	72.01	92.81	61.02	60.73	103.97	**58.51**
Average family size	2.02	2.12	2.16	2.19	2.20	1.81	2.14	2.19	2.00	2.24	2.26	1.73	1.68	1.30	1.93	1.99	1.17	**2.06**
Loss ratio (%)	118.78%	103.22%	83.43%	85.71%	92.67%	95.34%	73.90%	80.74%	73.72%	89.91%	91.85%	103.29%	86.36%	65.48%	58.00%	79.92%	66.82%	**90.09%**
Total non-healthcare expenses as a percentage of risk contributions (%)	5.20%	6.52%	11.03%	12.04%	9.66%	7.68%	14.29%	13.78%	10.65%	13.14%	12.96%	12.70%	9.54%	18.45%	6.44%	14.70%	25.80%	**11.56%**
Average non-healthcare expenses per member per month	492.14	495.57	478.42	492.84	495.43	498.53	482.00	472.51	492.86	488.45	476.93	280.98	175.75	260.48	492.77	470.93	441.20	**457.39**
Average non-healthcare expenses per beneficiary per month	241.41	233.16	220.94	224.44	225.11	274.59	225.16	215.70	245.26	218.16	211.28	162.36	105.34	201.24	248.76	236.60	379.51	**221.63**
Average age of beneficiaries (years)	47.46	44.51	41.73	35.49	41.09	50.36	32.76	38.87	40.04	36.58	40.60	31.27	35.54	35.56	42.66	32.26	35.46	**36.17**
Pensioner ratio (beneficiaries over 65 years)	28.52%	22.41%	18.11%	9.94%	16.68%	34.28%	7.12%	14.16%	15.16%	10.67%	16.02%	8.17%	13.18%	8.95%	18.13%	5.31%	4.72%	**11.25%**
Average relevant healthcare expenses per member per month	11 231.46	7 851.03	3 619.21	3 507.62	4 753.23	6 186.96	2 492.51	2 768.28	3 411.01	3 341.30	3 381.26	2 284.78	1 591.53	924.43	4 439.11	2 560.93	1 142.69	**3 499.91**
Average relevant healthcare expenses per beneficiary per month	5 509.31	3 693.88	1 671.42	1 597.38	2 159.71	3 407.74	1 164.36	1 263.72	1 697.40	1 492.35	1 497.90	1 320.25	953.96	714.17	2 240.92	1 286.61	982.91	**1 695.87**
Net surplus/(deficit) per benefit plan	(200 506)	(728 149)	255 589	1 025 293	54 328	(2 564)	1 027 975	236 171	54 669	133 761	30 779	(356 593)	55 758	30 648	15 697	242 855	168 544	**2 044 255**

Discovery Health Medical Scheme registration number 1125

OPERATIONAL STATISTICS PER BENEFIT PLAN *continued*

for the year ended 31 December 2021

2020	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	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**

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 and is repayable in terms of Regulation 10 of the Act.

NOTE 9 IN THE FINANCIAL STATEMENTS

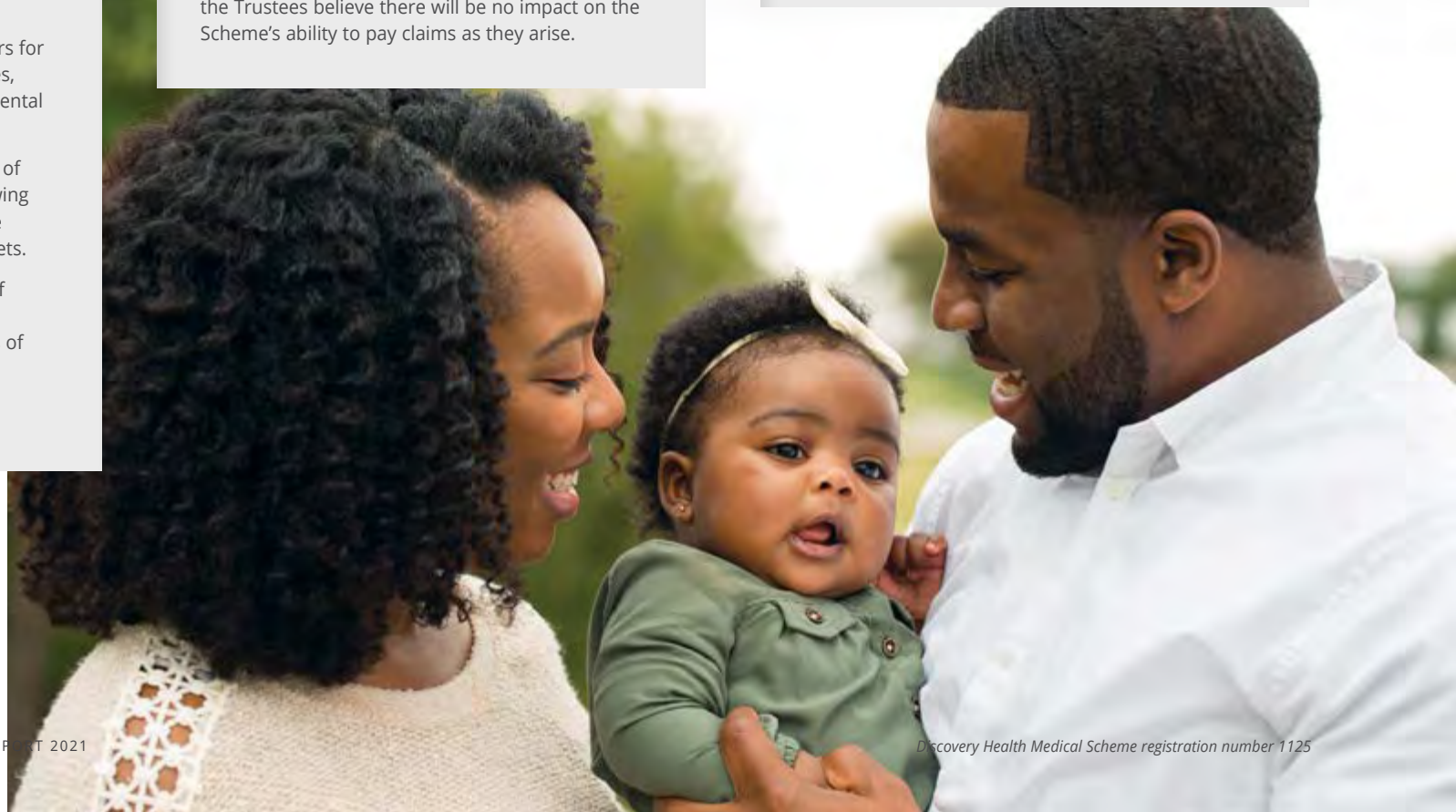
GOING CONCERN

Since the start of the COVID-19 pandemic in South Africa, marked by the declaration by the President of a national state of disaster on 15 March 2020, the Scheme has faced uncertainties around COVID-19's impact on healthcare utilisation. However, given the Scheme's strong financial position and reserve levels, and based on the 2022 expected claims experience, 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.

MORE ABOUT OUR AUDITORS



How Discovery Health supports the Scheme's value creation

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

In accordance with the Medical Schemes Act (the Act) and the Scheme Rules, the Board of Trustees (the Board or the Trustees) appoint an accredited administrator and managed care provider to deliver approved services to Discovery Health Medical Scheme (DHMS or the Scheme) and our members. We utilise a single provider, as the Trustees believe that an integrated model (rather than one employing multiple service providers) is better suited to the Scheme's strategic intent, delivering best value for money and optimal efficiency.

Robust relational governance practices underpin the Scheme's relationship with DH. Periodically, 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 DH, the Vested® model operationalises the Scheme's governance and oversight role and embeds its independence. It also allows us to leverage DH'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.

THE SCHEME IS IN THE PROCESS OF RENEWING ITS AGREEMENTS WITH DISCOVERY HEALTH.

VALUE FOR MONEY FROM DISCOVERY HEALTH

Our members benefit when our administrator and managed care provider adds more value than the fees paid to it by the Scheme. The value that DH 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 six open schemes[1].

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged Deloitte to perform an actuarial review on the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate, that the change in value added from 2019 to 2020 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[2]:

R1.88 2020

R2.03 2019

R2.12 2018

R2.09 2017

R2.00 2016

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. Deloitte have confirmed that the decrease in value for 2020 from 2019 is consistent with a decrease in utilisation experienced in 2020 as a result of the COVID-19 pandemic, while the administration and managed care fees have remained at similar levels in real terms.

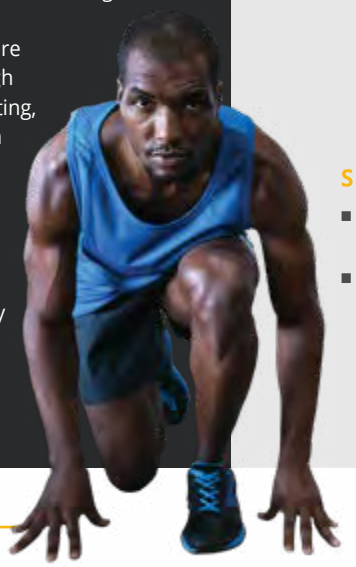
1 *Source: publicly available contribution information for DHMS and the next six largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a single member and for a family unit comprising one 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 six 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.*

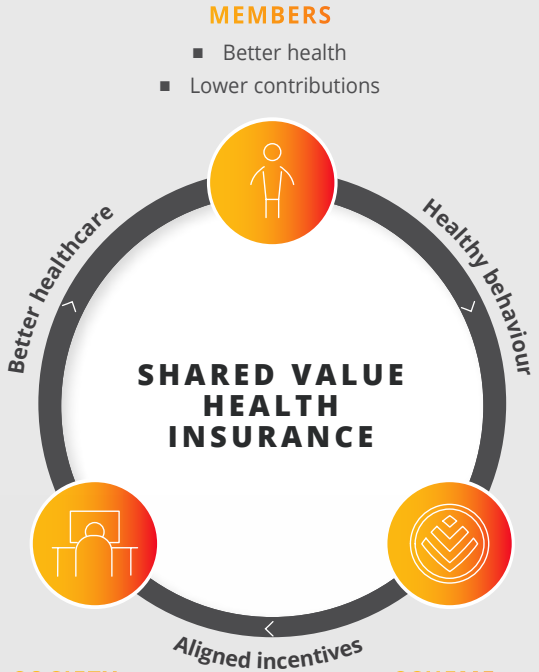
2 *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2020, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R1.88 (2019: R2.03) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*

Discovery Health Medical Scheme registration number 1125

DISCOVERY HEALTH'S BUSINESS MODEL: SHARED VALUE HEALTH INSURANCE

DH 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. DH'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.





ADMINISTRATION AND MANAGED CARE SERVICES RENEWAL

We outsource administration and managed care services to DH through comprehensive contractual agreements, utilising the principles of Vested outsourcing. The Vested model operationalises the Scheme's governance and oversight role and embeds its independence. It also allows us to leverage DH's expertise, systems, innovation and value-added services in the best interests of the Scheme and our members. Together with DH, we established Relationship Management and Innovation Committees which are mandated to monitor, review and improve the relationship based on specific measurement criteria and innovation that the Vested model promotes.

The agreements in place between DH and DHMS have an initial duration of five years, to the end of 2022, with the Scheme required to notify DH of renewal or termination by 31 December 2021. To do so, the Trustees appointed an ad hoc Board subcommittee, the Services Renewal Committee, to comprehensively review the options available to the Scheme in this regard and to provide a recommendation to the Board.

The Services Renewal Committee assessed extensive reports regarding the services provided by DH, including the objectives that the Scheme agrees with DH each year, value added by DH, innovation, operational elements, marketing and distribution, compliance, and the Health Market Inquiry's recommendations and the Council for Medical Schemes' (CMS') requirements.

The Committee appointed Deloitte to conduct an independent review of the administration and managed healthcare services landscape using publicly available information, across three areas; baseline criteria (including current administration and managed care capabilities, value added services, third-party networks and scale to accommodate a scheme of DHMS' size), benchmarking of top performing schemes, and innovation and competitive advantage against global best practice.

Based on the findings, the Trustees are confident that DH is the best administrator and managed care provider in the industry and have resolved to renew the managed care and administration agreements with DH, subject to final terms being agreed during 2022.

ADDRESSING VACCINE HESITANCY FOR THE GOOD OF MEMBERS AND SOCIETY

Concerned by the low uptake of COVID-19 vaccines, Discovery Health conducted an extensive campaign to address fears and misinformation about vaccination. Immunity from prior COVID-19 infection has a limited lifespan, and it has been comprehensively proven that vaccination decreases both asymptomatic and symptomatic infections, hospitalisation and death, and progression to Long COVID[1]. Beyond the benefits to individuals, transmission is reduced through lower and shorter infectiousness benefitting all of society[2].

DISCOVERY HEALTH'S EXCEPTIONAL RESPONSE TO THE PANDEMIC, IN THE SERVICE OF SOUTH AFRICA

Discovery's response to the COVID-19 pandemic, which included launching a prepaid platform with access to private primary healthcare products, opening five mass vaccination centres serving both public and private sector patients, and creating its own booking system, has seen its brand value soar by more than 26% over the past year, according to the latest rankings published by global market insights consultancy firm, Kantar[3].

Discovery's response to the COVID-19 pandemic, which included launching a prepaid platform with access to private primary healthcare products, opening five mass vaccination centres serving both public and private sector patients

1 *The World Health Organisation defines Long COVID as: "Post COVID-19 condition occurs in individuals with a history of probable or confirmed SARS CoV-2 infection, usually 3 months from the onset of COVID-19 with symptoms and that last for at least 2 months and cannot be explained by an alternative diagnosis. Common symptoms include fatigue, shortness of breath, cognitive dysfunction but also others and generally have an impact on everyday functioning. Symptoms may be new onset following initial recovery from an acute COVID-19 episode or persist from the initial illness. Symptoms may also fluctuate or relapse over time." Source: https://www.who.int/srilanka/news/detail/16-10-2021-post-covid-19-condition.*

2 *Sources: "Protection against SARS-CoV-2 after Covid-19 Vaccination and Previous Infection", https://www.nejm.org/doi/full/10.1056/NEJMoa2118691; "What is the vaccine effect on reducing transmission in the context of the SARS-CoV-2 delta variant?", https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8554481/.*

3 *Source: Kantar BrandZ Most Valuable South African Brands 2021.*

DISCOVERY HEALTH'S INITIATIVES FOR OUR MEMBERS

DH'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, and strategic focus on improving value through efficiency and quality of care initiatives promote better healthcare outcomes, further supported by their focus on comprehensive care, health support and the latest medical technologies and treatments.

In 2022, DH and the Scheme are extending virtual care capabilities, enabling healthcare professionals to offer care in the comfort of a patient's own home for eligible patients and conditions, in addition to COVID-19 care, where the attending doctor is comfortable with the safety and appropriateness of remote care.

MORE ABOUT WHAT WE DO FOR OUR MEMBERS

MORE FOR HEALTHCARE PROFESSIONALS

Protecting members through keeping them healthier

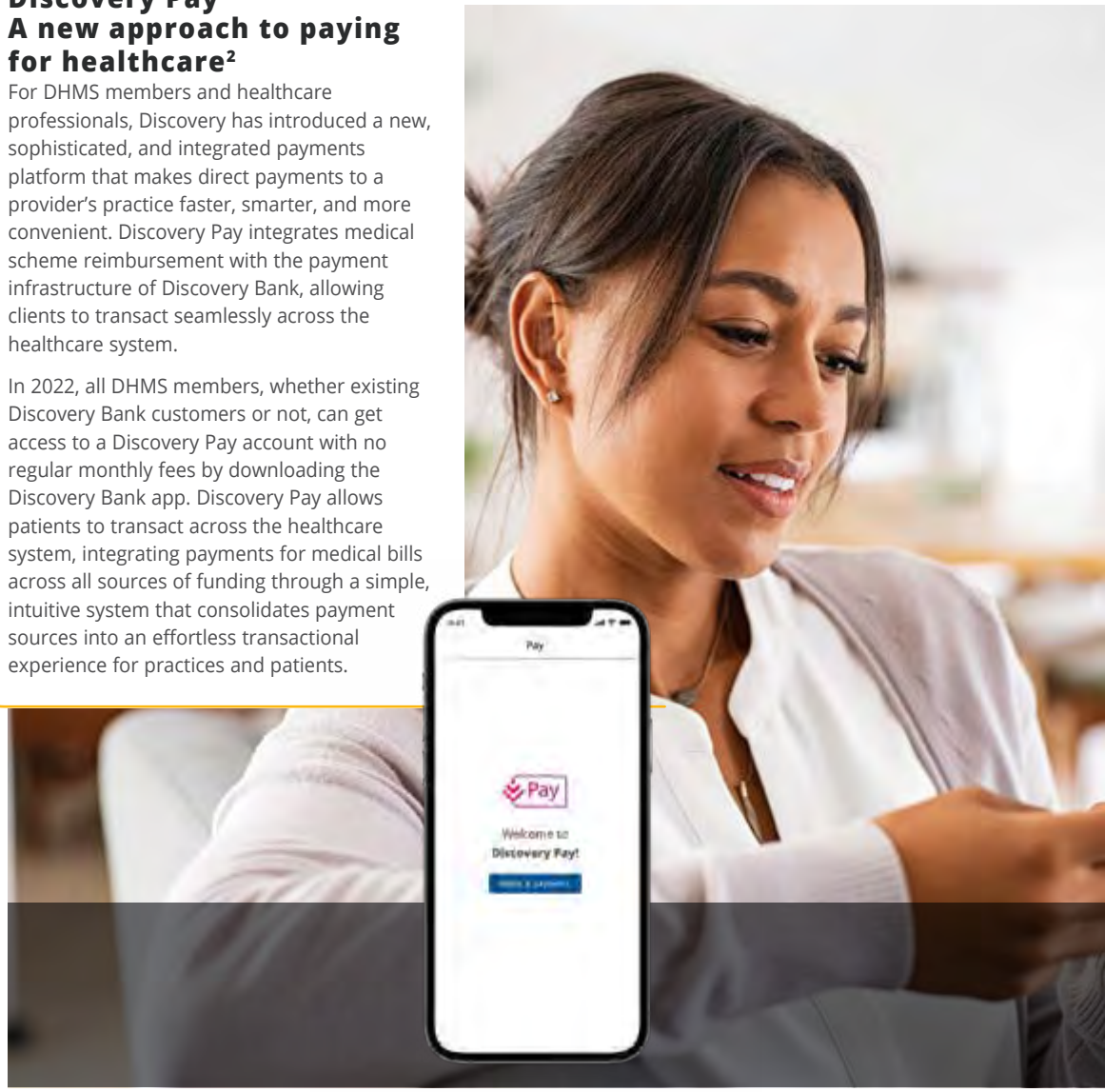
In early 2022, the British Journal of Sports Medicine (BJSM) published research showing that physical activity reduces severe COVID-19 outcomes by up to 42%. The research was produced in a collaboration between DH and the Witwatersrand Sport and Health Research Group. DH makes Vitality[1], a world-leading science-based wellness programme which encourages members to engage in healthy living, including exercise, available to DHMS members to join.

BJSM ARTICLE

Discovery Pay A new approach to paying for healthcare[2]

For DHMS members and healthcare professionals, Discovery has introduced a new, sophisticated, and integrated payments platform that makes direct payments to a provider's practice faster, smarter, and more convenient. Discovery Pay integrates medical scheme reimbursement with the payment infrastructure of Discovery Bank, allowing clients to transact seamlessly across the healthcare system.

In 2022, all DHMS members, whether existing Discovery Bank customers or not, can get access to a Discovery Pay account with no regular monthly fees by downloading the Discovery Bank app. Discovery Pay allows patients to transact across the healthcare system, integrating payments for medical bills across all sources of funding through a simple, intuitive system that consolidates payment sources into an effortless transactional experience for practices and patients.



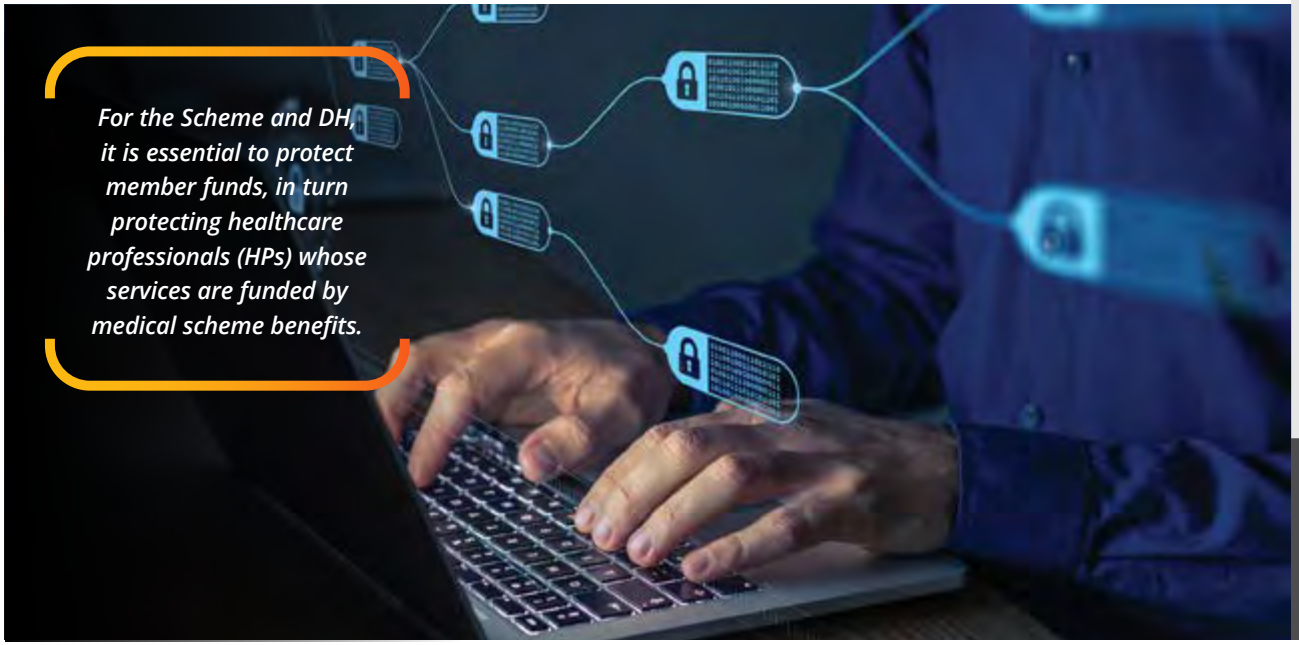
1 *Provided by Vitality, which members may elect to join. Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate science-based wellness programme, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.*

2 *Discovery Pay is not part of the benefits and services offered by Discovery Health Medical Scheme. Discovery Pay is made available by Discovery Bank Limited. Registration number 2015/408745/06. Discovery Bank is an authorised financial services provider (FSP48657) and registered credit provider (NCRCP9997).*

DISCOVERY HEALTH IS WORKING TO CONTINUOUSLY IMPROVE FORENSICS PROCESSES

DH undertakes investigation and forensics processes related to fraud, waste and abuse (FWA) activities on behalf of DHMS, in order to protect and, where relevant, recover the funds of our members that have been mistakenly, wastefully or fraudulently disbursed. As normal business practice, DH regularly reviews its core business processes, the forensic investigation process being one of them. In 2021, DH established the Health Professionals Reference Group (HPRG), comprised of seven practitioner groups, to engage on concerns around fairness, and to improve and make the forensic system more effective. DH also appointed independent professionals with healthcare management, legal and dispute resolution expertise to facilitate the review.

For the Scheme and DH, it is essential to protect member funds, in turn protecting healthcare professionals whose services are funded by medical scheme benefits. For the professionals, a well-managed and sustainable healthcare industry is essential to ensure access to quality healthcare for their patients. The HPRG acknowledged that the law empowers schemes to identify and recover irregular payments and that the vast majority of healthcare professionals are justifiably not affected by forensic investigations.



SOME NOTABLE IMPROVEMENTS DISCUSSED BY THE HPRG INCLUDED:

- Encouraging the early involvement of their associations or societies by HPs.
- An incremental approach to requesting information from HPs during the investigation process.
- Ensuring that HPs are encouraged to invite representation in forensics meetings.
- Engagement between DH and associations to resolve coding-related problems, and to separate these from other forensic matters.
- Collaboration on industry issues that require regulators for resolution.
- All engagements to be courteous, reasonable, proportionate and based on the presence of sufficient evidence.

The HPRG is of the view that the engagements had contributed positively towards progressively improving management of FWA, an essential intervention for the health industry to remain viable.

DISCOVERY HEALTH'S CUSTOMER JOURNEYS[1] DEMONSTRATE ITS CAPABILITIES AND THE IMPACT OF THE PANDEMIC

At 31 December 2021, DH administered approximately 3.5 million beneficiaries, including 2.8 million for DHMS. As such, DH services interacts with millions of individuals during any given year. The comprehensive and world-class service offerings, programmes and platforms DH provides gives DHMS assurance that our members always have access to the best services and information available to suit their health and care needs.

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

DH runs world-leading, highly sophisticated call centres, underpinned by service excellence. DH won the award for Best Contact centre at the International Customer Experience Awards for 2021[2]. This award recognises the best overall performance, capability, and strategy for call centres in companies with more than 10 000 employees.

1 *For members of all schemes administered by Discovery Health.*
2 *Source: https://internationalcxaward.com/hall-of-fame*

IN 2021:

NEW BUSINESS

A new membership activated every **25** *seconds*

SERVICE AND CLAIMS

Calls received per day **34 844**

Claims received per day **306 863**

Paid in claims per hour **R38.7** *million*

Hospital admissions approved per day **2 333**

Billed in contributions per month **R7.9** *billion*

DIGITAL SUPPORT

Website users per month **554 628**

Website logins per day **63 000**

Mobile users per month **358 333**

Mobile logins per day **11 900**

WhatsApp registered users **392 000**

WhatsApp interactions per day **810**

Current HealthID users **3 400**

Social media followers **1.1** *million*

BENEFIT MANAGEMENT

HIV Programme members **74 523**

Chronic Illness Benefit Programme members **1 001 306**

Oncology Programme members **75 336**

MEMBER PROFILES

Average principal member age **46**

Oldest member **109**

Average member makes **22** claims per year

Average member accesses website **6** times per month

Vitality checks per month **47 404**

Family memberships (single/family) **45%/55%**

Discovery Health Medical Scheme registration number 1125

08 FINANCIALS

Statement of responsibility by the Board of Trustees

FOR THE YEAR ENDED 31 DECEMBER 2021

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

The Financial Statements comprise the Statement of Financial Position at 31 December 2021, 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 2022. In considering this budget, the Trustees considered the continued impact of COVID-19 related expenses, such as vaccine costs, on the Scheme.

Although there is still uncertainty around the future impact of COVID-19 on the Scheme, including the timing of claims normalising to pre-COVID-19 levels,the Scheme's strong financial position and reserve levels allow the Scheme to absorb any potential increases in claims as a result. Based on the 2022 expected claims experience, this is not envisaged to impact the Scheme's ability to pay claims as they arise.

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

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Financial Statements and their unmodified report is presented on pages 107 – 109. The Financial Statements, which are presented on pages 110 – 194, were approved by the Board of Trustees on 13 April 2022 and are signed on its behalf by:

JOHN BUTLER
Chairperson

JOHAN HUMAN
Trustee

SELWYN KAHLBERG
Acting Principal Officer

Discovery Health Medical Scheme registration number 1125

REPORT OF THE AUDIT COMMITTEE
FOR THE YEAR ENDED 31 DECEMBER 2021

We are pleased to present our report for the financial year ended 31 December 2021. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit Committee terms of reference and assessment

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

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

The Committee is assessed on an annual basis either by external independent parties, or through self-appraisals.

Audit Committee members, meeting attendance and assessment

The membership and attendance of the Members of the Committee has been set out on page 60.

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 2021 to 31 December 2021 in accordance with section 36 (2) of the Act on 26 August 2021.

The Committee has satisfied itself that the External Auditor is independent of the Scheme as set out in Section 36 (3) of the Act. The Auditor narrated the audit firm's internal governance processes that support and demonstrate its independence.

The Committee ensured that the appointment of the Auditor at the Annual General Meeting complied with the Act and Scheme Rules relating to the appointment of auditors.

The Committee, following consultation with the Scheme's Executive Officers, approved the engagement letter, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2021. The Committee approved the actual audit fees for the year ended 2020.

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 17 to the Financial Statements.

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

Internal Auditors (IA)

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

The Committee considered and approved the IA charter.

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

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

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

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

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

Financial statements and accounting policies

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

Internal financial controls

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

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

* *Reasonable Assurance – The existing control framework provides reasonable assurance that material risks are identified and managed effectively.*
** *High Assurance – The existing control framework provides a high-level of assurance that the annual Financial Statements are fairly presented.*

Evaluation of the expertise and experience of the Chief Financial Officer and Finance function

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

Whistle blowing

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

Ethics and compliance

The Committee is responsible for reviewing any major breach of relevant legal and regulatory obligations. The Committee is satisfied that there has been no material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 35 to the Financial Statements. Certain members of the Audit Committee also serve as members of the Risk Committee.

Risk management

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

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

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

Going concern

The Committee has reviewed the going concern basis for the preparation of the Scheme's Financial Statements taking into account the operational and financial position at 31 December 2021 as well as the Scheme's budget for the year ending 31 December 2022.

Total members' funds exceeded R30.4 billion with a solvency level of 38.01% at 31 December 2021. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) at 31 December 2021 to cover monthly claims expenditure 6.88 times.

On the basis of this review and taking note of the current net surplus of R2 billion, the Committee considers that:

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

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

MR E MACKEOWN
Chairperson: Audit Committee

13 April 2022

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 110 to 194, which comprise the Statement of Financial Position as at 31 December 2021, and the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and the Statement of Cash Flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2021, 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 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 R2 257 054 000 at year-end, as described in Note 7 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 and Cost Per Event methods.	We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the outstanding claims provision, which included the design and implementation of controls within the process. 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 2021. The actual claims data reflects the most recent claims patterns, including the impact of COVID-19, and is taken into account in calculating the outstanding claims provision. We assessed the completeness of the claims data on the member administration system by understanding management's controls and selecting claim transactions from the claim source and agreeing these to the member administration system. No material inconsistencies were noted. We substantively tested a sample of claims received by the Scheme in the financial year ended 31 December 2021, selected from the member administration system, and confirmed the accuracy of the service and process dates and the validity of the claim against the relevant Scheme rules. No material inconsistencies were noted. We assessed the completeness of the claims data in the Scheme's actuarial model by understanding management's controls and testing the claims data interface between the member administration system and the actuarial model. No material inconsistencies were noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. We noted no matters for further consideration with respect to the estimation process. Our internal actuarial experts independently calculated the Scheme's outstanding claims provision, taking into account the claims data tested above. We compared our results with that of the Scheme and found the amounts to approximate each other.

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 could cause a material change to the amount of the provision.	We performed the following procedures to assess the adequacy of the outstanding claim provision: ■ We obtained the actual claims run-off report up to 31 March 2022 from the Scheme's management and compared the claims paid post year-end to the outstanding claims provision at year-end as part of subsequent event procedures. No material inconsistencies were noted. ■ For a sample of claims from the claims run-off report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates by agreeing the claims to underlying supporting documents on the member administration system and we identified no material inconsistencies. ■ We inquired from the Scheme's management whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. No such delays were identified. ■ We obtained a list of pre-authorisations approved prior to year-end from the administrator. For a sample of pre-authorisations with a service date before year-end, we requested the related claim documentation and assessed if the related claim had been included correctly in the claims run-off report up to 31 March 2022. No material inconsistencies were noted.

OTHER INFORMATION

The Scheme's Trustees are responsible for the other information. The other information comprises the information included in the document titled "Discovery Health Medical Scheme Integrated Report 2021". The other information does not include the financial statements and our auditor's report thereon.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

RESPONSIBILITIES OF THE SCHEME'S TRUSTEES FOR THE FINANCIAL STATEMENTS

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

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

AUDITOR'S RESPONSIBILITIES FOR THE AUDIT OF THE FINANCIAL STATEMENTS

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's Trustees.
- Conclude on the appropriateness of the Scheme's Trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt

on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.

- Evaluate the overall presentation, structure, and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

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 AMENDED (THE ACT)

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Act that have come to our attention during the course of our audit:

- **Non-compliances with Regulation 28 (2), 28 (5) and 28 (8) of the Act:**
  There were instances where some brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid.
- **Non-compliance with Section 29 (1) (o) and Regulation 8 of the Act:**
  There were instances where the Scheme did not pay claims in accordance with the scope and level of prescribed minimum benefits.
- **Non-compliance with Section 33 (2) (b) of the Act:**
  Certain benefit options were not self-supporting in terms of financial performance.

AUDIT TENURE

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Discovery Health Medical Scheme for 21 years.

The engagement partner, Linda Pieterse, has been responsible for Discovery Health Medical Scheme's audit for 3 years.

PricewaterhouseCoopers Inc.

PRICEWATERHOUSECOOPERS INC.

Director: Linda Pieterse
Registered Auditor
Johannesburg South Africa

28 April 2022

MORE ABOUT OUR AUDITOR'S TENURE

STATEMENT OF FINANCIAL POSITION
AT 31 DECEMBER 2021

	Notes	2021 R'000	2020 R'000
Assets			
Non-current assets		**24 719 222**	16 270 481
Property and equipment	1	**9 658**	11 144
Long-term employee benefit plan asset	27	**7 998**	6 427
Financial assets at fair value through profit or loss	3	**24 701 566**	16 252 910
Current assets		**16 566 181**	22 004 691
Financial assets at fair value through profit or loss	3	**9 987 157**	15 177 582
Derivative financial instruments	8	**–**	193 030
Trade and other receivables	4	**2 729 850**	2 625 411
Cash and cash equivalents		**3 849 174**	4 008 668
– Personal Medical Savings Accounts trust assets arising from amalgamation	5	**10 860**	–
– Medical Scheme assets	6	**3 838 314**	4 008 668
TOTAL ASSETS		**41 285 403**	38 275 172
Funds and liabilities			
Members' funds		**30 418 845**	28 215 475
Accumulated funds		**30 418 845**	28 215 475
Liabilities			
Non-current liabilities		**8 671**	9 394
Leases	2	**8 671**	9 394
Current liabilities		**10 857 887**	10 050 303
Leases	2	**1 961**	1 832
Derivative financial instruments	8	**–**	34 723
Outstanding claims provision	7	**2 257 054**	1 769 008
Personal Medical Savings Account liabilities	9	**7 081 549**	6 675 945
Trade and other payables	10	**1 517 323**	1 568 795
TOTAL FUNDS AND LIABILITIES		**41 285 403**	38 275 172

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	2021 R'000	2020 R'000
Risk contribution income	11	**62 459 297**	61 242 728
Relevant healthcare expenditure		**(56 271 074)**	(46 656 654)
Net claims incurred	12	**(54 399 878)**	(44 815 954)
Risk claims incurred	12	**(54 467 338)**	(44 957 497)
Third party claim recoveries	12	**67 460**	141 543
Accredited managed healthcare services (no risk transfer)	13	**(1 960 416)**	(1 883 081)
Net income on risk transfer arrangements	14	**89 220**	42 381
Risk transfer arrangement fees paid		**(271 813)**	(260 068)
Recoveries from risk transfer arrangements		**361 033**	302 449
Gross healthcare result		**6 188 223**	14 586 074
Broker service fees	15	**(1 438 916)**	(1 489 823)
Expenses for administration	16	**(5 554 748)**	(5 389 056)
Other operating expenses	17	**(224 677)**	(177 363)
Net impairment losses on healthcare receivables	19	**(135 524)**	(79 096)
Net healthcare result		**(1 165 642)**	7 450 736
Other income		**3 638 788**	1 920 700
Investment income	23	**1 771 609**	1 690 370
Net gains on financial assets	24	**1 838 553**	212 981
Sundry income	25	**28 626**	17 349
Other expenditure		**(428 888)**	(365 316)
Asset management fees		**(93 213)**	(78 608)
Other expenses	25	**–**	(2 372)
Finance costs	26	**(1 242)**	(1 429)
Interest paid on savings accounts	26	**(334 433)**	(282 907)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**2 044 258**	9 006 120

STATEMENT OF CHANGES IN FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	2021 R'000 Accumulated Funds	2020 R'000 Accumulated funds
Balance at beginning of the year		**28 215 475**	19 209 355
Total comprehensive income for the year		**2 044 258**	9 006 120
Reserves transferred from other Medical Schemes	31	**159 112**	
TOTAL MEMBER FUNDS END OF THE YEAR		**30 418 845**	28 215 475

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	2021 R'000	Restated 2020 R'000
Cash flows from operating activities			
Cash receipts from members	29	**75 929 680**	74 514 512
Cash received from members – contributions		**75 929 680**	74 514 512
Cash paid to providers, employees and members		**(76 660 618)**	(65 979 695)
Cash paid to providers and members – claims	29	**(68 596 626)**	(58 199 219)
Cash paid to providers and employees – non-healthcare expenditure	29	**(7 570 583)**	(7 290 880)
Cash paid to members – savings plan refunds		**(493 409)**	(489 596)
Cash generated from operations		**(730 938)**	8 534 817
Purchase of financial assets	29	**(8 738 440)**	(11 887 221)
Proceeds from disposal of financial assets	29	**7 735 859**	3 763 349
Increase in long-term employee plan asset		**(5 360)**	(3 472)
Interest received	29	**1 345 637**	1 534 060
Dividend income	23	**322 814**	156 310
Interest paid	26	**(4)**	(136)
Asset manager fees paid		**(93 217)**	(78 608)
Net cash (outflow)/inflow from operating activities		**(163 649)**	2 019 099
Cash flows from financing activities			
Payment of lease liabilities	2	**(1 832)**	(1 713)
Net cash outflow from financing activities		**(1 832)**	**(1 713)**
Net increase in cash and cash equivalents		**(165 481)**	2 017 386
Cash and cash equivalents at beginning of the year		**4 008 668**	1 991 282
Transfer of cash and cash equivalents due to amalgamation		**5 987**	
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**3 849 174**	4 008 668
Cash and cash equivalents comprise			
Personal Medical Savings Account trust assets		**10 860**	
Medical Scheme assets		**3 838 314**	4 008 668
		3 849 174	4 008 668

ACCOUNTING POLICIES

General information

Discovery Health Medical Scheme (DHMS or 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, revised IFRS, and changes in accounting policy as noted below.

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 34.

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 Rands (R'000), unless otherwise indicated.

Change in the accounting policy relating to the format of the statement of cash flows

During 2021 the Council for Medical Schemes (CMS) published Circular 52 of 2021: *Statement of Cash Flows*. In the circular it was noted that Paragraph 19 of IAS 7 encourages entities to report cash flows from operating activities using the direct method. The CMS introduced the direct method in its 2011 annual statutory returns.

The Statement of Cash Flows (SOCF) has been aligned to the prescribed format as set out in Circular 52 of 2021, with the most notable changes being the reporting of cash flows from operating activities using the direct method. The cash flows from operating activities were previously reported using the indirect method.

This change in accounting policy will be applied in preparing the Financial Statements for the year ended 31 December 2021. 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 SOCF.

TABLE 2: COMPARISON OF STATEMENT OF CASH FLOWS

	2020 Restated R'000		2020 Previously presented R'000
CASH FLOWS FROM OPERATING ACTIVITIES		**CASH FLOWS FROM OPERATING ACTIVITIES**	
Cash receipts from members	**74 514 512**	Cash flows generated from operations before working capital changes	**7 470 530**
Cash received from members – contributions	74 514 512	Working capital changes:	
Cash paid to providers, employees and members	(65 979 695)	Increase in trade and other receivables	(144 082)
Cash paid to providers and members – claims	(58 199 219)	Increase in outstanding claims provision	242 511
Cash paid to providers and employees – non-healthcare expenditure	(7 290 888)	Increase in Personal Medical Savings Account liabilities	1 153 332
Cash paid to members – savings plan refunds	(489 596)	Increase in trade and other payables	16 825
Cash generated from operations	**8 534 817**	**Cash generated by operations**	**8 739 116**
Purchase of financial assets	(11 887 221)	Payments for financial assets	(11 887 221)
Proceeds from disposal of financial assets	3 763 349	Proceeds from sale of financial assets	3 763 349
Increase in long-term employee plan asset	(3 472)	Increase in long-term employee plan asset	(3 472)
Interest received	1 534 060	Interest received	1 534 060
Dividend income	156 310	Dividend income	156 310
Interest paid	(136)	Interest paid	(283 043)
Asset manager fees paid	(78 608)		
Net cash inflow from operating activities	**2 019 099**	**Net cash inflow from operating activities**	**2 019 099**

The prior year financial statements incorrectly disclosed interest allocated to personal member savings accounts as a cash item. This error has been corrected retrospectively.

Implementation of new standards

New standards, amendments and interpretations effective and relevant to the Scheme

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. London Inter-Bank Offered Rate (LIBOR) as a benchmark rate is based on submissions from a panel of banks of the rates that prevail among them. This is however not based on actual transactions and can be thought of as a hypothetical rate. Additionally, high-profile investigations into LIBOR manipulation by regulators in the United States (US), United Kingdom (UK) and the European Union (EU) have resulted in large fines. This lack of liquidity and the manipulation scandals have driven the call for reform of existing interest rate benchmarks by regulators across the globe. In 2017, Andrew Bailey, the acting Chief Executive of the Financial Conduct Authority (FCA), which oversees LIBOR, announced that the FCA would no longer persuade or compel member panel banks to make LIBOR quote submissions after 2021 and that market participants should expect LIBOR to be subsequently discontinued, or at least to no longer be deemed representative. The Secured Overnight Funding Rate (SOFR) has emerged as the best replacement for LIBOR. This rate is based on actual transactions in the repo market and is considered a more accurate representation of short-term funding rates. The Ninety One Multi-Asset Credit Fund is the only fund within the Scheme's portfolio that was affected by this change, Ninety One identified the Secured Overnight Funding Rate (SOFR) as the replacement benchmark for the fund, which was previously the US Dollar three Month LIBOR. This conversion took place on 30 November 2021. The strategy for the fund has not changed and the manager does not anticipate that there would be any significant impact following the change. For reporting purposes, the new benchmark was effective on 1 December 2021, as the change was successfully implemented.	1 January 2021

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
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
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 (the premium allocation approach (PAA)) 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 or if the coverage period is one year or less. 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.	Annual periods beginning on or after 1 January 2023

IFRS 17: Insurance contracts *continued*	**Implementation assessment:** The contracts issued by the Scheme to members are included in the scope of IFRS 17 as they insure against the cost of a health event, arising from either, out of hospital (day to day events), in hospital events or chronic illnesses, or any combination of these events. 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. Personal Medical Savings Accounts are not distinct, are highly interrelated and cannot be purchased separately from the risk component. Under IFRS 17 Personal Medical Savings Accounts (PMSAs) do not meet the criteria to separate these from the insurance component, the are non-distinct investment components with the balances included in either Insurance Contract Assets or Liabilities in the Statement of Financial Position. While the cash flows are not recorded in the Statement of Comprehensive Income, they are considered in assessing onerous contracts. The Scheme's insurance contracts are included in a single portfolio and the coverage period is aligned with the reporting period (financial year). The insurance contracts will be recognised from 1 January or from inception of cover should a member join the Scheme after 1 January. Where the Scheme, as a whole is priced for a deficit position at the Net Healthcare Result level, all contracts would be onerous and the loss would need to be recognised when the contracts become onerous. As pricing for the Scheme is done in September for the following year, the onerous contract test would be assessed at this time, with the following year's loss being recognised in the current financial year. No discounting will be applied as no contract exceeds 12 months. **Implementation progress:** The contract boundary for the Scheme's insurance contracts do not exceed 12 months and is generally aligned with the Scheme's financial year. With the coverage period and the Scheme's financial year being the same, there would be no liability for remaining coverage at the year-end reporting date. The PAA can be used to measure the Scheme's insurance contracts. The only liability remaining at year end would be the liability for incurred claims, which comprises the fulfilment cash flows related to past service allocated to the group at that date.	Annual periods beginning on or after 1 January 2023

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 disclosed in Note 32.

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.

LIABILITY ADEQUACY TEST

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities 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 33. 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

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 International Financial Reporting Standard (IFRS) 16.

The asset's residual values and useful lives are reviewed at each reporting date and adjusted if appropriate. An assets' carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount. The recoverable amount is the higher of the asset's fair value less costs to dispose and value-in-use.

Gains or losses on disposals are determined by comparing the proceeds with the carrying amount. These are recorded in the surplus or deficit.

Note:

R'000	Right-of-Use Asset Land and Buildings	Leasehold improve-ment	Total
Non-current			
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**
Gross carrying amount	12 015	2 844	14 859
Accumulated depreciation	(4 205)	(996)	(5 201)
BALANCE AT 31 DECEMBER 2021	**7 810**	**1 848**	**9 658**

R'000	Right-of-Use Asset Land and Buildings	Leasehold improve-ment	Total
Non-current			
Balance at 1 January 2020	10 212	2 418	12 630
Depreciation charge	(1 201)	(285)	(1 486)
Balance at 31 December 2020	**9 011**	**2 133**	**11 144**
Depreciation charge	(1 201)	(285)	(1 486)
BALANCE AT 31 DECEMBER 2021	**7 810**	**1 848**	**9 658**

LEASED ASSETS

The right-of-use asset arises from the lease agreement for the Scheme's offices (Note 2).

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

2. Leases continued

LEASES OF LOW-VALUE ASSETS

The Scheme has elected not to recognise right-of-use assets and lease liabilities for leases of low-value assets, with a value of less than R100 000.

DISCLOSURE

The Scheme represents right-of-use assets in "Property and equipment" and lease liabilities in "Leases" in the Statement of Financial Position. The Scheme recognises the lease payments associated with short-term leases, with a lease term not exceeding 12 months, and leases of low-value assets as an expense on a straight-line basis over the lease term.

Note:

NATURE OF LEASING ACTIVITIES

The Scheme leases land and buildings for its office space. The lease for the office space is effective from 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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

2. Leases continued

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.

R'000	Land and Buildings	Total
Right-of-use asset		
Gross carrying amount	12 015	12 015
Accumulated depreciation	(3 004)	(3 004)
BALANCE AT 31 DECEMBER 2020	**9 011**	**9 011**
Gross carrying amount	12 015	12 015
Accumulated depreciation	(4 205)	(4 205)
BALANCE AT 31 DECEMBER 2021	**7 810**	**7 810**
LEASE LIABILITY		
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**
Gross carrying amount	12 015	12 015
Interest expense	4 537	4 537
Lease payments	(5 920)	(5 920)
BALANCE AT 31 DECEMBER 2021	**10 632**	**10 632**

R'000	2021	2020
Maturity analysis – contractual undiscounted cash flows		
Less than one year	**1 961**	1 832
One to five years	**12 065**	11 275
More than five years	**1 421**	4 171
TOTAL UNDISCOUNTED LEASE LIABILITIES AT 31 DECEMBER 2021	**15 447**	17 278
Lease liabilities included in the Statement of Financial Position at 31 December 2021		
Non-current	**8 671**	9 394
Current	**1 961**	1 832
	10 632	11 266
Amounts recognised in the Statement of Comprehensive Income		
Depreciation	**1 201**	1 201
Interest on lease liabilities	**1 238**	1 293
Expenses relating to leases of low-value assets	**73**	73
Amounts recognised in the Statement of Cash Flows		
Total cash outflow for leases	**1 832**	1 713

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

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.

The methodology applied to assess assets as non-current or current is summarised below:

Measurement class	Methodology
Offshore bonds	Offshore bonds are in collective investment schemes. The Scheme's intention is not to liquidate these portfolios however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result, these portfolios have been included as open ended.
Equities	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.
Short duration bonds (2020 classification: 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.
Flexible fixed income bonds (2020 classification: 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.
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.

NOTES TO THE FINANCIAL STATEMENTS continued
FOR THE YEAR ENDED 31 DECEMBER 2021

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

R'000	2021	2020
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
	34 688 723	31 430 492
– Offshore cash and bonds	**2 299 286**	1 975 533
– Equities	**7 578 533**	4 658 899
– Yield-enhanced bonds	**–**	8 871 310
– Short duration bonds	**10 604 304**	–
– Inflation-linked bonds	**–**	1 170 279
– Flexible fixed income bonds	**5 229 271**	–
– Money market instruments	**8 367 829**	14 323 269
– Property	**609 500**	431 202
	34 688 723	31 430 492
Open ended, available on demand (Included as non-current)	**24 701 566**	16 252 910
Expected to settle within 12 months (Included as current)	**9 987 157**	15 177 582
	34 688 723	31 430 492

Reconciliation of the balance at the beginning of the year to the balance at the end of the year:

R'000	2021	2020
At the beginning of the year	**31 430 492**	23 191 456
Acquisitions	**8 841 598**	11 887 221
Disposals	**(7 582 315)**	(3 470 050)
Transfer due to amalgamation	**155 632**	–
Net gains/(losses) on revaluation of financial assets at fair value through profit or loss (Note 24)	**1 843 316**	(178 135)
AT THE END OF THE YEAR	**34 688 723**	31 430 492

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

For the year ended 31 December 2021, the Net healthcare result generated a loss of R1.2 billion, a decrease of 116% compared to the year ended 31 December 2020, with total comprehensive income increasing to R2 billion after inclusion of investment and other income and expenditure. This performance increased accumulated funds by 8% to R30.4 billion with the statutory capital requirement increasing from 36.93% to 38.01%. The statutory solvency requirement exceeds the 25% minimum statutory requirement by R9.9 billion. Based on these results, the Scheme does not anticipate to liquidate the offshore, equities and properties portfolios.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

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 2021

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. Note 33 sets out information about impairment of other receivables.

Note:

R'000	2021	2020
Insurance receivables		
Contribution receivables	**2 349 186**	2 200 791
Contributions outstanding	**2 380 960**	2 223 262
Less: Provision for impairment	**(31 774)**	(22 471)
Member and service provider claims receivables	**98 046**	98 725
Amount due	**405 176**	421 649
Less: Provision for impairment	**(307 130)**	(322 924)
Other risk transfer arrangements	**372**	2 695
Recoveries due from other risk transfer arrangements	**52**	489
Share of outstanding claims provision (Note 7)	**320**	2 206
Broker fee receivables	**685**	469
Amounts due from brokers	**5 598**	2 365
Less: Provision for impairment	**(4 913)**	(1 896)
Other insurance receivables	**63 385**	41 340
Balance due by related party (Note 27)	**13 058**	13 688
Discovery Third Party Recovery Services (Pty) Ltd	**13 044**	13 688
Discovery Life Ltd	**14**	
Forensic receivables	**194 390**	253 483
Amount due	**207 216**	265 262
Less: Provision for impairment	**(12 826)**	(11 779)
TOTAL RECEIVABLES ARISING FROM INSURANCE CONTRACTS	**2 719 122**	2 611 191
Other receivables		
Sundry accounts receivable	**9 567**	13 297
Interest receivable	**1 161**	923
TOTAL RECEIVABLES ARISING FROM OTHER RECEIVABLES	**10 728**	14 220
	2 729 850	2 625 411

At 31 December 2021, the carrying amounts of "Trade and other receivables" approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

5. Cash and cash equivalents – Personal Medical Savings Account trust assets arising from amalgamation

(Monies managed by the Scheme on behalf of members)

ACCOUNTING POLICY:

Members' medical savings accounts: monies

The members' medical savings account, which constitutes a portion of the members' monthly contributions allocated for the exclusive benefit of a member and his/her dependants, represents 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 of the insurance contracts has been unbundled, since the Scheme can measure the deposit component separately. The insurance component is recognised as an insurance liability.

Unspent savings at the year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act, No 131 of 1998, as amended, (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 by the Scheme's funds, and the risk of impairment is carried by the Scheme.

No interest accrues to members on positive Personal Medical Savings Account (PMSA) balances.

Note:

R'000	2021	2020
Personal medical savings account trust portfolio (Managed by Coronation)		
Balance at beginning of the year	–	–
Net additional Investments	10 687	–
Interest Income	173	–
BALANCE AT THE END OF THE YEAR	10 860	–

Quantum Medical Aid Society (QMAS) amalgamated into Discovery Health Medical Scheme (DHMS or the Scheme) effective 1 August 2021. In accordance to the QMAS' rules the PMSA monies belong to the members. This resulted in the creation of a trust relationship between the scheme and the member. Personal Medical Savings Accounts accordingly constitute trust money as defined in section 1 of the Financial Institutions (Protection of Funds) Act 28 of 2001 read with Regulation 10 to the Act.

Personal medical savings are invested separately from scheme funds, which are further clarified by section 4 (5) of the Financial Institutions (Protection of Funds) Act 28 of 2001.

The PMSA trust relationship remains for QMAS members who did not transfer to DHMS on the amalgamation date, either due to leaving QMAS prior to the amalgamation date or choosing not to transfer to DHMS on amalgamation ("withdrawn members").

The difference between total Personal Medical Savings Account assets and Personal Medical Savings Account liabilities (Note 9) is reconciled monthly and arises from timing of cash flows to and from the portfolios.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

6. Cash and cash equivalents – medical scheme assets

ACCOUNTING POLICY:

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value. These instruments are not held for investment purposes.

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

- Money on call and short notice.
- Balances with banks.
- Money market funds

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes and are carried at cost, which, due to their short-term nature, approximates fair value.

Note:

R'000	2021	2020
Current accounts	**901 508**	875 860
Money market funds	**2 936 806**	3 132 808
	3 838 314	4 008 668

At the reporting date cash and cash equivalents are carried at amortised cost, which approximates fair value.

The money market funds are held in an actively managed portfolio by an independent asset manager. The asset manager invests in line with its best investment view, subject to the investment mandate which includes investment in interest bearing – money market and/or interest-bearing short-term collective investment scheme portfolios, subject to the Collective Investment Schemes Control Act 2002 (CISCA). The targeted return is the Short-Term Fixed Interest (STeFI) Call Deposit Index, and the weighted average term to final maturity never exceeds 90 days. The portfolio is highly liquid with 100% of the portfolio being available within three working days. 60% of the portfolio must be available for same-day value with the balance available within two working days.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

7. 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 considered to not be material.

Note:

R'000	**2021**	**2020**
Outstanding claims provision – not covered by risk transfer arrangements	**2 256 734**	1 766 802
Outstanding claims provision – covered by risk transfer arrangements (Note 4)	**320**	2 206
	2 257 054	1 769 008
Analysis of movement in outstanding claims		
Balance at beginning of the year	**1 769 008**	1 526 497
Payments in respect of prior year	**(1 705 525)**	(1 532 216)
Over/(Under) provision in prior year (Note 12)	**63 483**	(5 719)
Outstanding claims provision raised in current year	**2 193 571**	1 774 727
Not covered by risk transfer arrangements	**2 193 251**	1 772 521
Covered by risk transfer arrangements (Note 4)	**320**	2 206
BALANCE AT END OF THE YEAR	**2 257 054**	1 769 008
Analysis of outstanding claims provision		
Estimated gross claims	**2 351 130**	1 893 413
Less:		
Estimated recoveries from savings plan accounts (Note 9)	**(94 076)**	(124 405)
BALANCE AT END OF THE YEAR	**2 257 054**	1 769 008

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

8. Derivative financial instruments

Note:

R'000	2021	2020
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	–	193 030
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	–	(34 723)
DERIVATIVE FINANCIAL ASSET AT THE END OF THE YEAR	–	158 307
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset at the beginning of the year	**158 307**	60 490
Net realised gain on derivative financial instruments (Note 29)	**(153 544)**	(293 299)
Realised gains on derivative financial instruments	**(257 574)**	(333 865)
– Zero-cost currency collars	**(211 669)**	–
– Zero-cost equity fences	**(45 905)**	(333 865)
Realised losses on derivative financial instruments	**104 030**	40 566
– Zero-cost equity fences	**104 030**	
– Zero-cost currency collars	**–**	40 566
Net fair value (loss)/gain on derivative financial instruments (Note 24)	**(4 763)**	391 116
Gains on revaluation of derivative financial instruments to fair value	**64 544**	403 665
– Zero-cost equity fences	**15 337**	309 412
– Zero-cost currency collar	**49 207**	94 253
Losses on revaluation of derivative financial instruments to fair value	**(69 307)**	(12 549)
– Zero-cost equity fence	**(69 307)**	(12 549)
DERIVATIVE FINANCIAL ASSET AT THE END OF THE YEAR	–	158 307

The Scheme has in the past maintained fully hedged positions on its local equity and offshore fixed income portfolios to protect solvency levels. The Scheme's solvency has however increased significantly over the last 18 months and is expected to remain comfortably in excess of the minimum 25% level required. This has increased the Scheme's ability to take on volatility risk. The Scheme's investment consultants has over the course of 2021 recommended that the Scheme allow the equity hedges to expire as well as unwind the currency hedges it had in place. The Scheme currently has no hedge structures implemented and the consultants will continue to pro-actively monitor any changes and recommend changes accordingly.

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 33).

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

9. Personal Medical Savings Account liabilities

ACCOUNTING POLICY:

The Scheme Rules for 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, PMSA's were disclosed as trust liabilities. From 1 January 2018 the Scheme rules have been amended to no longer establish a trust relationship, therefore no longer requiring the disclosure as a trust liability.

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

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

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

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

Interest payable on members' PMSAs is expensed when incurred.

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	**2021**	**2020**
Balance on Personal Medical Savings Accounts at the beginning of the year	**6 675 945**	5 522 613
Add:		
Personal Medical Savings Accounts contributions received or receivable (Note 11)	**13 356 990**	13 294 773
Interest on Personal Medical Savings Accounts (Note 26)	**334 433**	282 907
Transfers received from other medical schemes	**19 618**	16 479
Savings plan liabilities transferred to the scheme upon amalgamation	**11 165**	–
Less:		
Claims paid to or on behalf of members (Note 12)	**(12 823 100)**	(11 785 757)
Refunds on death or resignation	**(493 293)**	(487 217)
Unclaimed Personal Medical Savings Accounts written off to scheme funds (Note 25)	**(116)**	(2 379)
COVID-19 Support: Contributions funded from PMSA	**(93)**	(165 474)
BALANCE DUE TO MEMBERS ON PERSONAL MEDICAL SAVINGS ACCOUNTS AT THE END OF THE YEAR	**7 081 549**	6 675 945

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2021 but not reported will amount to approximately R94m (2020: R124m) (Note 7).

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 2021, 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 R93k (2020: R165m). The Council for Medical Schemes (CMS) granted DHMS 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 2021

10. 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	2021	2020
Insurance payables		
Contributions received in advance	**179 707**	190 991
Contribution refunds due to employers	**218**	711
Reported claims not yet paid	**650 284**	635 017
Balance at the beginning of the year	**635 017**	634 337
Claims paid	**(68 596 626)**	(58 199 219)
Claims incurred	**68 611 893**	58 199 899
Broker fee creditors	**21 006**	95 036
Accredited brokers	**21 006**	95 036
TOTAL LIABILITIES ARISING FROM INSURANCE CONTRACTS	**851 215**	921 755
Financial liabilities		
Balances due to related parties (Note 27)	**631 225**	602 596
Discovery Health (Pty) Ltd	**631 124**	602 483
Discovery Life Limited	**–**	30
Discovery Central Services (Pty) Ltd	**101**	83
Unallocated funds	**9 884**	13 621
Total accruals	**24 999**	30 823
General accruals	**24 810**	30 652
Leave pay provision	**189**	171
Total arising from financial liabilities	**666 108**	647 040
	1 517 323	1 568 795

At 31 December 2021 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

11. 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	**2021**	**2020**
Gross contributions per registered Scheme Rules	**75 816 287**	74 537 501
Less:		
Personal Medical Savings Account contributions (Note 9)	**(13 356 990)**	(13 294 773)
	62 459 297	61 242 728

12. 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 2021

12. 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	2021	2020
Current year claims per registered Scheme rules	**66 802 391**	56 500 743
Claims not covered by risk transfer arrangements	**66 441 358**	56 198 294
Claims covered by risk transfer arrangements (Note 14)	**361 033**	302 449
Movement in outstanding claims provision	**488 047**	242 511
(Over)/under provision in prior year (Note 7)	**(63 483)**	5 719
Adjustment for current year	**551 530**	236 792
	67 290 438	56 743 254
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 9)	**(12 823 100)**	(11 785 757)
Claims incurred	**54 467 338**	44 957 497
Third party claim recoveries	**(67 460)**	(141 543)
	54 399 878	44 815 954

13. 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	2021	2020
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	**621 708**	601 002
Hospital Benefit Management Services	**587 575**	557 702
Managed Care Network Management Services and Risk Management Services	**555 526**	535 040
Pharmacy Benefit Management Services	**195 607**	189 337
	1 960 416	1 883 081

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

14. 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 the related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions, and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid, and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for insurance receivables. The impairment loss is also calculated following the same method used for these receivables. These processes are described in Note 4.

Note:

R'000	**2021**	**2020**
Risk transfer arrangement fees	**(271 813)**	(260 068)
Recoveries under risk transfer arrangements (Note 12)	**361 033**	302 449
	89 220	42 381

15. 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 when contributions are received by the Scheme and the related broker is accredited.

Note:

R'000	**2021**	**2020**
Brokers' fees	**1 438 916**	1 489 823
	1 438 916	1 489 823

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

16. Expenses for administration

ACCOUNTING POLICY:

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

Note:

R'000	2021	2020
The Scheme pays an all-inclusive fee to the Administrator which has been allocated into the following categories of services.		
Accredited administration services	**4 999 124**	4 850 005
Broker remuneration management	**72 456**	70 295
Claims management	**561 806**	545 048
Contribution management	**446 398**	433 082
Customer services	**2 481 413**	2 407 395
Financial management	**18 294**	17 748
Information management and data control	**910 822**	883 653
Member record management	**507 935**	492 784
Other administration services	**555 624**	539 050
Actuarial services	**8 574**	8 318
Advanced data analytics	**59 328**	57 558
Digital service offering	**21 968**	21 313
Distribution services	**38 078**	36 942
Enhanced employer reporting	**1 465**	1 421
Enhanced service offering	**11 957**	11 600
Enterprise risk management services	**11 796**	11 444
Forensic investigations and recoveries	**31 422**	30 485
Governance compliance and human resources	**7 510**	7 286
Internal audit services	**15 046**	14 597
Legal services	**3 542**	3 436
Marketing and stakeholder relations services	**259 648**	251 903
Product innovation	**14 166**	13 744
Quality management and monitoring services	**71 124**	69 003
	5 554 748	5 389 056

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

17. Other operating expenses

ACCOUNTING POLICY:

Other operating expenses include expenses, other than administration fees, and are expensed as incurred.

Note:

R'000	2021	2020
Association fees	**1 511**	1 779
Audit fees	**7 065**	9 345
Audit services for the year ended 2021	**3 161**	–
Audit services for the year ended 2020	**3 198**	3 182
Audit services for the year ended 2019	**–**	4 296
Other services	**706**	1 867
Audit Committee and Risk Committee fees (Note 18)	**1 850**	1 431
Audit Committee	**1 559**	1 145
Risk Committee	**291**	286
Bank charges	**9 238**	10 388
Benefit management services	**26 176**	11 703
COVID-19 (Note 27)	**25 756**	11 703
Diabetic Retinopathy	**420**	–
Clinical Governance Committee fees (Note 18)	**689**	544
Council for Medical Schemes	**58 620**	52 292
Debt collecting fees	**2 884**	2 693
Depreciation	**1 486**	1 486
Dispute Committee fees	**1 730**	1 701
Fidelity Guarantee Insurance	**26**	471
General meeting costs	**15 748**	2 982
Investment Committee fees (Note 18)	**245**	236
Investment reporting fees	**5 429**	4 523
Legal fees	**488**	325
Nomination Committee fees (Note 20)	**1 712**	250
Office operating costs	**4 494**	4 162
Other expenses	**32 093**	24 549
Principal Officer fees – Remuneration	**5 248**	4 647
Principal Officer fees – Unvested long-term employee benefit	**1 161**	285
Printing, postage and stationery	**261**	47
Professional fees	**10 048**	8 577
Remuneration Committee fees (Note 18)	**207**	161
Scheme office costs	**1 292**	950
Staff costs (Note 21)	**25 538**	23 799
Sundry amounts written off	**5**	9
Trustees' remuneration and consideration expenses (Note 22)	**9 433**	8 028
	224 677	177 363

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

18. Board Committee fees and considerations

Note:

2021 R'000	**Audit**	**Risk**	**Clinical Governance**	**Investment**	**Remuneration**	**Total**
S Ludolph	**316**					**316**
N Luthuli					**207**	**207**
P Maphumulo				**1**		**1**
N Mlaba			**331**			**331**
S Smith			**358**			**358**
E Mackeown	**886**	**162**		**244**		**1 292**
A Burger	**357**	**129**				**486**
TOTAL	**1 559**	**291**	**689**	**245**	**207**	**2 991**

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

For detail of the Chairperson of the respective committee refer to pages 56 – 57 and pages 72 – 73.

19. Net impairment losses on healthcare receivables

Note:

R'000	**2021**	**2020**
Insurance receivables		
Movement in provision of contributions that are not recoverable	**9 303**	4 649
Movement in provision of members' and service providers' portions that are not recoverable	**111 873**	56 602
Movement in provision of amounts due by brokers that are not recoverable	**3 017**	561
Movement in provision of forensic debtors that are not recoverable	**1 048**	(1 940)
Receivables written off directly to the Statement of Comprehensive Income	**10 283**	19 224
	135 524	79 096

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

20. Other committee fees

Note:

R'000	2021	2020
Nomination Committee fees		
P Goss – Independent Member (Chairperson)	**648**	154
T Wixley – Independent Member	**498**	25
R Shough – Independent Member	**566**	71
	1 712	250

21. 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	2021	2020
Salaries and bonuses	**19 974**	18 944
Pension costs – defined contribution plans	**1 669**	1 273
Medical and other benefits	**1 254**	1 001
Long-term employee benefit service cost	**2 628**	2 558
Increase in leave pay accrual	**13**	23
	25 538	23 799
Number of employees at 31 December	**13**	12

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

22. Trustees' remuneration and considerations

Note:

The following table records the remuneration and consideration paid to Trustees during the year:

		Committee fees									
2021 R'000	Services as Trustee	Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
N Morrison (Chairperson)	**1 136**		**32**	**274**			**110**			**11**	**1 563**
D Moodley	**695**			**333**	**347**	**181**		**184**		**11**	**1 751**
D King	**678**		**197**				**119**	**160**	**5**	**11**	**1 170**
J Adams SC	**470**		**129**		**185**			**132**		**24**	**940**
J Butler SC	**669**	**251**					**110**	**230**		**11**	**1 271**
J Human	**688**	**237**		**274**		**224**					**1 423**
S Brynard	**562**					**158**	**95**	**160**	**6**	**12**	**993**
L Harie	**155**		**46**		**75**			**46**			**322**
TOTAL	**5 053**	**488**	**404**	**881**	**607**	**563**	**434**	**912**	**11**	**80**	**9 433**

The following table records the remuneration and consideration paid to Trustees during the prior year:

		Committee fees									
2020 R'000	Services as Trustee	Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
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

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

23. Investment income

ACCOUNTING POLICY:

Investment income comprises dividends and interest received and accrued on investments at fair value through profit or loss and interest on cash and cash equivalents.

Interest income is recognised using the effective interest rate method, taking into account the principal amount outstanding and the effective interest rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income from investments is recognised when the right to receive payment is established – this is on the "last day to trade" for listed shares and on the "date of declaration" for unlisted shares.

Note:

R'000	2021	2020
Financial assets at fair value through profit or loss:	**1 591 605**	1 462 783
Dividend income	**322 814**	156 310
Interest income	**1 268 791**	1 306 473
Cash and cash equivalents interest income	**180 004**	227 587
INVESTMENT INCOME PER STATEMENT OF COMPREHENSIVE INCOME	**1 771 609**	1 690 370
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	**180 004**	227 587
Financial assets at fair value through profit or loss:		
Interest income	**1 268 791**	1306 473
TOTAL INTEREST INCOME	**1 448 795**	1 534 060

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

24. Net gains/(losses) on financial assets

Note:

R'000	2021	2020
Net fair value gains/(losses) on financial assets at fair value through profit or loss (Note 3):	**1 843 316**	(178 135)
Fair value gains on financial assets at fair value through profit or loss:	**1 852 079**	470 681
– Equities	**1 289 086**	301 446
– Money market instruments	**38 843**	23 499
– Inflation-linked bonds	**–**	2 568
– Flexible fixed income bonds	**222 709**	–
– Offshore bonds	**123 083**	124 434
– Property	**135 712**	–
– Yield-enhanced bonds	**–**	18 734
– Short duration bonds	**42 646**	–
Fair value losses on financial assets at fair value through profit or loss:	**(8 763)**	(648 816)
– Equities	**–**	(341 765)
– Offshore bonds	**–**	(69 227)
– Money market instruments	**–**	(8 625)
– Inflation-linked bonds	**–**	(15 549)
– Property	**–**	(211 580)
– Yield-enhanced bonds	**(8 763)**	(2 070)
Net fair value (losses)/gains on derivative financial instruments (Note 8):	**(4 763)**	391 116
Fair value gains on derivative financial instruments:	**64 544**	403 665
Fair value losses on derivative financial instruments:	**(69 307)**	(12 549)
	1 838 553	212 981

25. Sundry income

Note:

R'000	2021	2020
Prescribed amounts written back	**28 510**	14 970
Unclaimed personal medical savings accounts written off to scheme funds (Note 9)	**116**	2 379
	28 626	17 349
Reversal of stale cheques written back	**–**	(2 372)
	28 626	14 977

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

26. Finance costs

Note:

R'000	2021	2020
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings accounts (Note 9)	**334 433**	282 907
	1 242	1 429
Interest paid – other	**4**	136
Interest on lease liability (Note 2)	**1 238**	1 293
	335 675	284 336

27. 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 2021

27. Related party transactions continued

TRANSACTIONS WITH RELATED PARTIES

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members which includes Trustees and Executive Officers:

R'000	2021	2020
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	**(22 395)**	(15 025)
Trustee remuneration and consideration (Note 22)	**(9 433)**	(8 028)
Unvested long-term employee benefit	**(3 789)**	(2 843)
Contributions and claims		
Gross contributions received	**1 531**	1 230
Claims paid from the Scheme	**(371)**	(282)
Claims paid from the Personal Medical Savings Account	**(395)**	(318)
Interest paid on Personal Medical Savings Accounts	**(38)**	(22)
Statement of Financial Position transactions		
Long-term employee benefit plan asset	**7 998**	6 427
Plan asset	**15 269**	10 797
Plan liability	**(7 271)**	(4 370)
Long-term employee benefit plan asset	**7 998**	6 427
Balance at the beginning of the year	**6 427**	5 796
Additions	**5 360**	4 618
Withdrawals	**–**	(1 144)
Unvested long-term employee benefit	**(3 789)**	(2 843)
Contribution debtors	**123**	92
Personal Medical Savings Account balances	**(133)**	(96)

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

27. Related party transactions continued

The terms and conditions of the related party transactions were as follows:

Transactions	Nature of transactions and their terms and conditions
Compensation	This constitutes remuneration and consideration paid to Trustees and Executive Officers, short-term employee benefits and unvested long-term employee benefits.
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates determined by the Scheme from time to time at its discretion. The amounts are all current and would need to be payable on demand as applicable to other members.
Long-term employee benefits	The Restricted Equity Fund ("REF") refers to an award of restricted equity instruments in the form of equity shares in companies other than Discovery Limited or its subsidiaries, for the settlement of the obligation that will arise to DHMS on the fulfilment of the requisite vesting conditions by participating employees stipulated in the award letter.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

27. Related party transactions continued

R'000	2021	2020
TRANSACTIONS WITH ENTITIES THAT HAVE SIGNIFICANT INFLUENCE OVER THE SCHEME		
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(5 554 748)**	(5 389 056)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 10)*	**464 858**	(445 612)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 13)	**(1 941 334)**	(1 866 263)
Diabetes management services (Note 13)	**(19 082)**	(16 818)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 10)*	**166 266**	(156 871)
Discovery Health (Pty) Ltd – Lifestyle and health assessments		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**–**	(29 843)
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	**(25 289)**	(18 625)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 4)	**13 044**	13 688
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(401 848)**	(328 398)
Statement of Financial Position transactions		
Claims due to provider	**(1 613)**	(571)
Grove Nursing Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(41 874)**	(34 856)
COVID-19 management services (Note 17)	**(25 756)**	(11 703)
Statement of Financial Position transactions		
Balance due to provider	**(2 173)**	(2 154)

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R631 million (2020: R603 million), disclosed in Note 10.*

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

27. Related party transactions continued

R'000	2021	2020
TRANSACTIONS WITH ENTITIES THAT HAVE SIGNIFICANT INFLUENCE OVER THE SCHEME *continued*		
Medical Services Organisation International (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(55 176)**	–
Statement of Financial Position transactions		
Balance due to provider	**(317)**	–
Discovery Life Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Life Limited at year end (Notes 4 and 10)	**14**	(30)
Discovery Connect Distribution Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Broker fees paid	**(92 914)**	(82 600)
Statement of Financial Position transactions		
Balance due to Discovery Connect Distribution Services (Pty) Ltd at year end	**(1 127)**	(7 735)
Discovery Central Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Contractual lease and non-lease payments	**(6 327)**	(5 875)
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year end (Note 10)	**(101)**	(83)
Discovery Bank Ltd		
Statement of Financial Position transactions		
Negotiable Certificates of Deposits	**133 964**	141 636
Discovery Ltd		
Statement of Financial Position transactions		
Floating Rate Notes	**101 592**	69 781

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

27. Related party transactions continued

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:

- Actuarial services
- Accredited administration services
- Distribution services
- Forensic investigation and recoveries
- Governance compliance and human resources
- Internal audit services
- Marketing and stakeholder relations services

MANAGED HEALTHCARE AGREEMENT

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

The Scheme has contracted with the administrator to provide accredited managed healthcare services (no risk transfer). These services include bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis.

This agreement is in accordance with instructions given by the Trustees. The agreement is for a five-year period and effective from 1 January 2018. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

The Scheme's contracts with the administrator for administration and managed healthcare services expire at the end of 2022. The Scheme was required to notify Discovery Health (Pty) Ltd of the renewal or termination of the agreements by 31 December 2021. The Trustees appointed an ad hoc Board subcommittee, the Services Renewal Committee, to comprehensively review the options available to the Scheme and to make recommendations to the Board. The Committee reviewed extensive reports and engaged Deloitte to conduct an independent review of the administration and managed healthcare services landscape using publicly available information. Based on these investigations, the Trustees resolved to renew the administration and managed healthcare services agreements with Discovery Health (Pty) Ltd, subject to final terms being agreed during 2022.

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 2021 to 31 December 2021 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R14 million (2020: R10 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 and screening to members of the Scheme.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

27. Related party transactions continued

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 of 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$150 or €100 (One Hundred and Fifty US Dollars or One Hundred Euros) excess payment by the Member. This benefit is available to all members, except members on KeyCare plans.
- **The Africa Evacuation Benefit**
  Members are covered for emergency medical assistance with or without evacuation to the Republic of South Africa 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.

NEGOTIABLE CERTIFICATES OF DEPOSITS AND FLOATING RATE NOTES

As part of the Scheme's investment policy and investment diversification strategy the Board of Trustees approved a Strategic Asset Allocation. The Scheme implements the investment strategy by appointing independent asset managers to manage the respective portfolios through discretionary mandates with no influence by the Scheme and its officers over the selection of underlying instruments in the respective portfolios.

The Scheme's cash and bond asset managers have included negotiable certificates of deposits issued by Discovery Bank Ltd and floating rate notes issued by Discovery Ltd in certain fixed income portfolios.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

28. Surplus/(deficit) from operations per benefit plan

2021	Executive	Classic Comp	Classic Smart Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**907 510**	**9 860 527**	**40 946**	**2 452 506**	**15 477 187**	**4 685 786**	**960 787**	**6 003 771**	**2 024 618**
Net claims incurred	(1 066 031)	(10 015 807)	(23 084)	(1 977 562)	(12 805 099)	(4 230 624)	(897 653)	(4 220 987)	(1 563 043)
Risk claims incurred	(1 067 200)	(10 028 838)	(23 130)	(1 980 038)	(12 819 985)	(4 235 929)	(898 795)	(4 226 260)	(1 565 027)
Third-party claim recoveries	1 169	13 031	46	2 476	14 886	5 305	1 142	5 273	1 984
Accredited managed healthcare services (no risk transfer)	(12 000)	(163 035)	(668)	(68 935)	(461 339)	(112 053)	(18 459)	(216 403)	(71 885)
Net income/(expense) on risk transfer arrangements	47	972	2	302	1 625	539	102	391	189
Risk transfer arrangement fees paid	(1 712)	(23 907)	(93)	(2 118)	(14 635)	(5 749)	(2 058)	(4 205)	(1 736)
Recoveries from risk transfer arrangements	1 759	24 879	95	2 420	16 260	6 288	2 160	4 596	1 925
Relevant healthcare expenditure	**(1 077 984)**	**(10 177 870)**	**(23 750)**	**(2 046 195)**	**(13 264 813)**	**(4 342 138)**	**(916 010)**	**(4 436 999)**	**(1 634 739)**
Gross healthcare result	**(170 474)**	**(317 343)**	**17 196**	**406 311**	**2 212 374**	**343 648**	**44 777**	**1 566 772**	**389 879**
Broker service fees	(9 855)	(136 507)	(548)	(50 308)	(386 336)	(96 160)	(15 770)	(161 843)	(48 957)
Expenses for administration	(36 127)	(487 971)	(2 014)	(212 811)	(1 423 474)	(343 855)	(55 729)	(670 059)	(222 280)
Other operating expenses	(1 253)	(17 968)	(75)	(7 366)	(53 963)	(12 567)	(2 310)	(26 128)	(7 790)
Net impairment losses on healthcare receivables	(808)	(10 887)	(45)	(4 758)	(31 856)	(7 679)	(1 246)	(15 069)	(4 988)
NET HEALTHCARE RESULT	**(218 517)**	**(970 676)**	**14 515**	**131 068**	**316 745**	**(116 613)**	**(30 278)**	**693 673**	**105 864**
Investment income	10 559	142 771	588	62 257	416 790	100 592	16 311	196 446	65 061
Net gains on financial instruments	11 013	147 850	615	64 578	432 148	104 245	16 898	203 993	67 666
Sundry income	170	2 287	10	1 002	6 725	1 614	262	3 204	1 057
Other income	**21 742**	**292 908**	**1 213**	**127 837**	**855 663**	**206 451**	**33 471**	**403 643**	**133 784**
Asset management fees	(555)	(7 485)	(31)	(3 272)	(21 918)	(5 280)	(857)	(10 367)	(3 430)
Interest paid	(7)	(101)	–	(44)	(292)	(71)	(11)	(137)	(46)
Interest paid on savings accounts	(3 169)	(42 794)	–	–	(124 904)	(30 160)	(4 889)	(58 836)	–
Other expenditure	**(3 731)**	**(50 380)**	**(31)**	**(3 316)**	**(147 114)**	**(35 511)**	**(5 757)**	**(69 340)**	**(3 476)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**(200 506)**	**(728 148)**	**15 697**	**255 589**	**1 025 294**	**54 327**	**(2 564)**	**1 027 976**	**236 172**

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

28. Surplus/(deficit) from operations per benefit plan continued

2021	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Start	Classic Smart	Essential Smart	Total
Risk contribution income	**280 455**	**7 616 121**	**3 265 278**	**5 558 879**	**357 212**	**98 515**	**2 019 763**	**849 436**	**62 459 297**
Net claims incurred	(199 384)	(6 599 167)	(2 891 647)	(5 520 497)	(285 216)	(58 847)	(1 537 765)	(507 467)	(54 399 878)
Risk claims incurred	(199 614)	(6 607 260)	(2 895 174)	(5 527 534)	(285 602)	(58 925)	(1 539 792)	(508 237)	(54 467 338)
Third-party claim recoveries	230	8 093	3 527	7 037	386	78	2 027	770	67 460
Accredited managed healthcare services (no risk transfer)	(7 403)	(249 898)	(108 109)	(301 916)	(23 287)	(8 382)	(76 502)	(60 142)	(1 960 416)
Net income/(expense) on risk transfer arrangements	25	1 243	476	80 373	1	2 726	157	50	89 220
Risk transfer arrangement fees paid	(265)	(6 913)	(2 857)	(200 077)	1	(4 071)	(1 061)	(357)	(271 813)
Recoveries from risk transfer arrangements	290	8 156	3 333	280 450	–	6 797	1 218	407	361 033
Relevant healthcare expenditure	**(206 762)**	**(6 847 822)**	**(2 999 280)**	**(5 742 040)**	**(308 502)**	**(64 503)**	**(1 614 110)**	**(567 559)**	**(56 271 074)**
Gross healthcare result	**73 693**	**768 299**	**265 998**	**(183 161)**	**48 710**	**34 012**	**405 653**	**281 877**	**6 188 223**
Broker service fees	(6 225)	(201 608)	(77 752)	(158 460)	(10 219)	(2 927)	(50 632)	(24 809)	(1 438 916)
Expenses for administration	(22 816)	(771 434)	(333 887)	(512 636)	(21 220)	(14 233)	(237 244)	(186 958)	(5 554 748)
Other operating expenses	(834)	(28 007)	(11 417)	(35 042)	(2 629)	(1 015)	(8 944)	(7 369)	(224 677)
Net impairment losses on healthcare receivables	(511)	(17 249)	(7 461)	(21 172)	(1 640)	(590)	(5 338)	(4 227)	(135 524)
NET HEALTHCARE RESULT	**43 307**	**(249 999)**	**(164 519)**	**(910 471)**	**13 002**	**15 247**	**103 495**	**58 514**	**(1 165 642)**
Investment income	6 678	225 799	97 652	276 726	21 350	7 673	69 561	54 795	1 771 609
Net gains on financial instruments	6 934	234 027	101 274	287 438	22 200	8 015	72 385	57 274	1 838 553
Sundry income	108	3 635	1 569	4 467	348	125	1 137	906	28 625
Other income	**13 720**	**463 461**	**200 495**	**568 631**	**43 898**	**15 813**	**143 083**	**112 975**	**3 638 788**
Asset management fees	(351)	(11 865)	(5 129)	(14 559)	(1 128)	(405)	(3 675)	(2 906)	(93 213)
Interest paid	(5)	(158)	(69)	(194)	(15)	(5)	(49)	(38)	(1 242)
Interest paid on savings accounts	(2 002)	(67 679)	–	–	–	–	–	–	(334 433)
Other expenditure	**(2 358)**	**(79 702)**	**(5 198)**	**(14 753)**	**(1 143)**	**(410)**	**(3 724)**	**(2 944)**	**(428 888)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**54 669**	**133 760**	**30 778**	**(356 593)**	**55 757**	**30 650**	**242 854**	**168 545**	**2 044 258**

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

28. Surplus/(deficit) from operations per benefit plan continued

2020	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 on financial instruments	1 082	14 459	55	7 830	47 015	11 343	1 735	24 589	10 188
Sundry 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 2021

28. Surplus/(deficit) from operations per benefit plan continued

2020	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	490	11	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 on financial instruments	811	25 760	12 245	32 415	3 497	1 090	9 119	9 748	212 981
Sundry 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 2021

29. Reconciliation of movements in the statement of cash flows

R'000	2021	2020
Cash receipts from members	**75 929 680**	74 514 512
Gross contributions income	**75 816 287**	74 537 501
Transfers received from other medical schemes	**30 778**	16 481
Opening balance of accounts receivable	**2 625 412**	2 560 425
Closing balance of accounts receivable (Impairment incl.)	**(2 729 850)**	(2 625 412)
Transfer of accounts receivable due to amalgamation	**8 705**	–
Transfers received due to amalgamation	**(1 266)**	–
Contributions received in advance	**179 707**	190 991
COVID-19 Support: Contributions funded from PMSA	**(93)**	(165 474)
Cash paid to providers and members – claims	**(68 596 626)**	(58 199 219)
Relevant healthcare expenditure	**(56 271 073)**	(46 656 653)
Claims charged to members' Personal Medical Savings Accounts	**(12 823 099)**	(11 785 758)
Opening balance of outstanding claims	**(1 769 008)**	(1 526 497)
Closing balance of outstanding claims	**2 257 054**	1 769 008
Transfer of outstanding claims due to amalgamation	**(5 767)**	–
Opening balance of reported claims not yet paid	**(635 017**	(634 336)
Closing balance of reported claims not yet paid	**650 284**	635 017
Cash paid to providers and employees – non-healthcare expenditure	**(7 570 583)**	(7 290 880)
Broker service fees	**(1 438 916)**	(1 489 823)
Expenses for administration	**(5 554 748)**	(5 389 056)
Other operating expenses	**(360 201)**	(256 459)
Depreciation	**1 486**	1 486
Unvested long-term employee benefit	**3 789**	2 843
Sundry income	**28 625**	14 976
Opening balance of accounts payable	**(1 568 793)**	(1 551 968)
Closing balance of accounts payable	**1 517 329**	1 568 793
Transfer of accounts payable due to amalgamation	**(4 180)**	–
Contributions received in advance	**(179 707)**	(190 991)
Opening balance of reported claims not yet paid	**635 017**	634 336
Closing balance of reported claims not yet paid	**(650 284)**	(635 017)
Purchases of financial assets	**(8 738 440)**	(11 887 221)
Financial assets at fair value through profit or loss (Note 3)	**(8 841 598)**	(11 887 221)
Capitalised interest	**103 158**	–
Proceeds from disposal of financial assets	**7 735 859**	3 763 349
Financial assets at fair value through profit or loss (Note 3)	**7 582 315**	3 470 050
Derivative financial instruments (Note 8)	**153 544**	293 299
Interest received	**1 345 637**	1 534 060
Interest income (Note 23)	**1 448 795**	1 534 060
Capitalised interest	**(103 158)**	–

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

30. Events after the reporting period

Subsequent to the reporting date and prior to the date the financial statements were authorised for issue, the following matter remained ongoing.

REGULATION 30 – LIMITATION ON ASSETS

Regulation 29 of the Medical Schemes Act regulates the minimum accumulated funds to be maintained by a medical scheme. Regulation 29 (2) requires that a medical scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%.

Regulation 30 (1) requires that a medical scheme must have assets of the kinds and categories specified in column 2 of Annexure B of the Regulations, the aggregate fair value of which on any day, is not less than –

(a) the aggregate of the aggregate fair value on that day of its liabilities; and

(b) the minimum accumulated funds to be maintained in terms of Regulation 29, excluding accounts receivable and intangible assets.

Regulation 30 (2) requires that the assets that a medical scheme is required to have in terms of Regulation 30 (1), when expressed as a percentage of the aggregate fair value of the liabilities and the minimum accumulated funds to be maintained in terms of Regulation 29, must not exceed the percentages specified against it in column 3 of Annexure B – *"Maximum percentage of aggregate fair value of liabilities and the minimum accumulated funds to be maintained in terms of Regulation 29".* Explanatory Note 2 of Annexure B requires that the sum of deposits in categories 1 (a) (i) and 1 (a) (ii) shall not be less than 20%.

In demonstrating compliance with Regulation 30 and Annexure B, the Scheme measures the assets against the aggregate fair value of liabilities and "minimum accumulated funds", namely 25% of gross annual contributions as stated in Regulation 29, on which basis the Scheme is compliant.

During 2021, CMS notified DHMS that the Scheme was not compliant with Explanatory Note 2 of Annexure B as the Scheme's deposits in category 1 (a) (i) and 1 (a) (ii) fell below 20%. This assessment was conducted using the aggregate fair value of liabilities and total accumulated funds rather than "minimum accumulated funds" as stated in Regulation 29.

DHMS obtained a legal opinion from Knowles Husain Lindsay Inc. on 25 February 2022 to confirm the application of the Act, which clarified DHMS's application of Regulation 30 and demonstrated that DHMS is compliant with Explanatory Note 2 of Annexure B.

At the reporting date this matter had not been concluded and DHMS continues to engage CMS.

No other significant events occurred between the reporting date and the date the financial statements were authorised for issue.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

31. Amalgamations

ACCOUNTING POLICY:

Scheme amalgamations are accounted for by applying the acquisition method.

The cost of an amalgamation is measured as the fair value of the assets transferred and liabilities incurred or assumed at the date of exchange.

When an entity is amalgamated into the Scheme, all identifiable assets, liabilities and members' funds are accounted for at their fair values at the acquisition date. No consideration is paid for these transactions and they are recognised as from the transaction date, being the date confirmed by the Registrar of the CMS.

The Scheme recognises the net assets from amalgamated schemes as a direct addition to reserves in its Statement of Financial Position.

Section 63(14) of the Act, prescribes that relevant assets and liabilities of the party effecting the transfer shall vest in and become binding upon the party to which transfer is effected.

No goodwill is recognised on the amalgamation of schemes.

QUANTUM MEDICAL AID SOCIETY

An amalgamation between the Scheme and Quantum Medical Aid Society (QMAS) was confirmed and effective from 1 August 2021. The disclosures provided below have been provided to enable users to evaluate the nature and financial effect of the amalgamation.

QMAS was a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme was open to all current and retired employees of Bidvest Group Limited and Sun International Group Limited, or any associated company. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Act, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and QMAS voted that the amalgamation of QMAS with the Scheme would be in the best interest of the QMAS members.

The Scheme obtained control of QMAS by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 2 886 principal members and 5 753 beneficiaries joined the Scheme.

No goodwill is recognised as a result of this transaction.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

31. Amalgamations continued

QUANTUM MEDICAL AID SOCIETY *continued*

The acquisition date fair value of the QMAS members interest transferred, and the acquisition date fair value of each major class of assets and liabilities was:

R'000	2021	2020
Quantum Medical Aid Society		
Reserves effectively transferred:	160 456	–
(Acquisition date fair value of QMAS members' interest)		
Net recognised values of QMAS identifiable assets and liabilities:	160 456	–
Current assets	181 587	–
Financial assets at fair value through profit or loss	166 850	–
Cash and cash equivalents	5 987	
Member and service provider claims receivables	2 506	–
Provision for impairment	(1 985)	
Interest receivable	19	–
Other accounts receivable	8 190	–
Current liabilities	(21 111)	–
Outstanding claims provision	(5 767)	–
Reported claims not yet paid	(2 686)	–
Members' savings account trust liability	(11 165)	–
Unallocated funds	(11)	–
Discovery Health (Pty) Ltd	(1 051)	–
General accruals	(431)	–
Movement subsequent to amalgamation	(1 344)	
CLOSING BALANCE	159 112	–

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

31. Amalgamations continued

QUANTUM MEDICAL AID SOCIETY *continued*

As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below.

R'000	2021	2020
Fair value of receivables acquired:	**8 730**	–
Insurance receivables	**8 711**	–
Members claim debtors	**116**	–
Service provider claim debtors	**2 390**	–
Other accounts receivable	**8 190**	–
Provision for impairment	**(1 985)**	–
Loans and receivables	**19**	–
Interest receivable	**19**	–
Gross contractual amounts receivable:	**10 715**	
Insurance receivables	**10 696**	–
Member claim debtors	**116**	–
Service provider claim debtors	**2 390**	–
Other accounts receivable	**8 190**	–
Loans and receivables	**19**	–
Interest receivable	**19**	–
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(1 985)**	–
Member claim debtors	**(61)**	–
Service provider claim debtors	**(1 924)**	–

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

31. Amalgamations continued

QUANTUM MEDICAL AID SOCIETY *continued*

The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.

R'000	2021	2020
Non Current assets	–	–
Financial assets at fair value through profit or loss	–	–
Current assets	181 567	–
Financial assets at fair value through profit or loss	166 850	–
Cash and cash equivalents	5 987	
Member claim debtors	55	–
Service provider claim debtors	466	–
Interest receivable	19	–
Other accounts receivable	8 190	–
Current liabilities	(21 111)	–
Outstanding claims provision	(5 767)	–
Reported claims not yet paid	(2 686)	–
Contribution in advance	(11 165)	
Unallocated funds	(11)	–
Discovery Health (Pty) Ltd	(1 051)	–
General accruals	(431)	–
	160 456	–

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

32. Insurance risk management report

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and the requirements of legislation.

This section summarises these risks and the way in which they are managed.

INSURANCE RISK

The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated.

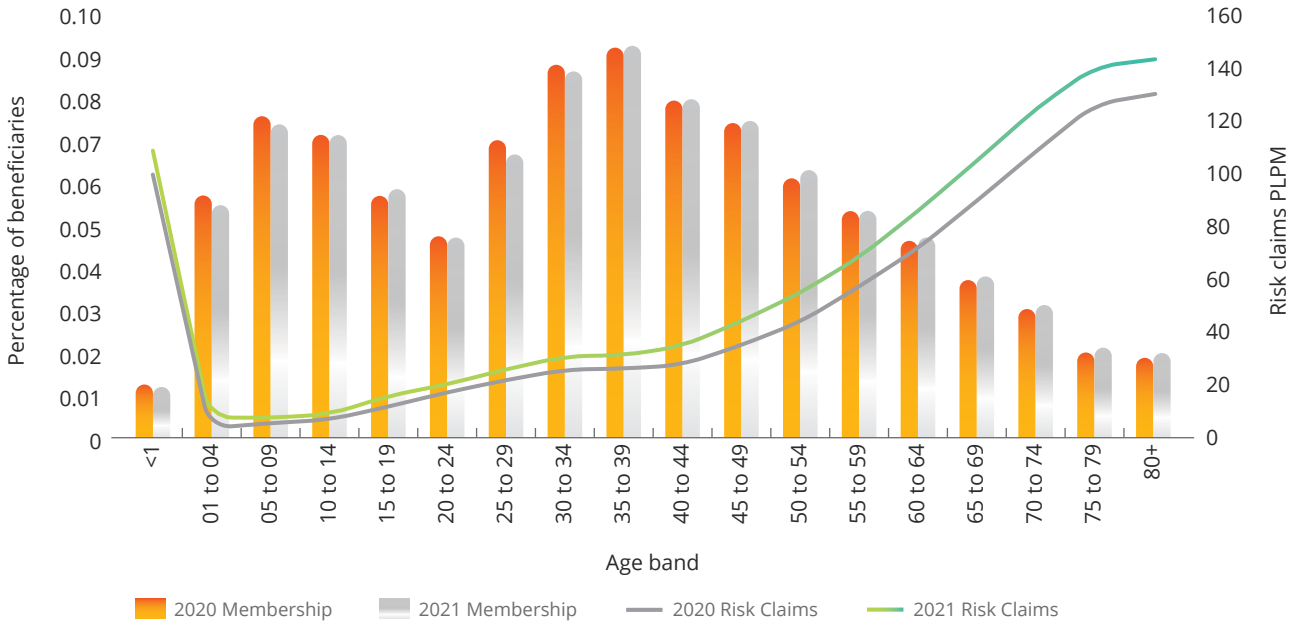
A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier induced demand and the cost of new technologies or drugs.

As the following graph illustrates, claims are expected to increase with age. In the absence of mandatory membership and a continuous inflow of young, healthy lives, the average age of lives covered by the medical scheme is expected to increase year-on-year. The increases expected from demographic changes are allowed for in the annual benefit and contribution reviews, but if this differs from the expected it may result in higher than expected inflationary increases in claims.

The following graph indicates the distribution of beneficiaries by age band for 2020 and 2021, as well as the risk claims paid. The risk claims are indexed to a value of 100 for the "<1" age band in 2020. There has been an increase in the proportion of beneficiaries older than 35 over the past year.

MEMBERSHIP DISTRIBUTION AND RISK CLAIMS
(RISK CLAIMS INDEXED TO AGE BAND "<1" 2020 = 100)



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:

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

32. Insurance risk management report continued

INSURANCE RISK *continued*

HOSPITAL BENEFITS

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional fees, medication, equipment and consumables.

DAY-TO-DAY BENEFITS

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the PMSA and an insurance risk element. This includes the Day-to-day Extender Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits.

CHRONIC BENEFITS

The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 50 listed conditions, including the 27 Prescribed Minimum Benefit (PMB) chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

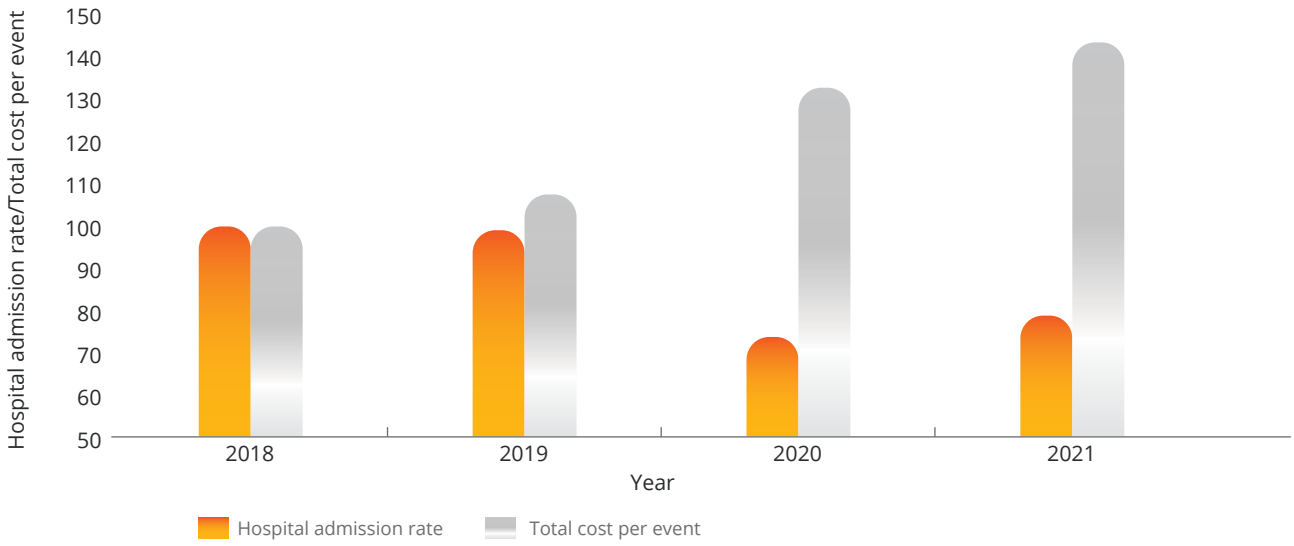
HOSPITAL BENEFIT RISK

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims 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 at 2018.

HOSPITAL CLAIMS EXPERIENCE (INDEXED TO 2018 = 100)



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 increased from 2020 to 2021 but remained at a lower level than in 2019. Given that the type of admissions that did occur were higher-risk and more complex, the cost per event increased significantly from 2019 to 2020 and continued to increase into 2021. This is largely due to the impact of COVID-19.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

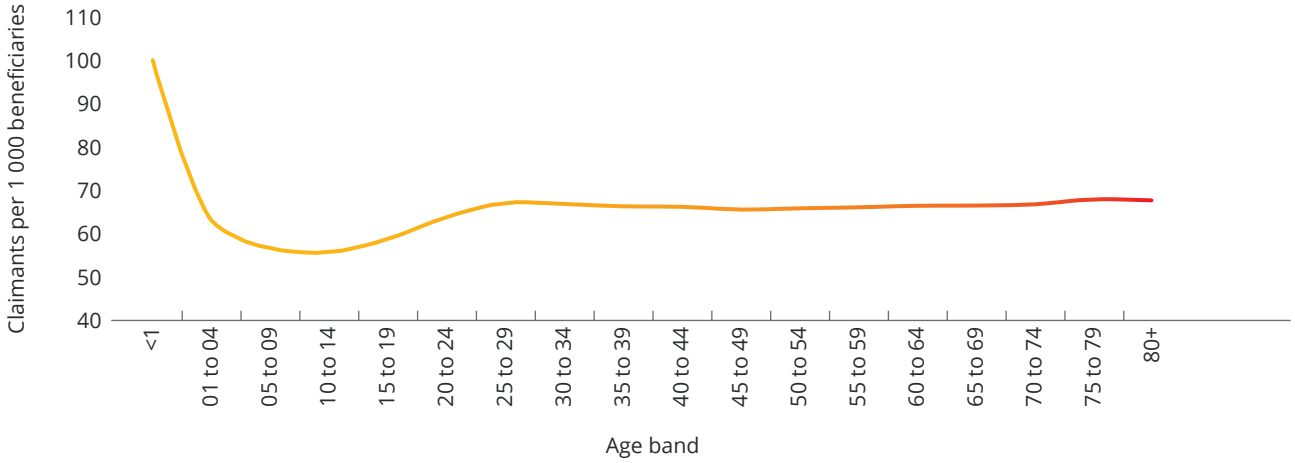
32. Insurance risk management report continued

INSURANCE RISK *continued*

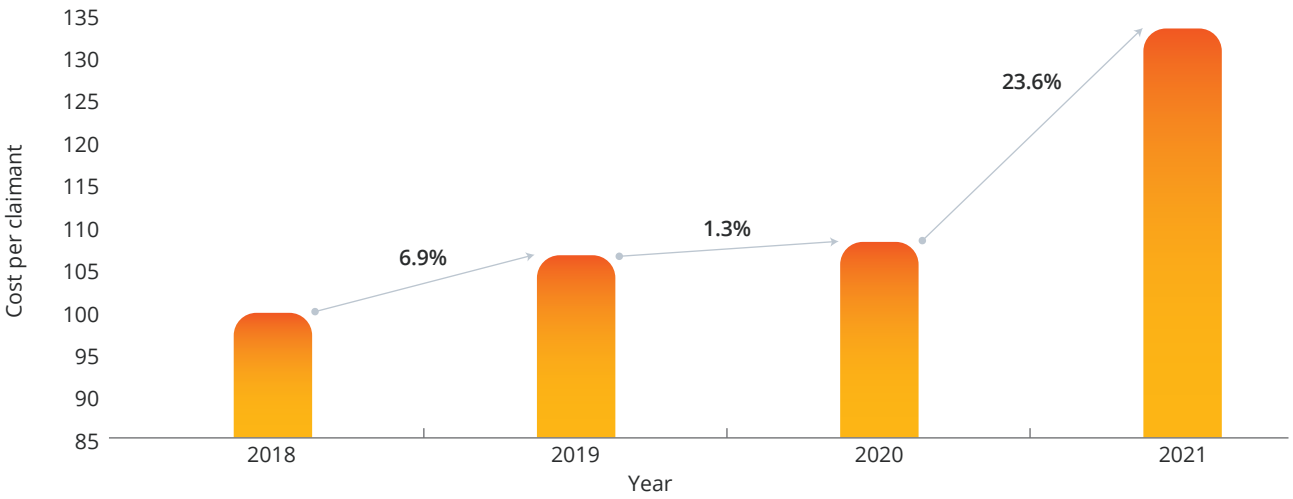
DAY-TO-DAY BENEFITS RISK

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 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 incur expenses in excess of their medical savings.

2021 CLAIMANTS PER 1,000 BENEFICIARIES FROM OH RISK BENEFITS (INDEXED TO AGE BAND "<1" 2020 = 100)



COST PER OH CLAIMANT (INDEXED TO JAN 2018 = 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 polymerase reaction (PCR) testing, which is the means used to identify positive COVID-19 cases. These PCR test costs offset some of the reduction seen in other OH claim categories for 2020.

There was a significant increase in OH claims from 2020 to 2021. Additional COVID-related costs such as COVID-19 vaccinations have contributed to these higher OH costs, together with less stringent lockdown restrictions which contributed to the higher cost per claimant than in 2020.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

32. Insurance risk management report continued

INSURANCE RISK *continued*

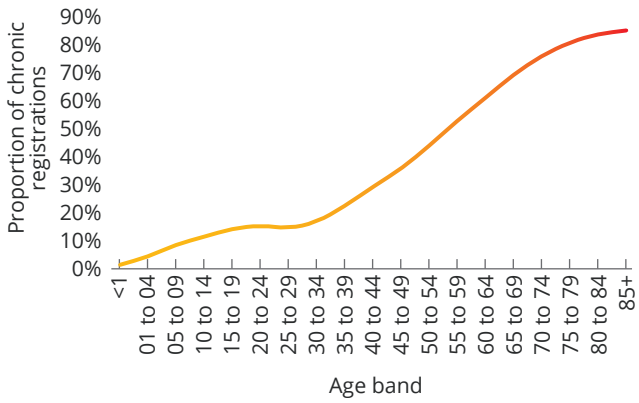
CHRONIC BENEFITS RISK

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

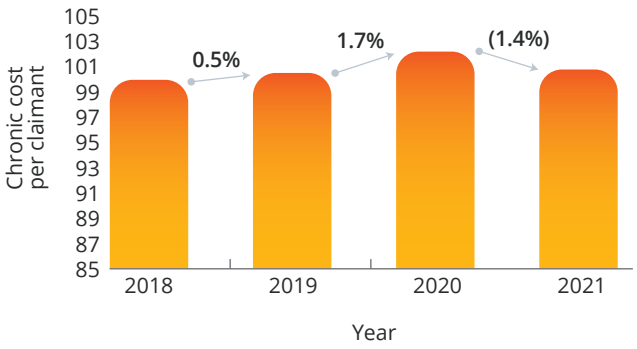
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. 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 2021, as well as the change in the cost per claimant over the past four years. The cost per chronic claimant decreased from 2020 to 2021 as a result of a lower number of items per patient as well as a lower cost per item. The cost per claimant graph is indexed to a value of 100 at 2018.

PROPORTION OF CHRONIC REGISTRATIONS BY AGE BAND



COST PER CHRONIC CLAIMANT (INDEXED TO 2018 = 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. 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 PMBs. In addition, the Centre for Clinical Excellence is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

32. 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.

ASSESSMENT OF CONTRIBUTION INCREASES:

Discovery Health Medical Scheme was the first and only open medical scheme to freeze contribution increases and defer the increase in contributions for 2021 by six months to 1 July 2021. The Contribution Freeze offered members much needed financial relief by taking advantage of the additional Scheme reserves that arose as a result of discontinuities in healthcare utilisation during 2020. The contributions for all Discovery Health Medical Scheme plans increased by 5.9% on 1 July 2021. The increase recognised the full impact of medical inflation on the Scheme and ensured that the Scheme could offer affordable contribution increases in 2022 and beyond, which are expected to be below market averages.

For the 2022 financial year, in order to balance the economic pressures faced by members and the longevity of the Scheme, it was decided to implement a 0.0% increase across all options from 1 January 2022 with a proposed contribution increase of 7.9% from 1 October 2022. This translates to an effective average increase of below 2% for 2022 off the December 2021 contributions. A lower increase would require a large increase for 2023 for the solvency of the Scheme to remain above 25%, which was not considered to be a viable option.

COVID-19 EXPERIENCE AND UNCERTAINTIES OVER THE NEXT YEAR:

Since the start of the COVID-19 pandemic, over 2 million PCR tests have been carried out for DHMS members. By the end of February 2022, we had received claims for 1.8 million vaccine doses administered during 2021 with a cost of over R753 million, although the actual vaccine doses administered are likely to be higher given the problems with the public sector billing. COVID-19 related claims have increased significantly from 2020. These include claims relating to admissions, testing and treating, non-PMB COVID-19 benefits, Personal Protective Equipment (PPE), and vaccination costs. At the end of February 2022, R10.6 billion of direct COVID-19 related costs have been paid by the Scheme in respect of treatment dates in 2020 and 2021 (R2.9 billion in respect of 2020 and R7.7 billion in respect of 2021). There is still a significant level of uncertainty relating to COVID-19 such as the frequency of boosters, new variants of the virus, future levels of testing, and whether claims will return to pre-COVID-19 levels.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

32. Insurance risk management report continued

CONCENTRATION OF INSURANCE RISK *continued*

CLAIMS DEVELOPMENT

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments are typically resolved within one year, 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 2021 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 data extracted from the Electronic Vaccination Data System (EVDS), an allowance of R450 million has been made for vaccines that were administered during 2021 and for which we have not yet received the claims.

Based on the processing patterns and claims development up to the end of December 2021 in respect of treatment dates during 2021, the recommended provision for outstanding claims at December 2021 is R2 257 million (2020: R1 769 million). Note that any changes in case mix are automatically accounted for in the methodology. A sensitivity test is shown further below.

R'000	**2021**	**2020**
The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**38 717 881**	32 366 608
Chronic claims incurred	**3 031 099**	2 982 270
Out-of-hospital risk claims incurred	**12 489 624**	9 347 126

The table below outlines the sensitivity of insured liability estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables.

	Change in variable %	**Impact on Outstanding claims provision 2021**	Impact on Outstanding claims provision 2020
In-hospital claims incurred	1% slower claims processing	**377 985**	501 329
Chronic claims incurred	1% slower claims processing	**7 451**	7 125
Out-of-hospital risk claims incurred	1% slower claims processing	**137 062**	129 094

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

32. Insurance risk management report continued

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 to the 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 technologies and the expected demographic profile of the Scheme membership.

33. 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, RisCura, 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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

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
2021				
Investments	**34 688 723**			
Offshore cash and bonds	**2 299 286**	✓		✓
Equities	**7 578 533**		✓	
Short duration bonds	**10 604 304**			✓
Flexible fixed income bonds	**5 229 271**			✓
Money market instruments	**8 367 829**			✓
Property	**609 500**		✓	
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			✓
Property	431 202		✓	

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently, changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 2021, R2.3 billion (2020: R2 billion) (Note 3) was invested in these portfolios.

- **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 R0.80)* or 15% *(increase or decrease of R2.39)* from a spot level of R15.96 to the US Dollar, with all other variables held constant. The Scheme has not hedged this portfolio.

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
2021				
(Loss)/gain arising from currency appreciation/depreciation	**(344 893)**	**(114 964)**	**114 964**	**344 893**
2020				
(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

PRICE RISK

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified at fair value through profit or loss. The value of the Scheme's listed equity and property investments amounted to R8.2 billion (2020: R5.1 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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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%, with all other variables held constant. The Scheme has not hedged this portfolio.

The following table indicates the 5% or 15% change in the respective index.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
2021				
(Loss)/gain arising from price decrease/increase	**(1 149 486)**	**(383 162)**	**383 162**	**1 149 486**
2020				
(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 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
2021				
(Loss)/gain arising from price decrease/increase	**(93 295)**	**(31 098)**	**31 098**	**93 295**
2020				
(Loss)/gain arising from price decrease/increase	(67 090)	(22 363)	22 363	67 090

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

INTEREST RATE RISK

The Scheme is exposed to interest rate risk as it places funds in short-dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

R'000	0 – 3 Months	3 – 12 Months	>12 Months	Total
At 31 December 2021				
Cash and cash equivalents	**3 838 314**	**–**	**–**	**3 838 314**
Money market instruments carried at fair value through profit or loss		**8 367 829**	**–**	**8 367 829**
Short duration bonds carried at fair value through profit or loss	**–**	**10 604 304**	**–**	**10 604 304**
Flexible fixed income bonds carried at fair value through profit or loss	**–**	**–**	**5 229 271**	**5 229 271**
Offshore bonds carried at fair value through profit or loss	**–**	**2 299 286**	**–**	**2 299 286**
At 31 December 2020				
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

■ 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
2021				
Local portfolios	**880 831**	**440 415**	**(440 415)**	**(880 831)**
Foreign portfolios	**151 426**	**75 713**	**(75 713)**	**(151 426)**
2020				
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 2021 62% of the investments were invested in variable interest rate instruments, 17% in fixed rate instruments, and the remaining 21% in non-interest bearing instruments. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets due to the short duration thereof.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

LEGAL RISK

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. All Scheme agreements are reviewed by the legal team in order to ensure that the contractual obligations are clearly defined and not ambiguous. At 31 December 2021, the Scheme considered there to be no significant concentration of legal risk and no provision has been raised.

INVESTMENT RISK

Investment risk is the risk that the investment returns on accumulated assets will 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, 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.

The following changes have been made to the naming of investment categories:

RENAME YIELD ENHANCED BONDS TO SHORT DURATION BONDS

This is merely a cosmetic change to more accurately distinguish the portfolios in this category from the Flexible Fixed Income category, which allows for modified duration exposure. Portfolio mandates in the short duration category limit the interest risk by only allowing bonds with short maturities or floating interest rates – in both cases this reduced the sensitivity to changes in interest rates.

REMOVE THE INFLATION LINKED BOND CATEGORY

The Scheme no longer has specialist inflation linked bond portfolios – therefore the category has been removed.

ADD THE FLEXIBLE FIXED INCOME CATEGORY

Based on the Scheme's ability to absorb capital volatility risk due to very high solvency levels, the Scheme has added a category of investment that gives managers the ability to allocate between cash, nominal bonds and inflation linked bonds, based on their investment view.

The Scheme makes use of cash or money market mandates to comply with minimum cash holdings required for compliance as well as having liquid assets available with low capital volatility, should cash be required to fund operational expenses. Both the Aluwani Money Market and Taquanta Core mandates are well suited to these requirements.

The Scheme also allocates to fixed income mandates that attempt to add additional yield, without increasing capital volatility risk. The mandates would typically take on more credit, term and liquidity risk, although interest rate risk is limited through the use of floating rate rather than fixed rate instruments. The Ninenty One Credit Income and Futuregrowth STeFI A+ mandates fulfill this role. The Taquanta Enhanced Income mandate is closer in nature to these mandates as yield enhancement is achieved through more credit exposure as well as harvesting term and liquidity premium, compared to typical money market mandates. This is further supported by the higher performance target of the Enhanced Income portfolio of STeFI + 2%, compared to the Taquanta Core target of STeFI 3m + 1.3% (a difference of approximately 100 basis points).

From a liquidity perspective, the Enhanced Income portfolio is also more similar to the other short duration bond portfolios, as a full withdrawal requires a three month notice period, where the money market portfolios are able to make 20% of the portfolio available within five working days and a full disinvestment is likely possible within weeks, rather than months.

The reclassification therefore better aligns the portfolio both from both a mandate, as well as from a portfolio construction perspective.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

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
2021				
Investments	**31 083 524**	**2 299 286**	**1 305 913**	**34 688 723**
Offshore cash and bonds	**–**	**2 299 286**	**–**	**2 299 286**
Equities	**7 578 533**	**–**	**–**	**7 578 533**
Short duration bonds	**9 298 391**	**–**	**1 305 913**	**10 604 304**
Flexible fixed income bonds	**5 229 271**	**–**	**–**	**5 229 271**
Property	**609 500**	**–**	**–**	**609 500**
Money market instruments	**8 367 829**	**–**	**–**	**8 367 829**
Cash and cash equivalents	**901 508**	**2 936 806**	**–**	**3 838 314**
	31 985 032	**5 236 092**	**1 305 913**	**38 527 037**
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
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

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 local money market portfolios comprise approximately 23% (2020: 46%) of the Scheme's Financial assets at fair value through profit or loss.

SHORT DURATION BOND PORTFOLIOS:

LOCAL PORTFOLIOS:

The Scheme has three short duration bond portfolios, managed by independent asset managers.

The one portfolio uses a specialist fixed income strategy with South African exposure and invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include, but are not limited to, listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is STeFI three-month index plus 150 basis points per annum. To manage liquidity, the asset manager endeavours to invest in securities such that the repayment of capital in relation to securities matches the Scheme's liabilities, as communicated to the asset manager from time to time.

The second portfolio is a specialist low interest rate yield enhanced portfolio with moderate risk limits that seeks diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions. This is achieved by investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is the STeFI Composite Index. The weighted average credit quality is A+ with a weighted average term to maturity of less than five years.
A minimum of 10% of the portfolio will be held in money market instruments with an expected term to maturity of less than 91 days.
A minimum of 20% of the portfolio must be held in money market instruments.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty, and sets exposure limits to unrated investments.

The third portfolio is a duration constrained mandate that seeks yield enhancement through responsible credit allocation as well as harvesting a liquidity premium. The maximum term to maturity of any instrument may be no longer than seven years. Notice of three calendar months is required for a full withdrawal from the portfolio.

These portfolios comprise approximately 31% (2020: 28%) of the Scheme's Financial assets at fair value through profit or loss.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

BREAKDOWN OF INVESTMENTS *continued*

OFFSHORE PORTFOLIOS:

The Scheme has two offshore portfolios managed by independent asset managers.

The first portfolio is a multi-asset credit strategy invested in an open-ended specialised investment fund on a non-discretionary basis. The fund is benchmarked against the Secured Overnight Funding Rate (SOFR) plus 400 basis points.

The second portfolio is actively managed on a discretionary basis investing in a portfolio of foreign offshore fixed income instruments. The primary objective is the long-term growth of capital and income. The benchmark for this portfolio is the Financial Times Stock Exchange (FTSE) World Government Bond Index (USD).

These portfolios comprise approximately 7% (2020: 6%) of the Scheme's financial assets at fair value through profit or loss.

FLEXIBLE FIXED INCOME:

The Scheme has two flexible fixed income portfolios, each managed by an independent asset manager.

Both portfolios have a composite benchmark of 50% FTSE/JSE All Bond Index (ALBI) and 50% FTSE/JSE Inflation Linked Bond Index (CILI). The mandates allow manages to switch between cash, nominal bonds and inflation linked bonds based on their investment view. The managers seek to outperform the benchmark through a combination of asset allocation as well as yield enhancement from security selection. The portfolios have no modified duration limits, but average weighted credit quality should be at least A+.

To limit concentration risk, limits are in place for both issuer and credit quality category.

These portfolios comprise approximately 15% (2020: 4%) of the Scheme's Financial assets at fair value through profit or loss.

EQUITY PORTFOLIOS:

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. These risks are mitigated by blending investment mandates across different manager styles and sectors.

The portfolios may only be invested in South African equities and are to be as fully invested as can practically be achieved at all times. One portfolio has a maximum cash allocation of 2% and the remaining portfolios a maximum allocation of 5%. The portfolios must comply with the Act and are prohibited from investing in Discovery Ltd. The Scheme has mitigated exposure to any single benchmark constituent by limiting investment in any single benchmark constituent to a maximum of 15%.

The Scheme considers responsible investing in all its investments. Managers are required to exclude tobacco manufacturers and related exposures by utilising negative screening. This includes all direct investments and indirect investments greater than 5%.

The performance of the actively managed portfolios is measured against the benchmark, which is the FTSE/JSE Capped Shareholder weighted index (SWIX) adjusted to exclude tobacco (as per the Scheme's Responsible Investment Policy) and capping the combined exposure to Naspers and Prosus to a maximum of 15%. The performance of the passive portfolio is measured against the same benchmark.

These portfolios comprise approximately 22% (2020: 15%) of the Scheme's Financial assets at fair value through profit or loss.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

BREAKDOWN OF INVESTMENTS *continued*

PROPERTY:

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. The benchmark for this mandate is the FTSE/JSE SA All Property Index.

The mandate does not permit investment in foreign listed shares or direct property investments and requires that there will always be more than six holdings in the portfolio.

This portfolio comprises approximately 2% (2020: 1%) of the Scheme's Financial assets at fair value through profit or loss.

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
2021						
Investments						
– Offshore bond portfolio	**2 299 286**	**–**	**–**	**–**	**2 299 286**	**2 299 286**
– Equities	**7 578 533**	**–**	**–**	**–**	**7 578 533**	**7 578 533**
– Short duration bond portfolio	**10 604 304**	**–**	**–**	**–**	**10 604 304**	**10 604 304**
– Flexible fixed income bond portfolio	**5 229 271**	**–**	**–**	**–**	**5 229 271**	**5 229 271**
– Property	**609 500**	**–**	**–**	**–**	**609 500**	**609 500**
– Money market portfolios	**8 367 829**	**–**	**–**	**–**	**8 367 829**	**8 367 829**
Cash and cash equivalents	**–**	**–**	**–**	**–**	**–**	**–**
– Medical Scheme assets	**–**	**3 838 314**	**–**	**–**	**3 838 314**	**3 838 314**
– Personal Medical Scheme assets	**–**	**10 860**	**–**	**–**	**10 860**	**10 860**
Trade and other receivables	**–**	**10 728**	**2 719 122**	**–**	**2 729 850**	**2 729 850**
Personal Medical Savings Accounts	**–**	**–**	**–**	**(7 081 549)**	**(7 081 549)**	**(7 081 549)**
Trade and other payables	**–**	**–**	**(851 215)**	**(666 108)**	**(1 517 323)**	**(1 517 323)**
Derivative financial instruments	**–**	**–**	**–**	**–**	**–**	**–**
Outstanding claims provision	**–**	**–**	**(2 257 054)**	**–**	**(2 257 054)**	**(2 257 054)**
	34 688 723	**3 859 902**	**(389 147)**	**(7 747 657)**	**30 411 821**	**30 411 821**

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

BREAKDOWN OF INVESTMENTS *continued*

	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
– 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
– 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

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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

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.

CASH AND CASH EQUIVALENTS

For cash and cash equivalents, these amounts are short dated/on demand deposits with highly rated banks and as a result there is no expectation of any credit losses as the probability of default is remote. As a result the amount at risk would be immaterial and no further analysis presented.

R'000	Current	Total
2021		
Expected loss rate	**0%**	
Gross carrying amount – other receivables	**10 728**	**10 728**
Sundry accounts receivable	**9 567**	**9 567**
Interest receivable	**1 161**	**1 161**
Gross carrying amount – cash and cash equivalents	**3 838 314**	**3 838 314**
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
Gross carrying amount – cash and cash equivalents	4 008 668	4 008 668

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 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
Balance at 1 January 2021	**22 471**	**322 924**	**–**	**1 896**	**11 779**	**359 070**
Increase in provision for impairment	**9 303**	**111 873**	**–**	**3 017**	**1 048**	**125 240**
Amounts utilised during the year		**(127 667)**				**(127 667)**
BALANCE AT 31 DECEMBER 2021	**31 774**	**307 130**	**–**	**4 913**	**12 826**	**356 643**

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 arrangements	Broker fee receivables	Other insurance receivables	Forensics receivables	Related party	Other receivables	Total
31 December 2021												
Not past due	**5 497**	**7 395**	**1 721**	**14 613**	**2 322 213**	**372**	**493**	**63 385**	**45 500**	**13 058**	**10 728**	**2 470 362**
Past due 30 – 60 days	**9 140**	**9 666**	**315**	**19 121**	**69 544**	**–**	**51**	**–**	**1 726**	**–**	**–**	**90 442**
Past due 61 – 90 days	**4 626**	**8 261**	**220**	**13 107**	**(14 400)**	**–**	**35**	**–**	**1 215**	**–**	**–**	**(43)**
Past due 91 – 120 days	**5 281**	**12 137**	**498**	**17 916**	**(421)**	**–**	**60**	**–**	**780**	**–**	**–**	**18 335**
Past due 121 – 150 days	**4 399**	**10 454**	**418**	**15 271**	**4 024**	**–**	**23**	**–**	**1 238**	**–**	**–**	**20 556**
Past due 151 – 180 days	**5 028**	**11 307**	**1 683**	**18 018**	**–**	**–**	**23**	**–**	**1 379**	**–**	**–**	**19 420**
181 days to more than one year	**31 620**	**236 917**	**38 593**	**307 130**	**–**	**–**	**4 913**	**–**	**155 378**	**–**	**–**	**467 421**
Gross Receivables	**65 591**	**296 137**	**43 448**	**405 176**	**2 380 960**	**372**	**5 598**	**63 385**	**207 216**	**13 058**	**10 728**	**3 086 493**
Provision for impairments	**(31 620)**	**(236 917)**	**(38 593)**	**(307 130)**	**(31 774)**	**–**	**(4 913)**	**–**	**(12 826)**	**–**	**–**	**(356 643)**
Trade and other receivables neither past due nor impaired	**33 971**	**59 220**	**4 855**	**98 046**	**2 349 186**	**372**	**685**	**63 385**	**194 390**	**13 058**	**10 728**	**2 729 850**
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

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 181 can be assessed by reference to historical information about counterparty default.

CONTRIBUTIONS DEBTORS

The Scheme collects over 93% 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 48% (2020: 55%) 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 80% (2020: 81%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

SERVICE PROVIDER CLAIMS DEBTORS

A provision for impairment covering 89% (2020: 71%) 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	**2021**	**2020**
– Offshore cash and bonds	**2 299 286**	1 975 533
– Short duration bonds	**10 604 304**	–
– Yield enhanced bonds	**–**	8 871 310
– Inflation-linked bonds	**–**	1 170 279
– Flexible fixed income bonds	**5 229 271**	–
– Money market instruments	**8 367 829**	14 323 269
– Cash and cash equivalents	**3 838 314**	4 008 668
– Derivative financial instruments	**–**	158 307
	30 339 004	30 507 366

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

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 184.

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 values stated above.

CREDIT RATING SCALES

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indicators of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

LONG-TERM RATING SCALES

AAA: HIGHEST CREDIT QUALITY
AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: VERY HIGH CREDIT QUALITY
AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: HIGH CREDIT QUALITY
A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: GOOD CREDIT QUALITY
BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

BB: SPECULATIVE
BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time, however business or financial flexibility exists which supports the servicing of financial commitments.

B: HIGHLY SPECULATIVE
B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met, however capacity for continued payment is vulnerable to deterioration in the business and economic environment.

CCC: POSSIBILITY OF DEFAULT
Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

CC: VERY HIGH LEVELS OF CREDIT RISK
Default of some kind appears probable.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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% (2020: 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
2021 At fair value through profit or loss:	**26 500 690**	**5 129 539**	**2 016 854**	**14 154 769**	**1 322 117**	**361 251**	**447 767**	**789 894**	**55 729**	**1 650**	**2 221 120**
– Offshore bond portfolio	**2 299 286**	**34 410**	**261 227**	**47 498**	**182 156**	**330 465**	**436 267**	**789 894**	**55 729**	**1 650**	**159 990**
– Short duration bond portfolio	**10 604 304**	**394 842**	**1 281 622**	**6 253 714**	**705 025**	**30 786**	**11 500**	**–**	**–**	**–**	**1 926 815**
– Flexible fixed income bond portfolio	**5 229 271**	**4 700 287**	**93 012**	**558 832**	**36 203**	**–**	**–**	**–**	**–**	**–**	**(159 063)**
– Money market portfolios	**8 367 829**	**–**	**380 993**	**7 294 725**	**398 733**	**–**	**–**	**–**	**–**	**–**	**293 378**
Cash and cash equivalents	**3 838 314**	**302 840**	**238 313**	**2 254 960**	**–**	**–**	**–**	**–**	**–**	**–**	**1 042 201**
Total*	**30 339 004**	**5 432 379**	**2 255 167**	**16 409 729**	**1 322 117**	**361 251**	**447 767**	**789 894**	**55 729**	**1 650**	**3 263 321**
% per rating band		**17.91%**	**7.43%**	**54.09%**	**4.36%**	**1.19%**	**1.48%**	**2.60%**	**0.18%**	**0.01%**	**10.76%**
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%

* *Excludes derivative financial instruments*

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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	2021 R'000	Authorised programme size	% of Authorised programme size	Fair Value Hierarchy		Debt Ranking		Credit Rating		Underlying assets	
				Level	%	Ranking	%	Rating	%	Asset	%
Residential mortgage-backed securitisations	**458 151**	R125 Billion	0.37%	Level 1	78%	Senior secured	35%	AAA	55%	Residential Mortgages	100%
				Level 2	22%	Secured	65%	AA- to AA+	23%		
								A+	0%		
								NR	22%		
Asset-backed securitisations	**175 739**	R25 Billion	0.70%	Level 1	100%	Senior secured	73%	AAA	85%	Equipment leases	6%
				Level 2	0%	Secured	20%	AA- to AA+	15%	Unsecured Loans	14%
						Senior Unsecured	7%	NR	0%	Vehicle Loans	80%
Commercial mortgage-backed securitisations	**4 490**	R3 Billion	0.15%	Level 1	100%	Secured	100%	AAA	100%	Commercial mortgage loans	100%

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

EXPOSURE TO CREDIT RISK continued

Name and description	2021 R'000	Portfolio size R'000	% of Portfolio size	Fair Value Hierarchy	Credit Rating	Fund
Collective investment schemes	**1 923 943**	18 768 004	10.25%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	84 217	41 512 945	0.20%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C2
	919 825	58 744 352	1.57%	Level 1	AA	Nedgroup Investments Core Income Fund Class C2
	2 232	30 377 128	0.01%	Level 2	AA+	Ninety One Corporate Money Market Class A
	3 059	39 773 785	0.01%	Level 2	AA+	Ninety One Money Market Fund Class A
	3 529	68 013 787	0.01%	Level 2	AA+	Stanlib Corporate Money Market Fund Class B5
	857 082	250 500 000	0.34%	Level 2	AA+	Legg Mason Brandywine Global Opportunistic Fixed Income Fund
	1 442 244	8 032 754	18.06%	Level 2	BB	Ninety One Global Alternative Multi-asset Credit

Name and Description	2020 R'000	Authorised programme size	% of Authorised programme size	Fair Value Hierarchy Level	%	Debt Ranking	%	Credit Rating	%	Underlying assets	%
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%

NOTES TO THE FINANCIAL STATEMENTS continued
FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 Global Alternative Multi-asset Credit

LIQUIDITY RISK

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 98% (R2.4 billion) (2020: 97% – 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.

NOTES TO THE FINANCIAL STATEMENTS continued
FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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
As at 2021			
Personal Medical Savings Accounts (Note 9)	**7 081 549**	**–**	**–**
Trade and other payables (Note10)	**666 108**	**–**	**–**
Derivative financial liabilities (Note 8)	**–**		
Leases (Note 2)	**1 961**	**2 098**	**6 573**
	7 749 618	**2 098**	**6 573**
As at 2020			
Personal Medical Savings Accounts (Note 9)	6 675 945	–	–
Trade and other payables (Note 10)	647 040	–	–
Derivative financial liabilities (Note 8)	34 723		
Leases (Note 2)	1 832	1 961	7 433
	7 359 540	1 961	7 433

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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. Financial risk management report continued

FAIR VALUE HIERARCHY FOR FINANCIAL ASSETS MEASURED AT FAIR VALUE

ASSETS MEASURED AT FAIR VALUE

	Fair value measurement at end of the year using:			
R'000	**Total**	**Level 1**	**Level 2**	**Level 3**
2021				
Current assets				
– Offshore cash and bonds	**2 299 286**	**–**	**2 299 286**	**–**
– Equities	**7 578 533**	**7 552 725**	**25 808**	**–**
– Short duration bonds	**10 604 304**	**6 096 091**	**4 508 213**	**–**
– Flexible fixed income bonds	**5 229 271**	**5 027 723**	**201 548**	**–**
– Property	**609 500**	**603 580**	**5 920**	**–**
– Money market instruments	**8 367 829**	**4 773 528**	**3 594 301**	**–**
	34 688 723	**24 053 647**	**10 635 076**	**–**
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	–
– 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	–

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market.

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable.

Level 3 – These are assets measured using inputs that are not based on observable market data.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

33. 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 2021	Fair value at 2020	Valuation techniques	Observable Input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**7 009 047**	5 552 336	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**3 594 301**	5 926 153	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	**31 728**	16 253	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
Derivative financial instruments	**–**	158 307	Discounted cash flow valuation, Black-Scholes model	Published index levels, published exchange swap curve, published interest rate curve, published credit spread curve, implied volatilities
	10 635 076	11 653 049		

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	2021	2020
Total members' funds per Statement of Financial Position	**30 418 845**	28 215 475
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(1 603 656)**	(686 683)
Accumulated funds per Regulation 29	**28 815 189**	27 528 792
Gross annual contribution income	**75 816 287**	74 537 501
Solvency margin		
= Accumulated funds/gross annual contribution income x 100	**38 01%**	36 93%

At 2021, the Scheme's regulatory capital level of 38.01% (2020: 36.93%) was R9.9 billion (2020: R8.9 billion) more than the statutory capital requirement of 25%.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

34. 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 32.

OTHER RISK TRANSFER ARRANGEMENTS

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 14.

IMPAIRMENT OF ASSETS

The critical estimates made by the Scheme are set out under Note 33 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 6.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

35. Non-compliance matters

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

During 2021, 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 2021 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/ surplus (R'000)
Executive	**(218 517)**	**(200 506)**
Classic Comprehensive	**(970 676)**	**(728 148)**
Classic Priority	**(116 613)**	**54 327**
Essential Comprehensive	**(30 278)**	**(2 564)**
Coastal Core	**(164 519)**	**30 778**
Coastal Saver	**(249 999)**	**133 760**
KeyCare Plus	**(910 471)**	**(356 593)**

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.

■ 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 exemption for a period of three years effective from 1 December 2019.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

35. Non-compliance matters continued

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 that they are correctly paid.

CLAIMS PAID IN EXCESS OF 30 DAYS

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

During the year, there were instances were claims were not paid within 30 days. These 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.

DIRECT OR INDIRECT BORROWING OF MONEY

In terms of Section 35 (6) (c) of the Act a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were instances during the year where the Scheme inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of this re-occurring.

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, exemption 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. Regulation 10 (3) of the Act states that funds deposited in a member's personal medical savings account shall be available or the exclusive benefit of the member and his or her dependants but may not be used to offset contributions. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R93k resulting from late applications. 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.

NOTES TO THE FINANCIAL STATEMENTS continued

FOR THE YEAR ENDED 31 DECEMBER 2021

35. Non-compliance matters continued

- **MID-YEAR CONTRIBUTIONS COMMUNICATION ERROR AND FAILURE**

  The Medical Schemes Act, Section 57 (4) (d), requires that members must be informed of their rights, benefits, contributions, and duties in terms of the rules of the medical scheme. DHMS Rule 15.2 stipulates those members must be informed of changes in benefits or contributions at least 30 days before such change is affected.

  DHMS mid-year contribution increase notifications were e-mailed on 28 May 2021. The link in the notification e-mail, to opening the increase letter, displayed an error message, resulting in some members not being able to view the content of the letter.

  Apology notifications were sent to the affected members on 17 June 2021 with a new link.

  The affected members received updated contribution letters and additional processes have been implemented to mitigate the risk of this re-occurring.

- **INCORRECT SUSPENSION OF DHMS MEMBERS**

  The Medical Schemes Act, Section 29 (2), states that a medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependents, except on certain grounds.

  Electronic Funds Transfer (EFT) payments received in December 2021 did not reflect on the payor transaction query due to a system error, which resulted in 722 members being incorrectly suspended.

  Members who were incorrectly suspended were unsuspended. Apology calls were made to the affected members, and they were provided with confirmation that the allocation was corrected.

09 RESOURCES

CONTACT DETAILS

PRINCIPAL OFFICER

Email **principalofficer@discovery.co.za** or call +27 11 529 2888 and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

COUNCIL FOR MEDICAL SCHEMES (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

IMPORTANT SOURCES OF INFORMATION

We include various useful links below. You may need to log into the website to view some information.

MEMBER SUPPORT

- Need something? Who to contact
- Choose the best plan for you and your family
- Plan and benefit information for 2022
- About DHMS and Scheme Rules
- Medical scheme terminology
- Benefits and cover; understanding your plan

OTHER INFORMATION

- The Medical Schemes Act
- The Council for Medical Schemes
- The King IV Report
- The International Integrated Reporting Framework

Discovery Health Medical Scheme registration number 1125

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 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

PRINCIPAL OFFICER
Charlotte Mbewu
Discovery Health Medical Scheme,
1 Discovery Place, Sandton, 2146

REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS
Discovery Health Medical Scheme, Ground Floor, The Ridge, Corner of Rivonia Road and Katherine Street, Sandton, 2146
PO Box 786722, Sandton, 2146

ADMINISTRATOR AND MANAGED CARE PROVIDER
Discovery Health (Pty) Ltd, 1 Discovery Place, Sandton, 2146
PO Box 786722, Sandton, 2146

AUDITORS
PricewaterhouseCoopers Incorporated,
4 Lisbon Lane, Waterfall City, Jukskei View, 2090
Private Bag X36, Sunninghill, 2157

PRINCIPAL BANKERS
Rand Merchant Bank, a division of FirstRand Bank Ltd, 1 Merchant Place, Cnr Fredman Drive and Rivonia Road, Sandton, 2196

INVESTMENT MANAGERS

ABAX INVESTMENTS (PTY) LTD
Coronation House, The Oval, 1 Oakdale Road, Newlands, 7700

ALLAN GRAY INVESTMENTS (PTY) LTD
1 Silo Square, V&A Waterfront, Cape Town, 8001

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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