
For the benefit of our

# members

2016 Integrated Annual Report

# 01 About our Report

Our Integrated Annual Report indicates the accountability of the Trustees of Discovery Health Medical Scheme to our members, and to the Scheme's other stakeholders who are integral to its ability to create value for its members and ensure the sustainability of the Scheme.

The Report provides an overview of Discovery Health Medical Scheme (the Scheme or DHMS), and a holistic assessment of its governance, business model, strategy and performance in the context of the key risks and opportunities in the South African private healthcare sector. In a time of increasing economic demands on Scheme members and above inflation increases in healthcare costs, the Report demonstrates the Scheme's efforts to balance the needs and expectations of its stakeholders. This balance underpins the Scheme's financial and operational sustainability, which in turn supports the overall capacity and viability of the private healthcare sector.

## Board of Trustees responsibility and approval

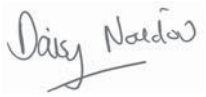
The Trustees are committed to providing our members with accurate and reliable information. We recognise our responsibility to assure the integrity of the Integrated Annual Report, and are confident that it covers all material matters, complies with the Scheme's responsibility to account for its operations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

The Trustees are satisfied that the Report complies with the requirements of the Medical Schemes Act 131 of 1998 (the Act), as amended, the Scheme Rules, and the Accounting Guide for Medical Schemes, issued by the South African Institute of Chartered Accountants (SAICA), including compliance with International Financial Reporting Standards (IFRS), and all additional financial reporting requirements of the Council for Medical Schemes (CMS).

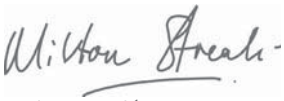
The Trustees are also satisfied that the Scheme has adequate resources to continue with its operations in the foreseeable future. The Scheme's Annual Financial Statements have therefore been prepared on a going concern basis.

**Signed on behalf of the Trustees**

Michael van der Nest, SC
**Chairperson**



Daisy Naidoo
**Trustee**



Milton Streak[1]
**Principal Officer**

*1 Mr Streak was the Principal Officer during 2016, and resigned with effect from 31 December 2016.*

The Information Toolkit on **pages 154 – 156** of this Report directs stakeholders to more information on DHMS, important contact details, and how to submit a complaint or compliment, or report fraud or unethical behaviour.

It also provides details that stakeholders can use to give feedback on the Report.

A glossary of terms is provided on **page 157**.

For more information within this Report.

For more information available online.

## Scope and boundary

The Report covers the benefit year from 1 January 2016 to 31 December 2016, also referred to as the 2016 financial year ('the year').

The Report takes guidance from the King Code of Governance Principles (King III). Although it is only formally applicable to the Scheme from 1 January 2018, the Scheme is working to incorporate the newly released King IV Code into its governance policies, practices and disclosures. The Scheme uses the International Integrated Reporting Framework as the basis for preparing and improving its Report, and applies it insofar as it is relevant and applicable to medical schemes in South Africa.

Although we do not explicitly conform to the six capitals model of the International Integrated Reporting Framework, the Report discusses how the Scheme manages its resources and relationships responsibly to create value for its members and other stakeholders. The boundary of the report includes, therefore, our interactions with entities outside the organisation that underpin our ability to create value for our members and other stakeholders.

In line with its Vested® outsourcing business model, the Scheme contracts with Discovery Health as its Administrator and Managed Care Provider. The Scheme reviews and monitors the value that Discovery Health delivers to the Scheme and its members as a matter of course, which includes a specific methodology to assess the value for money obtained from them. This assessment of the work Discovery Health does and the value it adds is an important aspect of the Report.

Read more about our business model on **pages 16 – 17**, and about Discovery Health's initiatives for the Scheme on **pages 74 – 81**.

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

## Materiality determination

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

The Trustees scan the environment and consider Board and Scheme Office reports, the Scheme's risk register, and product and benefit enhancement opportunities to determine material matters. Stakeholder feedback obtained through a range of interactions is also considered, both formal (stakeholder activities and feedback sessions) and informal (emails and calls to the Scheme).

The Trustees ensure that the Scheme's strategic priorities are adapted, where appropriate, to ensure that all material matters are considered in the implementation of the Scheme's strategic objectives.

The material matters relevant to the benefit year are set out on **page 11**, and discussed comprehensively in the Report.

## Combined assurance

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

- **First line:** Scheme Management provides the Trustees with assurance that the Scheme's risk management plan is integrated into the day-to-day running of the Scheme and that it is monitored on an ongoing basis.
- **Second line:** the outsourced Group Risk Management, Compliance, and Forensics functions assess the effectiveness of the Scheme's internal control and risk management processes.
- **Third line:** Scheme Management and the Trustees receive external assurance on the Scheme's financial performance and internal control frameworks from Internal Audit, external audit and an independent actuarial firm.

Scheme Management assures the Integrated Annual Report, with the external auditors providing independent assurance of the Annual Financial Statements.

## Auditor independence

PricewaterhouseCoopers Inc have audited the Scheme's Annual Financial Statements. The Trustees believe the external auditors have observed the highest level of business and professional ethics, and have no reason to believe that they have not acted independently. Audit tenure and rotation of the designated partner form part of the independence assessment. The Audit Committee is satisfied that the auditor was independent of the Scheme.

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

# 2016 Integrated Annual Report

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

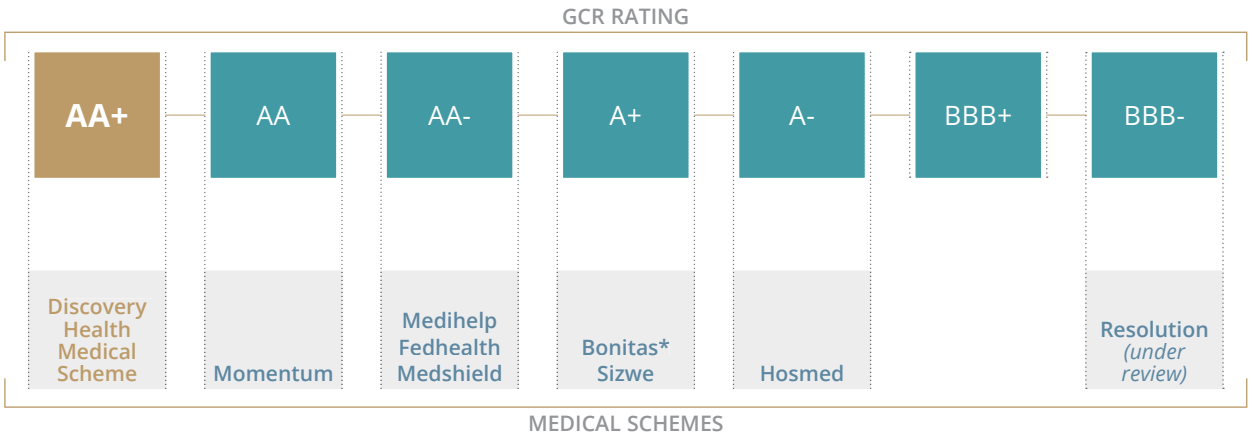
# 02 Performance Highlights

## Overview

Discovery Health Medical Scheme delivered a positive net healthcare result of R102 million for the year ended 31 December 2016 (2015: R507 million). The year-on-year decrease in the operating result was mainly attributable to medical inflation and increased utilisation of benefits. Despite difficult investment markets, the Scheme generated healthy investment income of R1 257 million (2015: 1 019 million) contributing to the net surplus for the year of R1 305 million (2015: R1 276 million).

This solid financial performance increased members' funds to R14.2 billion (2015: R12.9 billion) with a solvency level of 26.33% (2015: 25.98%). The Scheme's financial strength and ability to pay claims was once again confirmed with a credit rating of AA+, the highest possible rating in the industry, from independent credit rating agency, Global Credit Rating Co (GCR).

## DHMS maintains AA+ credit rating

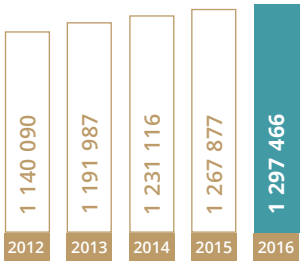



* *Withdrawn in 2017.*

## KEY HISTORICAL PERFORMANCE INDICATORS

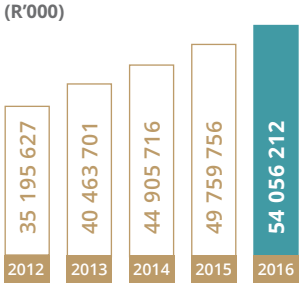
The Scheme continues to build on its excellent historical performance, evidenced by the increase over the last five years in our principal members, Scheme lives, gross contributions and members' funds.

**Increase in Scheme principal members**



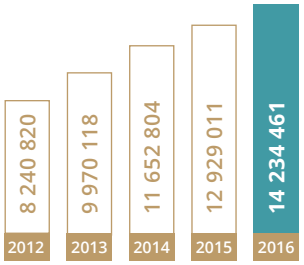

▲2.33%*

**Increase in gross contributions (R'000)**



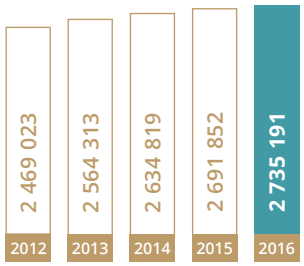

▲8.63%*

**Growth in members' funds (R'000)**




▲10.10%*

**Increase in Scheme lives**




▲1.61%*

* *Year-on-year change.*

## KEY INDICATORS FROM 2016

**AA+**
Independent credit rating for claims-paying ability
(2015: AA+)

**26.33%**
Statutory solvency level
(2015: 25.98%)

**55%**
Share of open scheme market
(2015: 53%)

**5%**
Annualised lapse rate
(2015: 5%)

**2.45%**
Average growth in principal members
(2015: 3.24%)

**2.11**
Average family size
(2015: 2.12)

**2.60%**
Managed care as % of gross contributions
(2015: 2.62%)

**7.68%**
Admin fees as % of gross contributions
(2015: 7.79%)

**8.79%**
Average return on investments
(2015: 6.01%)

**8.92%**
Pensioner ratio
(2015: 8.55%)

**34.17**
Average age at year end
(2015: 33.86)

For further detail on the Scheme's performance, please see **pages 64 – 73**.

# 03 About DHMS

# WHO WE ARE

Discovery Health Medical Scheme (DHMS) is an open medical scheme. Any member of the public can join the Scheme, subject to its Rules[1]. Covering 2 735 191 beneficiaries at 31 December 2016, it is the largest open medical scheme in South Africa with an open medical scheme market share of 55%[2].

The Scheme is a non-profit entity governed by the Medical Schemes Act[3] (the Act), and is regulated by the Council for Medical Schemes (CMS). The Scheme belongs to its members and an independent Board of Trustees (the Board) oversees its business.

Read more about the Board and management structures on **pages 18 – 25**.

The Scheme operates by way of a formal contractual arrangement with Discovery Health (Pty) Ltd, with its business model based on Vested® outsourcing.

## We exist for our members

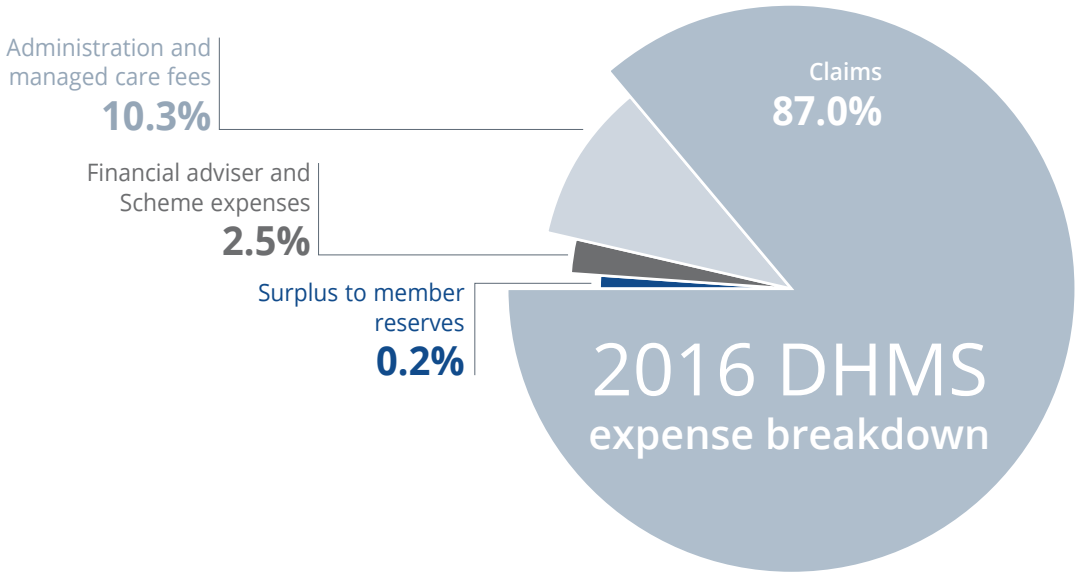
The Scheme's purpose is to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality healthcare that meets their needs now and into the future.

## 87% of contributions received are used to fund member benefits

The Scheme's income is predominantly derived from member contributions and investment returns. In pricing for contributions from members for each year, the Scheme's objective is to return a surplus to meet regulatory requirements as well as to have a cushion against unexpected cost increases. This is in accordance with the fundamental operating principles of a non-profit organisation.

The Scheme's income is used to fund activities to ensure the sustainability of the Scheme as well as those for the support and benefit of members – such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

Apart from the reserves and these activities, all of the Scheme's income is used to fund claims.




1 *The Scheme Rules are available to registered users at www.discovery.co.za/medical-aid/scheme-rules.*
2 *Based on beneficiaries, according to the Council for Medical Schemes Annual Report 2015–2016 (www.medicalschemes.com/Publications.aspx).*
3 *Medical Schemes Act 131 of 1998, as amended.*

# Ensuring the Scheme's sustainability

The Scheme's ability to pay claims and its sustainability over the long term are of critical importance to its members. The Scheme considers the following to be key metrics for its sustainability:

## Growth and Sustainability

**Membership size**

Greater risk pooling means more predictable claims experience and accuracy in pricing, leading to stable performance.

**Contribution increases**

Reflects effective risk management and value proposition to members.

**Membership growth**

Continuous growth of young and healthy lives improves risk pooling and reflects attractiveness and competitiveness of the Scheme through cross-subsidisation principles.

**Plan movements**

Indicates satisfaction, stability in benefit design and appropriate pricing.

## Financial Strength

**Absolute reserves**

Demonstrates ability to meet large, unexpected claims variation.

**Pricing sufficiency**

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

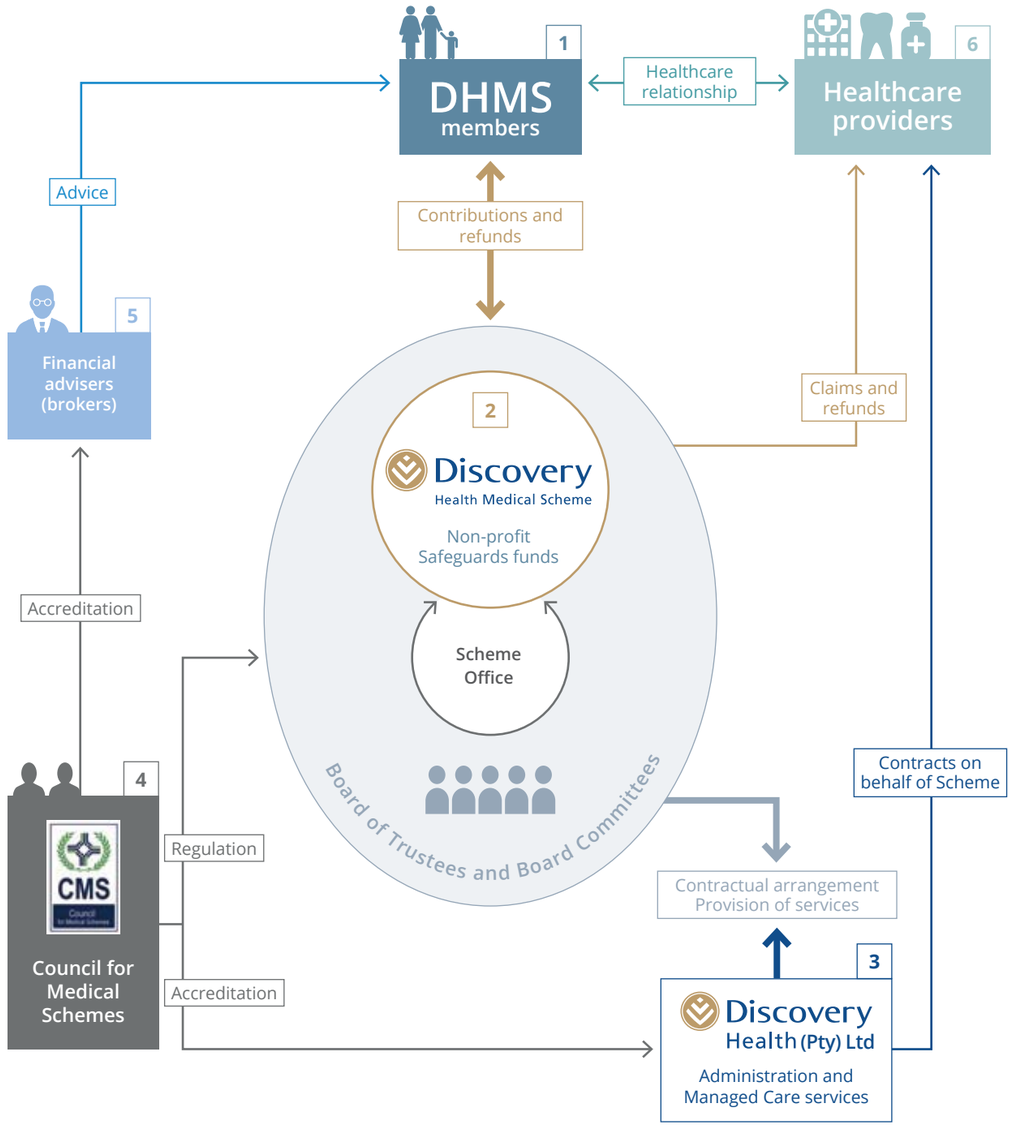
Read more about these key aspects of our sustainability in our Chairperson's statement, our Principal Officer's review of the year, and Discovery Health Medical Scheme performance, starting on **pages 38** and **64 – 73**, respectively.

## DHMS receives exceptional value for its administration and managed care expenses

For every R1 spent on administration and managed care fees in 2015, beneficiaries of the Scheme derived R1.85 in value.

Read more about our business model and how we assess value received from Discovery Health on **pages 16 – 17**.

# OUR WORLD




## How our key stakeholders interact to create value for our members

### 1 DHMS members

Discovery Health Medical Scheme exists for its members. The Scheme's 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 healthcare that meets their needs now and into the future.

Any member of the public can join Discovery Health Medical Scheme[1] and can select from sixteen benefit options and six network efficiency discount options designed to cater for a wide range of affordability and healthcare needs[2].

### 2 Discovery Health Medical Scheme

Discovery Health Medical Scheme is a registered medical scheme, and like all other medical schemes in South Africa is a non-profit entity. The Scheme pools all members' contributions in order to fund members' claims. Any surplus funds are transferred to Scheme reserves for the benefit of members. The Scheme exists to serve its members' interests through enabling the sustainable provision of high-quality and affordable healthcare to all of its members.

#### Scheme Office

**(Principal Officer and executive management team)**

The Board of Trustees appoints a Principal Officer, who is the chief executive officer of the Scheme and is accountable to the Trustees for the day-to-day management of the Scheme and the implementation of its strategy.

The Principal Officer, supported by an executive management team, is key to the effective operation of the Scheme. The Principal Officer and the management team collaborate closely with the Scheme's Administrator and Managed Care Provider, Discovery Health, in the implementation of strategy and daily operations. The management team's expertise includes medical, actuarial, risk management, business management, financial management, legal, compliance and research capabilities.

#### Board of Trustees

The Trustees oversee the affairs of the Scheme in the best interest of our members and stakeholders.

Trustees are highly skilled individuals who offer their diverse knowledge and experience to the Scheme. They may be elected or appointed, but at any time at least 50% of the Board must be elected by Scheme members.

#### Board Committees

The Board delegates some of its work to various Board Committees equipped with the necessary specialist skills. These Committees may consist of Trustees and/or additional independent members. All Committees report back to the Board and make recommendations in line with their respective mandates.

### 3 Discovery Health (Pty) Ltd

**(Administration and Managed Care Provider)**

Discovery Health has been appointed by the Trustees to provide administration and managed care services to the Scheme.

Administration services provided include:

- Member and provider servicing;
- Marketing, communication and advertising;
- Financial services;
- Governance, risk, compliance and internal audit;
- Research and development;
- Actuarial and business analytics;
- Benefit design; and
- Fraud and forensics investigation.

Managed care is the provision of appropriate, affordable, quality healthcare services through rules-based, clinical and disease management programmes.

Managed care services provided include:

- Active disease risk management and support services;
- Hospital benefit management services;
- Managed care network, negotiations and risk management services; and
- Pharmacy benefit management services.

### 4 Council for Medical Schemes

The CMS is a statutory body responsible for regulating the medical schemes industry in South Africa: it administers and enforces the Act.

### 5 Financial advisers

Financial advisers (commonly referred to as "brokers") provide members with independent advice about their health plan options based on individual medical and affordability needs.

Financial advisers are regulated by and must be registered with the Financial Services Board. In addition, they are accredited by the CMS to provide advice on private healthcare cover. The Scheme pays contracted financial advisers a legislated commission.

### 6 Healthcare providers

Healthcare providers are the health professionals who deliver healthcare services, for example, doctors, nurses, dentists, specialists, hospitals, pharmacies and managed care organisations.

Read more about how the Scheme creates value for all its stakeholders on **pages 26 – 35**.

*1 Subject to any applicable Scheme Rules and restrictions of the Medical Schemes Act.*
*2 Members and potential members can discuss their unique needs with a financial adviser to select the most appropriate plan for them.*

# OUR OPERATING CONTEXT

Healthcare in South Africa is governed by the Department of Health, which established the Council for Medical Schemes (CMS) to regulate the private healthcare sector according to the Medical Schemes Act 131 of 1998, as amended (the Act). The CMS interacts frequently with the industry and publishes regular circulars to guide medical schemes on interpreting and implementing the Act. It also reviews the finances, benefit plans and rules of each scheme. The CMS also accredits medical scheme administrators and managed care providers to provide services to medical schemes and their members, and accredits financial advisers to provide advice to the public on private healthcare cover.

During 2016, there were 83 medical schemes registered with the CMS covering over 8.8 million beneficiaries and with total contributions of approximately R151.6 billion[1]. DHMS facilitates access to private healthcare for over 2 735 000 beneficiaries[2], approximately 31% of the industry.

All medical schemes in South Africa are non-profit entities that operate in a complex and tightly regulated sector. Schemes price their benefit plans for the following year based on utilisation, financial performance and industry factors, as well as on financial and actuarial forecasts. Pricing is a function of balancing a number of factors – holding sufficient reserves to weather times of economic difficulty, to address increased utilisation of healthcare services and the cost of treatment, optimising benefits and ensuring equitable treatment of all scheme members, while keeping contributions affordable.

Through its Administrator and Managed Care Provider, Discovery Health, DHMS works to ensure better coordinated and higher quality of care for its members in a fragmented healthcare system. The Scheme also works closely with regulatory authorities as necessary, which in the last few years has related to Prescribed Minimum Benefit (PMB) reforms by the CMS, the National Healthcare Insurance (NHI) debate and the Competition Commission's inquiry into private healthcare in South Africa.

1 *Source: CMS Annual Report 2015–2016 (www.medicalschemes.com/Publications.aspx).*
2 *At 31 December 2016.*

## THE SCHEME'S MATERIAL MATTERS ARE THE MOST IMPORTANT ASPECTS THAT UNDERPIN ITS ABILITY TO CREATE VALUE FOR ITS MEMBERS AND ENSURE SUSTAINABILITY IN THIS COMPLEX OPERATING ENVIRONMENT.

Our material matters are interrelated, reflect the Scheme's top risks and, with careful management, present opportunities for the Scheme to differentiate itself, enhance its reputation and protect its leading market position in South Africa. The Trustees review material matters formally on an annual basis in relation to the Scheme's strategic objectives.

# OUR STRATEGY

The Trustees regularly review the Scheme's major risks, focus areas, potential challenges and opportunities and performance towards objectives. A formal strategy session is held once a year, and the Trustees provide regular guidance to the Scheme Office on strategic direction and responding to emerging risks.

Considering internal and external factors and material risks is essential to ensure that the strategy is responsive to the operating environment and the needs of stakeholders, in the context of the Scheme's long-term sustainability. While these considerations require that the strategy evolves over time, its development is always guided by the Scheme's core purpose: to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality healthcare that meets their needs now and into the future. As such, we strongly support the development of a member-centric healthcare system.

Once the Trustees have set the strategy, they identify or reconfirm relevant strategic themes. These are broken down into work streams, aimed at achieving specific objectives related to the theme. Key performance indicators are set for each work stream so that the Trustees can objectively measure progress and assess outcomes. The work streams are not necessarily tied to a specific benefit year, and may be carried over to the following year or even over several years depending on the complexity of the objectives. Work streams and related objectives are adjusted in response to changing circumstances. The work involved in achieving strategic objectives (which incorporates risk mitigation) is monitored by the Scheme Office through weekly management meetings as well as through formal individual performance reviews.

The strategic themes discussed in our 2015 Integrated Annual Report have been retained but their wording and categorisation has been amended in line with management's priorities, as shown in the table alongside. They are shown in relation to the top risks the Scheme faces and the material matters that affect its ability to create value for members and ensure its sustainability.

## LINKING RISKS, STRATEGY AND MATERIAL MATTERS

### TOP RISKS AND MITIGATION

#### Contribution competitiveness and affordability

Maintaining annual contribution increases at the lowest possible level while offering members access to optimised benefits and service levels in accordance with their chosen benefit plan is core to the Scheme's strategy. Claims and therefore contributions are expected to continue increasing at a rate higher than consumer price inflation (CPI) due to tariff and utilisation increases, supply and demand side factors, including new technology, high-cost procedures and drugs, and legislative requirements within the private healthcare system. Through Discovery Health, the Scheme continues to benefit from interventions that support affordability, which is fundamental to its ability to attract members whose risk profile supports the sustainability of the Scheme.

#### Insurance risk

Contribution rates are set before the end of each benefit year for the following year. In addition, benefits are changed and innovations are introduced with the aim of increasing value to members. There is a risk of claims being higher than the expected contribution income, taking into account the actual impact of the benefit changes and innovations with a resultant negative impact on the Scheme's financial position. New high-cost procedures, drugs and devices also place the Scheme at risk from both financial and stakeholder impact perspectives. These drivers of healthcare utilisation and cost inflation are closely monitored by the Scheme and Discovery Health and longer-term strategic interventions, as well as shorter-term tactical interventions in response to emerging trends, are implemented to mitigate the impact on the Scheme's financial position and sustainability.

#### Investment risk

The Scheme invests members' funds in a variety of asset classes with the objective of maximising targeted investment returns, within risk appetite parameters set by the Trustees. Careful management of the Scheme's investment strategy by the Scheme Office and governing bodies helps to mitigate but does not eliminate the risk of counterparties failing to meet their financial obligations, and negative movements in the value of the Scheme's investments or income generated from those investments due to market factors.

### PERFORMANCE AGAINST STRATEGIC THEMES

#### Lowest healthcare costs

- The average contribution of a Scheme member was 14.6% lower[1] than the next nine largest open schemes, an exceptional achievement given the large increase in healthcare utilisation from July 2016.
- A turnaround of R700 million was achieved from the implementation of risk management strategies to address excessive utilisation.

#### Superior quality of care for members

- The Scheme continually monitors adherence to clinical policies and made good progress on integrating the stages of disease management.
- Since its publication on the website, the Patient Satisfaction Score (PaSS) has been viewed more than 36 500 times and the PaSS score has increased from 56% in 2013 to 60% in 2016 in response to the sharing of results with hospitals.
- The Scheme also obtains regular reports on quality indicators, metrics, standards and benchmarks, and participates in the Health Quality Assessment's annual assessment of quality in healthcare by medical schemes. The Scheme participated in the CMS' PMB Review process.

#### Personalised, predictive, preventative approach

- In line with the goal of making members healthier, the screening and prevention benefit for at risk members was improved and launched in 2017.
- Our members have voluntary access to a world-leading science-based wellness programme, Vitality[2], and the launch of Vitality's Active Rewards saw increased member engagement, with 43% of members on the programme and 23% making use of Active Rewards.

#### Withstanding unpredictable market conditions

- The Scheme manages its investment portfolio in a diversified manner with the aim of optimising investment returns within its approved risk appetite.
- Despite the difficult market conditions, the Scheme managed an overall investment return of 8.79% for 2016 (2015: 6.01%).

### LINK TO MATERIAL MATTERS

#### Scheme sustainability

Balancing reserves, contributions and benefits to ensure financial stability and contribution affordability for our members, in the context of increasing economic pressures and healthcare inflation.

#### The South African healthcare system

Strengthening the Scheme's industry-leading and competitive positioning and working with Discovery Health and the industry to increase the focus on member wellbeing, reduce fragmentation and optimise reimbursement models and quality of care.

Read more about the Scheme's financial performance on **pages 66 – 71**.

Read more about Discovery Health's initiatives for the Scheme on **pages 74 – 81**.

Read more about the Scheme's investment results on **page 68**.

*1 Based on the rate for a principal member plus one adult beneficiary and one child beneficiary.*
*2 Vitality is administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider.*

Linking risks, strategy and material matters *continued*

# TOP RISKS AND MITIGATION

## Stakeholder engagement

Although the Scheme exists to serve its members, the quality of its relationships with all its other stakeholders enables it to create value for members and to remain sustainable. The Scheme manages its relationships with all its stakeholders actively, seeking to balance their needs and expectations by working collaboratively, in good faith and towards a common purpose. In all its interactions, the Scheme undertakes to uphold its values and the highest ethical standards. The Scheme constantly monitors perceptions of members and other stakeholders and any serious incidents are managed and monitored by the relevant Board Committee.

## Outsourcing risk

The Scheme conducts its operations through formal arm's-length administration and managed care outsourcing agreements with Discovery Health. The failure to execute on these outsourcing agreements would result in an inability to service members and providers. Discovery Health reports extensively to the Trustees, the Board Committees and the Scheme Office on a regular basis, which enables the Trustees to ensure that the strategic and operational requirements agreed on, and which are set out in extensive service level requirements, are met.

## Regulatory impact

The Scheme operates in a highly regulated environment requiring extensive controls to ensure ongoing compliance with its legislated obligations. Non-compliance with regulatory requirements would adversely affect the operations of the Scheme. Recommendations from the Competition Commission's Healthcare Market Inquiry, expected at the end of 2017, and several other regulatory developments increase the uncertainty of the Scheme's operating environment. The Scheme maintains constructive relationships with its regulators and the Trustees monitor compliance with existing legislation and regulation, and ensure adequate preparation for any changes, on an ongoing basis.

## Governance

Within a complex and highly regulated environment, the Trustees are responsible for ensuring the Scheme's sustainability and that optimised benefits are designed and delivered to members. Their fiduciary duties require effective governance structures tailored to the needs of the Scheme. Governance failures could impact the sustainability of the Scheme, and as such the Trustees ensure that governance excellence underpins everything the Scheme does.

# PERFORMANCE AGAINST STRATEGIC THEMES

## Member-centric servicing

- Discovery Health's focus on improving member perception, first call resolution, and service levels supported an average member perception score of 9.17 out of 10 (2015: 9.13). Discovery Health's ongoing incorporation of new technologies to enhance members' experience and track member concerns now includes voice biometrics, web chat and the Discovery member app.

## Best practice outsourcing

- An expert review of the Scheme's Vested outsourcing business model was conducted, with positive results. Recommendations for improvements were made, which the Scheme and Discovery Health started implementing immediately. Enhancements to the outsourcing model will continue to be implemented.
- The Scheme has developed a revised pragmatic, replicable methodology for measuring the value added by Discovery Health. The methodology showed that in 2015, for every R1.00 the Scheme spent on administration and managed care services, R1.85 of value was added by Discovery Health. This is an increase from the R1.73 of value added in 2014.

## Excellent governance and regulatory response

- Frequent interactions were held with the Scheme's regulators, particularly the CMS, which publishes regular circulars and other guidelines to the industry to which the Scheme submitted comprehensive responses as required. The Scheme continued to engage extensively with the Competition Commission's Health Market Inquiry, including making presentations at voluntary public hearings.
- In line with best practice governance, the Scheme follows the principles of King III and is moving to incorporate the newly released King IV into its governance policies, practices and disclosures. The Scheme also formally reviews the Vested outsourcing relationship with and value added by its Administrator and Managed Care Provider, and embraces the Treating Customers Fairly principles.
- In 2016, the Scheme outsourced Trustee elections process to an independent electoral body, PwC. 155 nominations were received and the candidates were vetted against fit and proper criteria. 111 candidates stood for elections at the Annual General Meeting and four were elected by members and did extensive induction training. Two new Trustees will be elected in 2017 and the Scheme will apply the same governance practices.

# LINK TO MATERIAL MATTERS

## Stakeholder needs

Empowering and engaging with members to ensure excellent service delivery and supporting healthcare providers to further develop a quality of care focus in South Africa, for the benefit of all our stakeholders and society as a whole.

Read more about the Scheme's stakeholder engagement approach and activities **pages 26 – 35**.

Read more about Discovery Health's initiatives for the Scheme on **pages 74 – 81**.

## The Vested® outsourcing business model

Retaining, embedding and sustaining the model to ensure the best value for our members. Working with Discovery Health to incorporate the challenges and opportunities of disruptive change and technological developments, and supporting innovation in the best interest of our members.

Read more about how we operate and Vested outsourcing on **pages 16 – 17**.

## Navigating the complex regulatory landscape

Working effectively with the regulatory authorities to navigate the outcomes of National Health Insurance, the Competition Commission's Healthcare Market Inquiry, Prescribed Minimum Benefit reforms, and regulatory uncertainty.

Read more about how we are governed on **pages 39 – 59** and the regulatory and industry matters dealt with in 2016 on **pages 60 – 61**.

# HOW WE OPERATE

The Act and the Scheme Rules allow the Trustees to appoint an accredited administrator and managed care provider on terms and conditions required for the execution of the Scheme's operations.

Discovery Health Medical Scheme purchases its administration and managed care services from a single provider, Discovery Health (Pty) Ltd, as the Scheme believes that this integrated model (as opposed to a fragmented model, using multiple service providers) delivers optimal efficiency and value to members. Administration and managed care agreements ensure that clearly defined and measured outcomes are achieved, and that performance management principles through service level agreements (SLAs) are strictly adhered to and reported on.

These SLAs set out the expected level of performance across a wide range of key operational measures. Discovery Health reports to the Scheme on contractually agreed key performance indicators on a monthly, quarterly and annual basis.

The transactional and relational governance elements of the working relationship between the two organisations are governed by a Vested® outsourcing business model.

## Validating the value for money Discovery Health provides

Our members are better off when the Administrator and Managed Care Provider adds more value than the fees paid to it by the Scheme. A formal value-for-money assessment is done, which is an important tool used by the Scheme's Trustees to evaluate Discovery Health's performance.

In the past, the Scheme used a methodology developed by Deloitte to assess the value added. This methodology relied on publicly available information. Due to differences in the specification of the underlying data across the industry the method is no longer suitable. A revised pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied for 2014 and 2015. The assessment takes account of value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members and innovation.

The results are expressed as the value added by Discovery Health for each Rand paid to it: value added of greater than one means that Scheme beneficiaries receive more value than what has been paid on their behalf.

**TOTAL VALUE ADDED**

| 2014 PER R1 | 2015 PER R1 |
|---|---|
| 1.73 | 1.85 |

The results show that in 2015, for every R1.00 spent by DHMS on administration and managed care services, R1.85 of value was added by Discovery Health. This is a 6.9% increase from the R1.73 of value added in 2014.

The Scheme engaged Deloitte to review the reasonability of the data, methodology and results. Deloitte concluded that the methodology is appropriate and that they did not encounter any significant anomalies in the data and calculations reviewed. Deloitte are of the opinion that the increase in value added from 2014 to 2015 is reasonable.

# Our Vested® outsourcing business model

The outsourcing model used to optimise the relationship between Discovery Health Medical Scheme and Discovery Health is Vested outsourcing and aligns with global best outsourcing practice.

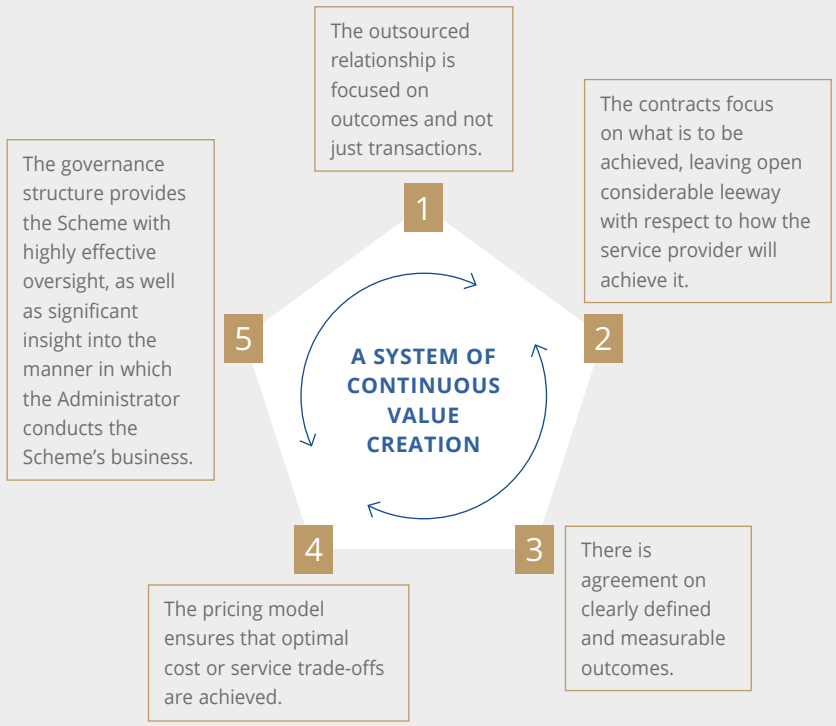
A Vested outsourcing agreement is characterised by a shared vision and aligned objectives, with organisations working to find the best solutions together. The agreement also balances risk and reward for both parties, leading to fairness, sustainability and the best outcomes. In effect, it frees both organisations to do what they do best by contracting for results and not activities – which allows for innovation, improved service and continuous value creation.

Vested outsourcing relationships depend on active collaboration, transparency, flexibility and trust, and commit both organisations to the success of each business. This strengthens the strategic alignment between organisations and encourages a value-driven relationship.

The Vested outsourcing business model recognises and embeds the Scheme's independence through robust governance arrangements, while allowing the Scheme to leverage Discovery Health's considerable knowledge, expertise, systems, innovation and value-added services in the best interests of the Scheme and its members. The Scheme engages in an operating relationship characterised more by insight rather than merely oversight, according to the five principles of Vested outsourcing.

An expert review of the Scheme's **Vested outsourcing business model** was conducted, with positive results. Recommendations for improvements were made, which the Scheme and Discovery Health started implementing immediately.

## The five principles of Vested outsourcing




*The five core principles of Vested outsourcing have been adapted from "The Vested Outsourcing Manual" (Palgrave McMillan, 2011) by Kate Vitasek with Jaqui Crawford, Jeanette Nyden and Katherine Kawamoto.*

## What this means for our members

The improved outcomes from the Vested outsourcing business model has seen the following tangible results based on the relationship between the Scheme and Discovery Health:

- An unmatched record of innovation.
- High levels of member satisfaction with service levels.
- More focused and sustainable clinical risk management solutions resulting in significant claims cost reduction.
- Improved stakeholder relations through a shared vision and aligned objectives.
- Continued membership growth from an already high base.
- Improved outsourcing governance translating into robust reporting and evaluation processes.

### THE CONTINUAL IMPROVEMENT JOURNEY

Optimising an outsourcing model is a journey. Both organisations have to adapt to working in new ways, and these changes need to be embedded at all levels, creating a sustainable system for continuous value creation. Enhancements to the Vested outsourcing business model will continue to be implemented.

# WHO LEADS US

## Our Trustees

The Board of Trustees (the Board) comprises high-calibre professionals with diverse skills, experience, background and gender. This brings multiple perspectives to bear in discussion and debate, ensuring robust oversight and strategic decision-making.

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

The Trustees focus their attention on overseeing the Scheme's material matters, in discharging their duties and in ensuring the Scheme's sustainability, which forms the basis for any Board decisions. The Trustees are accountable to the Scheme's members. Their duties include:

- Overseeing and directing the management of the Scheme's outsourced activities performed by the Administrator and Managed Care Provider.
- Applying sound business principles to ensure the financial soundness of the Scheme.
- Ensuring that proper control systems are employed by and on behalf of the Scheme.
- Ensuring that the Scheme Rules and Scheme operation and administration comply with the provisions of the Act, and all other applicable laws.
- Ensuring that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Scheme Rules.
- Overseeing the implementation of strategy.

Trustees may be elected or appointed. At least half of the Trustees are elected by Scheme members, and the Board may appoint additional Board Committee members to fill any knowledge, experience and skills gaps.

Trustees and Committee members are remunerated for their service according to the Scheme's Remuneration Policy.

Read more about the Scheme's governance structure and framework on **page 39**.

Read more about the remuneration of Trustees and Committee members on **pages 54 – 59**, and refer to Note 15 of the Annual Financial Statements on **page 109** for more information.

### MR MICHAEL VAN DER NEST SC

**BA LLB**

**CHAIRPERSON**

Mr van der Nest, SC has been in private practice for 30 years and was appointed Senior Counsel in 2000. He has been an Acting Judge of the High Court of South Africa on various occasions, and has arbitrated various commercial disputes. His practice is of a specialised commercial nature in merger and competition cases, accounting and valuation, mining, contractual disputes, insurance, aviation and construction disputes, financial instruments, banking and regulatory matters.

Mr van der Nest was appointed as a Trustee in 2011 and 2014, and has served as Chairperson of the Board for both periods. He also serves on the Remuneration and Stakeholder Relations Committees.

### MR DAVE KING

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

Mr King is a seasoned business executive with over 20 years' multinational experience. He spent 12 years as Human Resources Director of Brandhouse Beverages and was instrumental in that entity becoming a formidable competitor in the South African drinks industry. Previously, he chaired the Board of Trustees of Oxygen Medical Scheme. He is an expert in executive leadership and employee engagement.

Mr King was elected as a Trustee in 2016 and currently serves on the Remuneration, Non-healthcare Expenses and Stakeholder Relations Committees. He previously served on the Audit, Risk and Stakeholder Relations Committees as an independent member.

## DR DHESAN MOODLEY

**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 also the Chairman of Pinpoint Solutions, a healthcare organisation. In the past he was President of Alexander Proudfoot, CEO of Bluepeter Consulting, Partner of Ethos Private Equity Technology Fund, Partner at Accenture and Principal at Gemini Consulting. He has deep expertise in health insurance and healthcare. His past and present affiliations include the Young Presidents' Organisation; World Presidents' Organisation; American Academy of Anti-aging Medicine; South African Medical Association; Black Management Forum of South Africa and American Chamber of Commerce.

Dr Moodley served the Scheme as Chairperson and a member of the Board of Trustees between 2001 and 2011. In 2016, he was again elected as a Trustee and currently serves on the Clinical Governance, Investment, Product and Stakeholder Relations Committees.

## MS DAISY NAIDOO

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

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

Ms Naidoo was elected as a Trustee in 2016 for a second term. She serves on the Audit, Risk, Investment, Product and Non-healthcare Expenses Committees.

## MR NEIL MORRISON

**MA (Economics); BSc (Hons) Physics**

Mr Morrison's recent work was as an external consultant to McKinsey and Company in Johannesburg, for the past four years. Previously, he was Special Advisor to the Minister of Public Enterprises and until 2004, CEO of Deutsche Bank, Johannesburg Branch and head of the Global Markets division.

Prior to that he was Head of Public Sector Finance at Rand Merchant Bank. Before 1994, he worked for the ANC and various associated organisations for 10 years with his last position being Head of Money and Finance policy. He was a member of the constitutional negotiations team.

Mr Morrison was elected as a Trustee in 2016 and currently serves on the Audit, Risk, Investment and Non-healthcare Expenses Committees.

## MR GILES WAUGH

**MA; FIA (Fellow of the Institute of Actuaries UK); FASSA (Fellow of the Actuarial Society of South Africa)**

Mr Waugh has worked as an actuarial consultant for the past 30 years in South Africa and the UK, and now operates as an independent actuary involved in life and short-term insurance.

Mr Waugh was appointed as a Trustee in 2011 and 2014. He serves on the Audit and Risk Committees, chairs the Product Committee and also chairs the Non-healthcare Expenses Committee.

## Who leads us *continued*

*Independent co-opted member of the Board*

### MR JOHAN HUMAN

**B.Bus.Sc; FIA (Fellow of the Institute of Actuaries UK); FASSA (Fellow of the Actuarial Society of South Africa)**

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

Mr Human was appointed as an independent co-opted member to the Board on 5 September 2016, and serves on the Non-healthcare Expenses Committee.

*Trustees who retired during 2016*

### MR PUKE MASERUMULE

**BA LLB; Postgraduate Diploma in Labour Law**

Mr Maserumule has been an admitted attorney for 27 years, 25 of which he has spent in private practice. He specialises in all aspects of employment law and general litigation, and has acted as a Labour Court and High Court Judge. He is also an accredited Tokiso mediator, facilitator and arbitrator.

Mr Maserumule was elected as a Trustee in 2010 and 2013. He chaired the Investment Committee and served on the Stakeholder Relations Committee until his term ended on 23 June 2016.

### MR NOEL GRAVES SC

**BA LLB**

Mr Graves, SC had a BA LLB degree conferred on him by the University of Cape Town in 1985, after which he practiced law as an attorney at Bowman Gilfillan, and subsequently as a partner at the Sampson, Okes, Higgins law practice. He was admitted as an advocate in 1993 and was appointed Senior Counsel in 2009. He is a member of Advocates Group 621, the oldest group of advocates at the Johannesburg Bar.

Mr Graves was elected as a Trustee in 2010 and 2013. He chaired the Non-healthcare Expenses Committee and served on the Product, Remuneration and Investment Committees until the end of his term on 23 June 2016.

### PROF ZEPHNE VAN DER SPUY

**MBChB; MRCOG; PhD; FRCOG 1991; FCOG (SA)**

Professor van der Spuy is Emeritus Professor/Senior Scholar in the Department of Obstetrics and Gynaecology at the University of Cape Town. She received the Distinguished Teachers Award in 2010. An obstetrician gynaecologist by training, Professor van der Spuy has a particular interest in women's health and reproductive medicine. She is an Honorary Fellow of the Academy of Medicine, Singapore; the Ghana College of Surgeons; the Academy of Medicine, Malaysia; the Royal Australasian College of Physicians; the Royal College of Physicians of Ireland; and most recently The Colleges of Medicine of South Africa. She is a National Research Foundation rated scientist with 65 publications in peer reviewed journals and 40 invited articles and chapters in books.

Prof van der Spuy was elected as a Trustee in 2010 and 2013. After her term ended on 23 June 2016, she was appointed by the Board as an independent member of the Clinical Governance Committee.

# Our executive management team: leading us into 2017

The Board appoints a Principal Officer, in accordance with the Act and Scheme Rules. The Principal Officer is the chief executive officer of the Scheme and is accountable to the Board for the day-to-day management of the Scheme and the implementation of its strategy.

The Principal Officer, supported by an executive management team, is key to the effective operation of the Scheme. The Principal Officer and the management team collaborate closely with the Scheme's Administrator and Managed Care Provider, Discovery Health, in the implementation of strategy and daily operations. The management team's expertise includes medical, actuarial, risk management, business management, financial management, investment, legal, compliance and research capabilities.

The Board and the Remuneration Committee direct and oversee remuneration for the Scheme Office, which is based on best practice, carefully structured and independently benchmarked according to the experience and skills required. This is aimed at attracting and retaining high-calibre staff.

*Not shown*

## MR MILTON STREAK

**Executive Principal Officer (appointed by the Board in 2009) B.Pharm, Master of Management (MM) (Entrepreneurship and New Venture Creation)**

*Mr Streak was the Principal Officer during 2016, and resigned with effect from 31 December 2016.*

*Read more about the search for and appointment of our new Principal Officer in Our Chairperson's statement on page 39.*

## MR HOWARD SNOYMAN

**Head: Legal and Regulatory Affairs**

LLB; MSc Med (Bioethics and Health Law); Dip Sports Management; Adv Dip Sports Management; Certified Vested Deal Architect (in progress)

## DR NOZIPHO SANGWENI

**Chief Medical Officer during 2016; appointed Principal Officer with effect from 1 January 2017**

MBChB; MBA; Postgraduate Diploma in Occupational Health; Postgraduate Diploma in Civil Aviation Management

## MS MICHELLE CULVERWELL

**Head: Special Projects and Stakeholder Relations**

MBA in Executive Management; BA (Hons)

## MS YASHMITA MISTRY

**Head: Governance and Compliance**

LLB

## MR JAN VAN STADEN

**Chief Financial Officer**

CFA; CA(SA); B Accounting (Hons);

## MR SELWYN KAHLBERG

**Chief Risk and Operations Officer**

CFA; FASSA; FIA; BSc (Hons)

# OUR COMMITTEE MEMBERS

## MS DAISY NAIDOO ▲ ■ ✳ ≣ ▼

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

Deep knowledge of finance, accounting, banking, investment, risk and general business; specific experience as a dealmaker, tax consultant and financial planner for corporate companies.

## MR BARRY STOTT ▲ ■ ✳

**CA(SA)**

Deep understanding of the financial services industry; member of audit panels, risk and investment committees and independent non-executive director at financial services institutions.

## MR NEIL MORRISON ▲ ■ ✳ ≣

**MA (Economics); BSc (Hons) Physics**

Extensive leadership experience in banking and financial markets; has held high-profile public policy advisory and management consulting roles.

## MR MILTON STREAK ■ ≣ ▼ ●

See note below.[1]

## MR MICHAEL VAN DER NEST SC ○ ●

**BA LLB**

In private practice specialising in the resolution and arbitration of a range of commercial disputes, including in the insurance industry.

## MR JOHN BUTLER SC ●

**MA (Jurisprudence); BA LLB; BCom**

Specialist in all aspects of commercial litigation, including competition law, and an arbitrator in commercial disputes; has served as an Acting Judge of the High Court.

## MR DAVID KING ▲ ■ ○ ≣ ●

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

Extensive multinational experience; expert in employee engagement and executive leadership, as a Human Resources Director for over a decade.

## DR DHESAN MOODLEY □ ✳ ▼ ●

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

Extensive experience in healthcare and health insurance gained in private medical practice; extensive experience in management consulting at the helm of various respected firms.

## MR DON ERIKSSON ○

**CA(SA)**

More than 40 years' experience in business leadership, as an executive and non-executive director; chairperson of various insurance companies, non-executive director and committee chairperson for a number of bluechip companies.

## MR GILES WAUGH ▲ ■ ≣ ▼

**MA; FIA; FASSA**

More than 30 years' experience as an actuarial consultant in South Africa and the UK; works as an independent actuary in life and short-term insurance.

## MR IMTIAZ AHMED ✳

**CA(SA)**

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

## MR JOHAN HUMAN ≣ ▼

**B.Bus.Sc; FIA; FASSA**

More than 20 years' experience in actuarial and healthcare consulting to large corporates and medical schemes; works in private equity, infrastructure fund management and structured finance.

- ▲ Audit
- ■ Risk
- □ Clinical Governance
- ▼ Product
- ✳ Investment
- ◆ Nomination
- ● Stakeholder Relations
- ≣ Non-healthcare Expenses
- ○ Remuneration

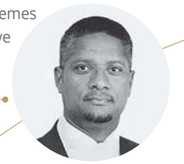
*1 Milton Streak sat on the Product, Risk, Non-healthcare Expenses and Stakeholder Relations Committees. Scheme executive management also sits on the Risk Committee. More information on the Committees is available on pages 42 – 53.*

## Our Committee members *continued*

### MR PETER GOSS ◆

**MA: Criminal Justice; P/G BTech: Forensic Investigation; National Diploma: Police Administration; Diploma: Criminal Justice & Forensic Investigations; Certificate Programme: Corporate Governance. Accreditations: Commercial Forensic Practitioner (ICFP); Certified Forensic Investigation Professional (CFIP)**

Deep expertise in business advisory with a specific focus on governance, risk and strategy, in particular fraud risk management, including for medical schemes and the public sector; holds various non-executive directorships for bluechip companies.



### MRS PHILILE MAPHUMULO ▲ ■

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

More than 10 years' experience in investment banking; served as a non-executive director on various company boards.

### PROF MIKE SATHEKGE □

**PhD; MBChB; MMed**

Specialist physician and expert in the design and implementation of innovative point-of-care diagnostics and therapies in nuclear medicine; has received local and international recognition for his outstanding achievements in the public and private medical sectors.

### PROF SELMA SMITH □

**MBChB; M Prax Med; FCFP(SA)**

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

### MR NOEL GRAVES SC ✳ ≣ ▼ ○

**BA LLB**

Over 25 years' experience as an attorney, advocate and Senior Counsel.

### PROF ZEPHNE VAN DER SPUY □ ▼

**MBChB; MRCOG; PhD; FRCOG; FCOG (SA)**

Specialist physician and expert in women's health and reproductive medicine; National Research Foundation rated scientist with an extensive body of published research in her field.

### TOM WIXLEY ◆

**CA(SA); BCom**

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

### MR PUKE MASERUMULE ✳ ●

**BA LLB; Postgraduate Diploma in Labour Law**

Specialises in all aspects of employment law and general litigation, and accredited mediator, facilitator and arbitrator; has acted as a Labour Court and High Court Judge.

### MR STEVEN GREEN ▲ ■

**BSc (Hons) Information Systems; BSc Computer Science**

Deep expertise in IT architecture design and implementation, and IT risk assessment and management particularly in relation to outsourcing; gained experience in a wide range of technology-related areas, including data analytics, working in South Africa, the USA, and the UK.

### MRS SUSAN LUDOLPH ▲ ■

**CA(SA)**

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 of South Africa's first top 100 CFO Forum to guide, influence and lead on issues affecting CFOs and business.

### MR ROY SHOUGH ◆

**CA(SA); HDipBDP; Certified Information Systems Auditor (CISA), (Lapsed) through Information Systems Audit + Controls Association; ISACA Certified Internal Auditor (CIA); IIA**

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

- ▲ Audit
- ■ Risk
- □ Clinical Governance
- ▼ Product
- ✳ Investment
- ◆ Nomination
- ● Stakeholder Relations
- ≣ Non-healthcare Expenses
- ○ Remuneration

# HOW WE ADD VALUE TO OUR KEY STAKEHOLDERS

## 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 healthcare that meets their needs now and into the future.

The quality of the Scheme's relationships with its stakeholders supports its ability to fulfil its purpose. Creating lasting value for our members requires, necessarily, that the Scheme is sustainable in the long term, which means also creating value for the healthcare ecosystem of which it is a part. Balancing the needs and expectations of all stakeholders within this ecosystem, and thereby for society as a whole, is a constant challenge that we embrace wholeheartedly.

## 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 business model to lead healthcare innovation and create value.

We will work closely with our regulators, our administrator and the industry to shape an inclusive and complete healthcare system in South Africa.

We envision a future in which South Africa has an integrated and cohesive healthcare system. To this end, the Scheme's approach is to engage with stakeholders on the understanding that, although needs may differ, working collaboratively, in good faith and towards a common purpose is the only way to harmonise these needs over time. In all its interactions, the Scheme undertakes to uphold its values: integrity; mutual respect; adaptability and agility; support and care; resilience; the pursuit of excellence; and social responsibility.

Importantly, Discovery Health which provides administration and managed care services for our members is completely aligned to our purpose, vision and values. Discovery Health is part of the Discovery Group, and has a core purpose to make people healthier and enhance and protect their lives.

The Discovery Group is a shared value insurance company whose purpose and ambition are achieved through a pioneering business model that incentivises people to be healthier, and enhances and protects their lives. Their shared value insurance model delivers better health and value for clients, superior actuarial dynamics for the insurer, and a healthier society.

Read more about Discovery at **https://www.discovery.co.za/discovery_coza/web/linked_content/pdfs/investor_relations/discovery_sustainable_development_report_2016.pdf.report_2016.pdf**.

# Our approach to stakeholder relations

The Stakeholder Relations Committee oversees all stakeholder engagement activities and reports to the Trustees on all matters within its mandate. The Committee receives regular reports from the Administrator and Managed Care Provider on stakeholder engagement and perceptions, supplemented by presentations and discussions on significant matters of concern to the Scheme. The Committee uses a defined risk assessment framework and methodology to understand the Scheme's stakeholders, which entails identifying stakeholder groups and assessing their needs. The Committee ensures that appropriate management and engagement plans are in place and monitors their effectiveness, with close attention given to any specific incidents and their resolution.

Discovery Health conducts certain of the Scheme's stakeholder engagement work, in accordance with the Vested outsourcing business model. For example, Discovery Health responds to our members' queries via call centres and through e-mail; engages with doctors through multiple communication channels to demonstrate new tools and initiatives; provides training and support to financial advisers on the Scheme's products; and develops healthcare provider networks to keep costs down for our members and the Scheme.

## APPLYING THE KING IV PRINCIPLES FOR SOCIAL AND ETHICAL GOVERNANCE

The Scheme is currently investigating the incorporation of the principles espoused by the King IV Report on Corporate Governance for South Africa 2016 (King IV), which recommends the oversight of and reporting on organisational ethics, responsible corporate citizenship, sustainable development and stakeholder relationships by means of a mandated Committee. The Stakeholder Relations Committee is co-ordinating and driving this process on behalf of the Board.

Read more about the Stakeholder Relations Committee on **pages 52 – 53**.

# Our approach to ethics

The Scheme operates to the highest ethical standards, specifically those relevant to a medical scheme, and as an employer. The Scheme's policies specify the standards of ethical behaviour expected of its Trustees and employees in such areas as compliance with the law, human rights, employee rights, the protection of personal information and business practices (including anti-competitive behaviour).

These standards of behaviour are aligned with the ethical values and moral duties of King III, and the expectations of the CMS, set out below.

### MORAL DUTIES:

- Conscience
- Stakeholder inclusivity
- Competence
- Commitment
- Courage

### ETHICAL VALUES FOR GOVERNANCE, MANAGEMENT AND OPERATIONS:

- Discipline
- Transparency
- Independence
- Accountability
- Fairness
- Responsibility

The Scheme encourages the reporting of fraudulent or unethical behaviour. The Information Toolkit explains how on **page 155**.

## EMBRACING THE FAIR TREATMENT OF CUSTOMERS

The TCF (Treating Customers Fairly) Framework has its foundation in sound business principles and good governance. The Scheme embraces the TCF principles and recognises their relevance to the service that Discovery Health provides to our members. As a registered Financial Service Provider in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS), Discovery Health has implemented the TCF framework.

**The outcomes of TCF are envisaged to be:**

- Customers can be confident they are dealing with firms where TCF is central to the corporate culture.
- Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.
- Customers are provided with clear information and kept appropriately informed before, during and after point of sale.
- Where advice is given, it is suitable and takes account of customer circumstances.
- Products perform as firms have led customers to expect, and service is of an acceptable standard and as they have been led to expect.
- Customers do not face unreasonable post-sale barriers imposed by firms to change product, switch providers, submit a claim or make a complaint.

## Engaging with our members

Our purpose recognises that the Scheme exists for its members. They entrust their healthcare funding needs to the Scheme, which aims to ensure the long-term affordability of contributions so that our members can continue to access private healthcare of the highest standard. Building and maintaining strong relationships with all our other stakeholders supports our ability to achieve these objectives.

The Scheme, through Discovery Health, is deeply engaged in many quality of care initiatives and ongoing monitoring to ensure that our members have access to the safest, most efficient healthcare available in South Africa. The Scheme also empowers our members with information that is relevant to their needs.

Discovery Health's infrastructure and member support systems provide a range of engagement options for our members: they can make contact through a call centre, via the website (www.discovery.co.za), through the Discovery Member App on their smart phones and tablets, or by visiting five walk-in centres around the country. These member support systems are designed to provide members easy access to accurate information about their benefits, claims and other plan information. Various customer satisfaction and operational metrics are monitored on an ongoing basis to assess whether our members' service expectations are being met.

The Scheme ensures that all our members are continuously informed of changes in benefits and contributions, formularies and the Rules governing their health plans. This enables them to make informed decisions about the plan type best suited to their healthcare and affordability needs, even as these needs change.

Do you want to submit a complaint or compliment, or lodge a dispute? The Information Toolkit explains how on **page 155**.

### ENSURING OUR MEMBERS STAY SATISFIED

Discovery Health constantly monitors members' perceptions of the service they receive. Feedback is obtained at walk-in centres, member lounges, after-claims processes and when members make use of the call centre. For 2016, the average perception score across all these areas was 9.17 out of 10.

2016 member perception score

9.17/10

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

# Engaging with our members *continued*

## PROVIDING QUALITY NURSING CARE TO OUR MEMBERS IN THE COMFORT OF THEIR OWN HOMES

Discovery HomeCare[1] is a unique home-based healthcare service, which offers our members high-quality nursing and care worker support. Home care has been shown to improve the healthcare experience and outcomes when a hospital stay is not necessary. Discovery HomeCare provides support and convenience for patients with specific conditions, and saves on hospitalisation costs.

Launched in 2015 as an alternative to hospitalisation for eligible patients, the service was developed to prevent hospital admissions, reduce the length of hospital stays and to potentially avoid readmissions – thereby adding huge value to the member, treating doctor and the Scheme. Highly qualified ICU-trained nurses care for patients in the comfort of their own homes, reducing exposure to hospital-acquired infections, allowing patients to recover more quickly, improving appropriate hospital bed allocation and alleviating the burden of travelling to and from hospital for families.

**The programme currently focuses on four main therapeutic areas:**

- **Intravenous infusions:** antibiotics, steroids, enzymes, iron, immunoglobulins and fluid replacement.
- **Wound care:** moderate to severe wounds not requiring hospitalisation.
- **Postnatal care:** three visits by a qualified midwife for both mother and baby if safely discharged one day early.
- **End-of-Life care:** working together with the relevant hospices and Advanced Illness Benefit teams.

HomeCare is available in all large cities and towns throughout South Africa, and in more remote areas on a case-by-case basis. The programme has grown strongly over the last year with approximately 400 visits per month in 2016, and has realised significant savings for the Scheme of R3.3 million from intravenous infusions alone.

**The service has been well received by our members, with nursing care consistently highly rated at around 9.57 out of 10 by patients. An example of patient feedback:**

> *"I just wanted to thank you and give you some feedback on my experiences with the HomeCare nurses over the last week. They are nothing short of absolutely brilliant! During the five days I was tended by Sisters Thandi, Florence, Lebo and Anna, they were always on time, absolutely professional, caring and absolutely fantastic ambassadors for Discovery. We spent many hours chatting while I was taking in IV and they are absolutely passionate about what they do. I cannot thank you enough for arranging this. This is so infinitely better than staying in a hospital bed it defies comparison."*

Several new initiatives are planned for HomeCare in 2017. An Aged Care pilot will be run in certain retirement homes in Gauteng, providing quality care for residents either in their units or care centres, reducing the need for hospital admissions or allowing for earlier discharge to a safe environment for optimal recovery and care.

## IMPROVING THE QUALITY OF LIFE OF OUR MEMBERS WITH ADVANCED CANCER, AND THEIR FAMILIES

Over 60% of our members die in a high care or an intensive care unit, in line with the international norm. But research shows that more than 80% of people worldwide wish to die at home.

The Scheme offers its members the Advanced Illness Benefit (AIB), which gives members with advanced stages of cancer access to a comprehensive palliative care programme, which includes Discovery HomeCare. With unlimited benefits, access to home-based care and a care coordinator, the service has had a significant impact on patients and their families by reducing the psychosocial, logistical and funding challenges.

**The AIB provides:**

- Cover for the involved palliative care doctor, palliative care nurses, social worker, and other associated services in partnership with the Hospice Palliative Care Association of South Africa.
- Access to and funding for home-based care services such as oxygen and pain management.
- A dedicated Discovery Health care coordinator who supports the patient and family throughout, and ensures holistic palliative care and seamless logistics.
- Access for both the patient and their family to counselling support.

1 *Discovery HomeCare is operated by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.*

**Examples of feedback to Discovery Health about the service from Scheme members and their families:**

> *Thank you, I'm very impressed with this benefit from Discovery. It's great to know this support is available at this difficult time.*

> *Thank you, your company has tremendous empathy and is really appreciated.*

> *Just to say thank you very much for all your help regarding my mom's sickness. Without the assistance of Discovery and Hospice we could have not managed on our own. Mom passed away very peacefully on Monday. I am lost for words at this moment. Love you all although I never met you.*

> *Thank you so much for your contact. I feel so much calmer now that I know there is someone to contact and help is available.*

> *You have no idea how much peace of mind you gave my sister the day you called. It has been a roller coaster of a time since my dearest brother-in-law passed away on the 7th.... In the meantime, a big thank you for facilitating everything so compassionately.*

> *Thank you so much for the information, booklets etc. but, most of all, thank you for your absolute professionalism when you contacted me. This is a scary time and things seem to be moving so fast so your efficiency and calmness was so welcome to me.*

Discovery Health is working to extend this benefit to members other than cancer patients requiring palliative care. It is also working with the Hospice Palliative Care Association to increase awareness of the importance of advance care planning and to assist with training healthcare professionals to have this conversation with their patients.

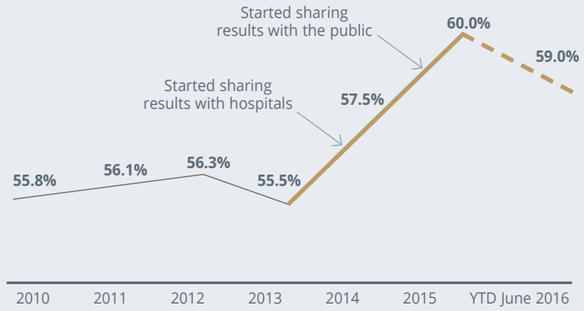
To find out more about Discovery Health's initiatives for the Scheme, see **pages 74 – 81**.

## EMPOWERING OUR MEMBERS WITH RELEVANT INFORMATION

In 2015, Discovery Health embarked on an initiative to inform Scheme members of the quality of care and patient experience provided by private hospitals, rated by members themselves. Since its publication on the Discovery website, the Patient Satisfaction Score (PaSS) has been viewed more than 36 500 times and the PaSS score has increased from 56% in 2013 to 60% in 2016 in response to the sharing of results with hospitals.

Continuous investment in the quality of care

**Patient Satisfaction Score: national average**




Discovery Health intends to extend these measures of hospital experience to include specific clinical outcomes such as mortality and infection rates.

Logged in members can access PaSS at **www.discovery.co.za/portal/individual/hospital-scorecard**.

# Engaging with healthcare providers and professional societies

The Scheme is committed to working in collaboration with and supporting healthcare providers in the pursuit of quality, cost-effective healthcare for their patients – our members.

We believe that healthcare providers (which include doctors and specialists, nurses, pharmacists and paramedics, as well as private hospital groups and specialist practices), form an integral part of South Africa's healthcare ecosystem and are a national asset.

Healthcare professionals work in a challenging environment of rapidly increasing costs, and are often placed in a position of conflict between their patients, for whom they wish to provide the best possible care, and medical schemes, who must balance the needs of all scheme beneficiaries with those of individual members, while ensuring sustainability over the long term.

Healthcare inflation was a specific challenge for the entire sector during 2016. DHMS and Discovery Health worked closely with healthcare providers to implement targeted initiatives to address the inflation concerns, while at the same time continuing to provide access to quality care via Scheme networks and reimbursement arrangements implemented over the last few years.

Most general practitioners and specialists in private practice participate in the Scheme's network and reimbursement arrangements, playing a crucial role in ensuring the sustainability of private healthcare delivery.

The Scheme has also led the industry in the implementation of innovative alternative reimbursement models with the major hospital groups. These, together with effective risk management by Discovery Health, have allowed the Scheme to achieve a substantial cost advantage over competitor schemes in relation to hospital costs, a key component of the Scheme's claims expenditure. The Scheme also has contracts with all major pathology groups and radiology practices, as well as most other healthcare professionals. These arrangements provide members with certainty of cover and a wide range of options to avoid co-payments, while also allowing the Scheme to comply with Prescribed Minimum Benefit legislation in terms of the Act.

The Scheme and Discovery Health engage actively and continuously with the representatives of healthcare professionals through their respective professional societies, to understand how best to support them in meeting quality of care challenges. Regular meetings, workshops and thought leadership summits are held where pertinent issues affecting healthcare delivery in South Africa and other industry issues are examined. Continuous engagement with the pharmaceutical industry aims to secure the best possible prices of medicines for members, thereby protecting the pool of funds from which members' claims are paid.

**In 2016 the following engagement activities were conducted:**

- Workgroups with various healthcare providers and professional societies to address a variety of topics, including provider challenges, new technology and claims coding services continued with good progress made in all areas. The focus remained on enhancing quality care affordably and sustainably.
- Doctor launch events were held in all major centres to explain underlying industry trends and present the Scheme's funding strategy for 2017.
- Ongoing engagement with societies and representative bodies in the industry.
- Articles were published in medical journals and the press to showcase improving quality of care initiatives and collaboration with doctors.

Major strides were made in moving away from traditional fee-for-service reimbursement to value-based, alternative reimbursement models and initiatives that focus on quality of care. These included the launch of the Premier Plus initiative with family doctors to address major non-communicable diseases; projects with general and spinal surgeons; and new and ongoing initiatives with numerous other disciplines.

As part of the Scheme and Discovery Health's continued focus on improved quality of care and healthier members, we will look to expand our value-based contracts to lower overall healthcare costs and remunerate healthcare providers to achieve better clinical outcomes.

CASE STUDY

## PARTNERING WITH RENAL SPECIALISTS TO MEASURE AND IMPROVE OUTCOMES IN KIDNEYCARE

More than 5 million South Africans live with chronic kidney disease and over 4 000 of our members suffer from it.

In response to this growing pandemic, Discovery Health established the KidneyCare programme in 2008 to:

- Ensure coordinated participation by patients, doctors and dialysis care providers in improving the quality of dialysis care.
- Measure and report on the comprehensive management of the patient in order to improve care programmes.
- Improve the quality of life for patients on chronic dialysis and reduce additional costs incurred, caused by repeat hospital admissions and avoidable complications in care.
- Provide educational material to affected Scheme members.

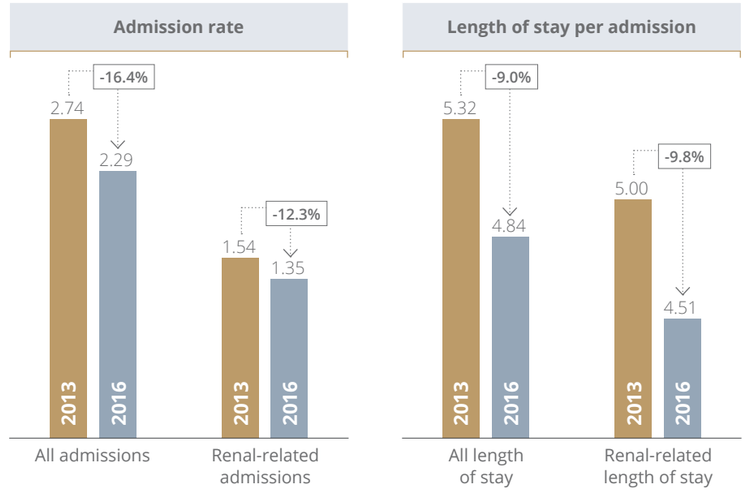
Clinical and pathology data is collected on all Scheme members undergoing chronic dialysis. Reporting includes a comprehensive member report as well as three-monthly reports to the treating specialists and the providers of chronic dialysis. These reports highlight specific opportunities for targeted interventions to improve the provision of care, clinical outcomes and avoidable complications.

There are currently 1 968 members, 138 specialists, seven dialysis providers and 173 chronic dialysis units on the programme, and we receive comprehensive clinical results for 1 581 members.

The outcomes of this programme have been very positive. Targeted interventions by the KidneyCare programme have resulted in clinical outcome measures improving by 2.4% from 2013 to 2016. DHMS patients enrolled on the programme have a 2.44% lower mortality rate than non-enrolled chronic dialysis members. In addition, there has been a significant reduction in the hospital admission rate and length of stay between 2013 and 2016 for those members enrolled on the programme.

### Value-based contracts with health professionals

- Detailed monitoring of key dialysis metrics
- 100% of dialysis centres and patients enrolled
- Detailed reporting and feedback



## Engaging with financial advisers (brokers)

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

Financial advisers introduce individual consumers and employers to the full spectrum of medical schemes in the industry and assist 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 for their services according to legislated fees and their contractual arrangements with the Scheme; members do not pay them directly. Financial advisers are regulated by and must be registered with the Financial Services Board, and must comply with the Financial Advisory and Intermediary Services Act. In addition, they are accredited by the Council for Medical Schemes to provide advice on private healthcare cover.

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

**In 2016 the following engagement activities were conducted:**

- Annual product updates on the Scheme's product and benefit enhancements for the new benefit year were provided in a nationwide rollout to over 200 broker consultants and agents, and broadcast to more than 7 000 financial advisers from the annual product launch event.
- Nationwide presentations to corporate brokerages provided information on the Scheme's strategies, industry position, financial results and fraud management.
- Broker consultants were trained and their knowledge of the Scheme's products, the private healthcare sector, and sales and presentation skills were assessed.
- Major corporate brokerages were provided with a comprehensive analysis of the South African medical schemes industry, and comparative analysis of 2015 open medical scheme financials.
- Perception surveys were conducted to establish how satisfied brokers are with the service they receive. The overall perception score by brokers of Discovery Health for the year was 8.7 out of 10 (target: above 7.5).

## Engaging with Discovery Health (Pty) Ltd

Discovery Health is the largest administrator and managed care provider for medical schemes in South Africa, covering over 3.3 million lives which includes DHMS, the largest open scheme in South Africa, as well as 18 restricted schemes as clients.

The Scheme and Discovery Health have an arm's-length contractual relationship that governs all activities outsourced by the Scheme to Discovery Health. The working relationship between the two organisations is governed by a Vested outsourcing business model, which focuses on outcomes and is characterised by a shared vision and aligned objectives to ensure that both organisations work to the ultimate benefit of members.

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

**The agreement that the Scheme has with Discovery Health contains extensive service level requirements, against which the Trustees monitor and measure Discovery Health's performance. The engagements between the Scheme and Discovery Health are frequent and focus on:**

- Scheme performance and risk management;
- Implementation of the Scheme's strategy;
- Product design and implementation of Scheme benefits;
- Marketing and sales;
- Member and other key stakeholder communication;
- Regulatory and industry matters;
- Service level agreement assessments and monitoring;
- Combined assurance; and
- Stakeholder relations – Discovery Health engages extensively with various stakeholders, including our members, on behalf of the Scheme.

Read more about the Vested outsourcing business model and how we conduct our operations on **pages 16 – 17**.

## Engaging with employer groups

Many employers offer their employees the opportunity to join a medical scheme as part of their employee benefit package. Employees may fund this membership through a specified subsidy or a structured salary package. Publicly available information suggests that DHMS is the most popular open medical scheme among employers – 73% of members belonging to an open medical scheme as part of an employer group belong to DHMS[1].

**In 2016 the following engagement activities were conducted:**

- Corporate wellness days allowed interaction with members who are part of an employer group.
- Focused service and engagement strategies were developed with employer groups, tailored to suit their workforce's servicing needs.
- Annual product updates regarding the Scheme's product and benefit enhancements for the new benefit year were provided in a nationwide rollout to employer groups.

## Engaging with our employees

The Scheme is committed to protecting the dignity, safety and health of our employees, providing decent work, fair remuneration, training and development opportunities, and treating them equitably and ethically. A comprehensive set of Board-approved human resources policies are embedded in the Scheme's daily operations, and our Head of Human Resources manages and facilitates any employee-related matters.

The Scheme employs a small team which is essential to its effective operations, ensuring sustainability while responding in an agile way to industry developments and challenges. It is imperative that all employees are nurtured and developed to ensure the best efforts of fulfilled, engaged members of staff. Training and development opportunities are regularly identified and all staff members attend training relevant to their work and their potential within the Scheme. Periodic assessment and audit of the Scheme's value proposition to employees ensures staff satisfaction and retention, and quarterly performance assessments and discussions help employees stay on track in terms of their role objectives and career development.

Read more about the Scheme Office team on **page 21**.

1 *Based on 2015 Global Credit Ratings reports for open medical schemes.*

## Engaging with our regulatory bodies

The Scheme and Discovery Health are required to adhere to strict legislation, primarily the Medical Schemes Act (the Act). Maintaining constructive relationships with its regulators is critical to the Scheme's ability to create value, and we work hard to build and maintain a collaborative working approach and keep lines of communication open with the relevant authorities.

### COUNCIL FOR MEDICAL SCHEMES

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

- Protecting and educating the public regarding their medical scheme cover.
- Assessing and registration of 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.
- Working with the Department of Health regarding regulatory and policy interventions.

The Scheme engages actively with the CMS on matters of policy, application and interpretation of rules, benefit design, Scheme finances and resolution of disputes with members. The Scheme enjoys a cordial and transparent working relationship with the CMS.

In 2016, the CMS published 90 circulars and the Scheme submitted responses where required. The CMS also publishes an annual report covering activity across the private healthcare industry.

Find out more about the CMS at **www.medicalschemes.com**.

### THE COMPETITION COMMISSION

The Competition Commission's market inquiry into the private healthcare sector continues. The inquiry is a general investigation into the state and types of competition in the market and does not relate to any specific organisations. One of the aims of the inquiry is to promote competition to the benefit of consumers. Its final report is expected in December 2017.

During 2016, the Scheme engaged regularly with the Health Market Inquiry Panel, made data and information submissions as required, and cooperated fully and openly in the process.

Find out more about the Healthcare Market Inquiry at **www.compcom.co.za/healthcare-inquiry/**.

# 04 Governance

# OUR CHAIRPERSON'S STATEMENT

"As healthcare funders we stand at the intersection of medicine, healthcare and wellness, tasked with a vital and intricate challenge as these fields advance in response to an increasing burden of disease. We need to make equitable access to world-class healthcare a reality for our members, neither at the expense of affordability nor the sustainability of the Scheme. The 2016 benefit year proved to be challenging in this regard, but the Scheme emerged stronger for it."

The unprecedented spike in the utilisation of benefits posed a significant challenge for the Scheme in 2016. However, the Scheme's well-established governance and risk management processes, twinned with the capability and capacity of our Administrator and Managed Care Provider, Discovery Health, supported a strong and swift response. This allowed the Scheme to turn a mid-year forecasted operating loss into an operating surplus, which in addition to a good investment performance despite extraordinary volatility, returned the Scheme to a robust financial position.

Besides confirming our confidence in the value generated by Discovery Health, the year's achievement demonstrated the importance of governance best practice. To this end, the Trustees strongly endorse the revised King Code of Governance (King IV), which was launched in the year. King IV has yet again set a progressive and pragmatic standard for governance recognised as international best practice. The Scheme aims to comply fully with King IV by 1 January 2018, when it is formally applicable to the Scheme.

The terms of office of three Trustees ended in 2016, requiring members to elect their new Trustees. We received no less than 155 nominations and our Independent Electoral Body, PwC, vetted each of the candidates against fit and proper criteria. Held in June at the Scheme's Annual General Meeting, 111 candidates stood for election. Mr Neil Morrison, Mr Dave King and Dr Dhesan Moodley were elected and Ms Daisy Naidoo was re-elected. I welcome them to the Board of Trustees and look forward to their respective contributions to the Scheme's wellbeing.

Constructive engagement with our regulators continued in 2016. The Scheme engaged extensively with the Council for Medical Schemes (CMS) as a matter of course, with our discussions including governance, financial, legal, marketing and Scheme Rules and benefit plans. On behalf of the Scheme, I extend our condolences to the family, friends and colleagues of Dr Humphrey Zokufa, who was appointed Registrar of the CMS in September 2016, on his untimely passing.

Specific engagement included the Scheme's voluntary participation in the public hearings of the Competition Commission's Health Market Inquiry (HMI). The Scheme has responded extensively to requests from the HMI Panel and will continue to work closely with the Commission and other stakeholders towards a positive outcome for the healthcare market and its consumers. The HMI is expected to release its final report and recommendations in December 2017.

The Scheme also made submissions in response to the National Health Insurance (NHI) White Paper, and we look forward to further clarity on the NHI Fund, expected to be established in 2017. We believe that the establishment of the Fund, focused on critical primary healthcare services including maternal and child health services, is a significant and positive step forward. The Scheme strongly supports the objectives of universal health coverage and sees the NHI as an opportunity for the Scheme to work closely with the Department of Health to establish how best the private healthcare sector, which is undoubtedly a national asset, can work towards those objectives.

The final demarcation regulations for the long-term and short-term insurance industry, to govern medical gap cover, hospital cash plans and primary healthcare policies, were published in December 2016 and take effect from 1 April 2017. These regulations provide much-needed clarity on the role of medical schemes, and provide for gap cover and low-cost primary care products to co-exist with the offerings of medical schemes without competing with them. This is good news for our members as it will bolster the sustainability of the Scheme.

Heralding a new era for the Scheme, Dr Nozipho Sangweni succeeded Milton Streak as Principal Officer in 2017. Dr Sangweni has had a long association with the Scheme, as a Trustee and then an independent Committee member before joining the Scheme Office as Chief Medical Officer in 2015. The Trustees conducted an extensive external and internal search for the most suitable candidate, and were delighted to appoint Dr Sangweni. Her extensive business and governance experience in both the public and private sectors, together with her medical background, made her the best possible candidate to lead the Scheme into the future.

On behalf of the Trustees, I convey our deep thanks to Milton Streak, whose exceptional knowledge and dedication to the Scheme has made it what it is today: the leading open Scheme in South Africa. We wish him well in his future endeavours.

I would like to thank our three retiring Trustees, Professor Zephne van der Spuy, Mr Noel Graves and Mr Puke Maserumule, for their time, expertise and dedication to the Scheme. My thanks are also due to my current colleagues on the Board of Trustees and the Scheme's management team, and at Discovery Health. Your dedication to the Scheme, notwithstanding the complex responsibility we assume for the benefit of our members and the greater good of the healthcare system, is exemplary.

MICHAEL VAN DER NEST, SC
**CHAIRPERSON**

# HOW WE ARE GOVERNED

All medical schemes in South Africa are governed by the Medical Schemes Act 131 of 1998, as amended (the Act). The Scheme Rules are developed in accordance with the Act and approved annually by the CMS. Additional governance guidance is taken from the King Code of Governance Principles, 2009 (King III), which sets the standard for good corporate governance in South Africa, and is recognised internationally as best practice.

## Governance framework and structure

Discovery Health Medical Scheme is governed by an independent Board of Trustees (the Board), which is responsible for the oversight of the business of the Scheme. The Board holds the decision-making power of the Scheme and is ultimately responsible for overseeing the implementation of the Scheme's strategy and the sound management of its business. The Board's overriding objective is to ensure the best interests of Scheme members are served in the context of the sustainability of the Scheme.

In compliance with the Act and the registered Scheme Rules and in line with best practice governance principles, the Board has implemented appropriate governance structures to navigate and manage the complex operating environment, risks and strategic objectives of the Scheme. The Board is supported by 10 Board Committees, constituted and structured based on the needs of the Scheme to assist the Board to fulfil its fiduciary and oversight duties effectively. Board Committee members consist of both Trustees and independent members.

Scheme Rules are available to registered members at **www.discovery.co.za/medical-aid/scheme-rules**.

The Committees report regularly to the Board, and each has its own terms of reference and clear procedures for reporting. The terms of reference set out each Committee's role and responsibilities, which are reviewed on an annual basis to ensure that they remain relevant to the business of the Scheme, and that the skill and expertise of members on the Committee are appropriate and relevant. The Committees make recommendations to the Board for approval of any decisions to be taken.

The Board appoints and delegates the accountability for the day-to-day management of the Scheme to a Principal Officer, who is the chief executive of the Scheme. The Principal Officer executes the Board's decisions and implements strategy and is supported by an executive management team.

The Scheme uses the Governance Assessment Instrument (GAI) to evaluate the implementation of governance structures and processes as recommended in King III. The survey tool shows a meaningful score which reflects the Scheme's adoption of King III. The Scheme is currently working to incorporate King IV into all of its governance policies and practices, although it is only formally applicable to the Scheme from 1 January 2018.

# OUR BOARD OF TRUSTEES

The Board comprises independent, highly skilled professionals with expertise in clinical, financial, business, legal and actuarial disciplines.

## THE ROLE OF THE TRUSTEES IS TO:

- Evaluate, direct and monitor the Scheme's strategy, ensuring that it is aligned with the purpose and value drivers of the Scheme, and 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 the Scheme and its members, and offer value for money.
- Monitor innovation and oversee the improvement of all levels of the Scheme's operations.
- Monitor adherence to the Scheme Rules and the provisions of the Act in the day-to-day running of the Scheme's affairs.
- Consider stakeholder perceptions and their impact on the Scheme's reputation.

The Trustees are required at all times to act with due care, diligence, skill and good faith in the best interests of the Scheme and its members.

## THE DUTIES OF THE TRUSTEES, SET OUT IN THE ACT AND SCHEME RULES, ARE TO:

- 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, acting with impartiality in respect of all beneficiaries.
- Ensure the proper and sound management of the Scheme by applying sound business principles to ensure the Scheme's 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.
- Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Scheme Rules.

**According to the Scheme Rules,** "the affairs of the Scheme must be managed according to these Rules by a Board of fit and proper persons (i.e. persons with the requisite character, integrity, skill, competence, financial soundness and ability to exercise a fiduciary duty) of at least five and a maximum of eight persons.
A Trustee shall serve a term of three years and shall be eligible for re-election or re-appointment. Such Trustees shall not serve more than two consecutive terms."

**Board meetings**
attendance in 2016

| | | 20 Jan | 29 Feb | 30 Mar | 07 Apr | 25 May | 09 Jun | 04 Jul | 05 Sept | 15 Oct | 20 Oct | 10 Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trustees | Mr Michael van der Nest SC | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Mr Puke Maserumule# | × | ✓ | × | ✓ | × | ✓ | – | – | – | – | – |
| | Mr Noel Graves SC# | ✓ | ✓ | × | × | ✓ | ✓ | – | – | – | – | – |
| | Prof Zephne van der Spuy# | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | – | – | – | – | – |
| | Mr Giles Waugh | × | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Ms Daisy Naidoo#* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ |
| | Mr Neil Morrison* | – | – | – | – | – | – | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Mr Dhesan Moodley* | – | – | – | – | – | – | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Mr Dave King*∞ | – | ✓ | ✓ | ✓ | – | – | × | ✓ | ✓ | ✓ | ✓ |
| Independent co-opted member | Mr Johan Human◆ | – | – | – | – | – | – | – | – | – | – | ✓ |
| Chairperson: Audit and Risk Committee | Mr Barry Stott | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

*# Term as a Trustee ended on 23 June 2016.*

** Elected as a Trustee on 23 June 2016.*

*∞ Mr Dave King attended meetings prior to June in his capacity as a member of the Stakeholder Relations Committee and due to specific meeting requirements.*

*◆ Appointed as an independent co-opted member of the Board on 05 September 2016.*

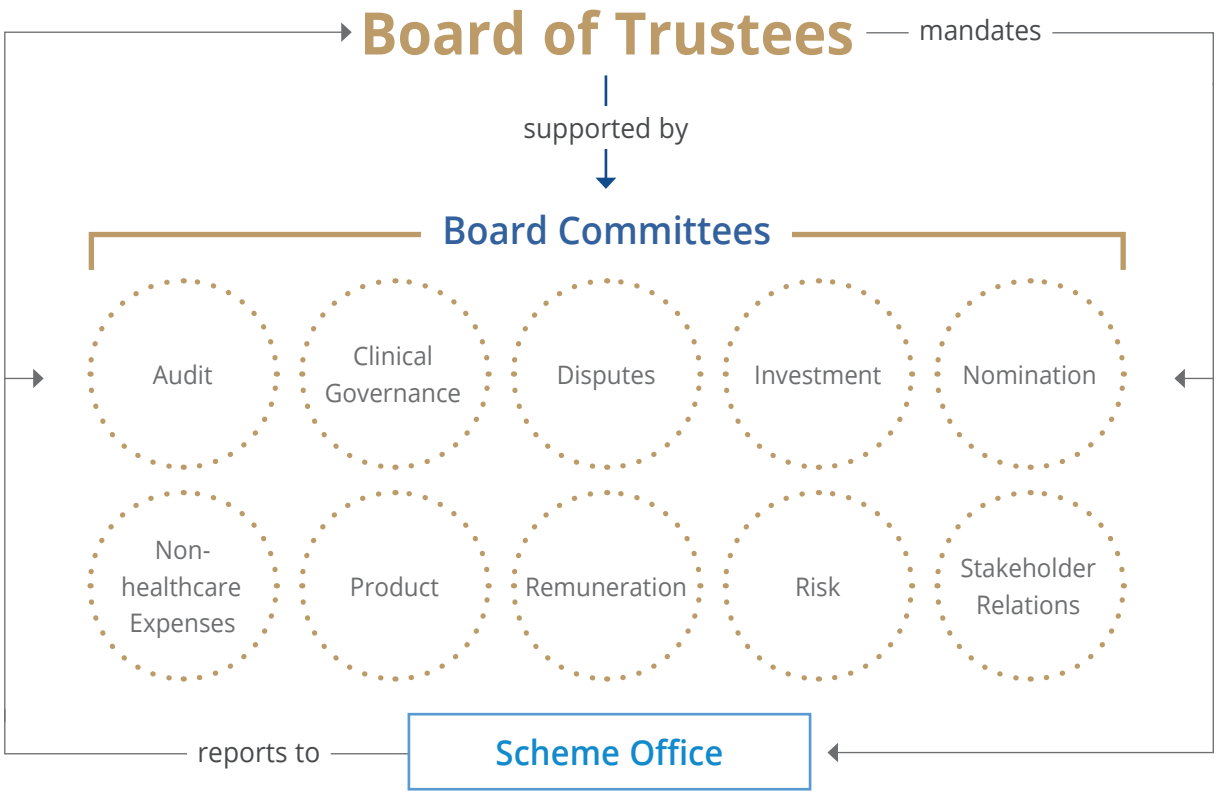
- *The Board strategy held on 30 March 2016 was attended by the following independent Committee members: Dave King, Sue Ludolph, Phlile Maphumulo, Steven Green, Imtiaz Ahmed and Mike Sathekge.*
- *The 15 October 2016 and 20 October 2016 Board meetings were held to conduct Principal Officer interviews.*

# OUR BOARD COMMITTEES

Ten Committees, which are established according to governance best practice and the requirements of legislation, assist the Board to fulfil its fiduciary and oversight duties effectively.

Committee members are remunerated for their service to the Scheme with a market-benchmarked professional fee, which is discounted based on the non-profit status of the Scheme. An annual self-assessment of effectiveness is performed by each Committee, which covers such areas as:

- Committee composition;
- Number of meetings held;
- Maintaining a constructive relationship with management;
- Interaction between Committee members; and
- Adherence to specific deliverables in the terms of reference.



# Audit Committee

The Audit Committee is a statutory committee established in terms of Sections 36 (10) to (13) of the Act, and assists the Board in discharging its responsibilities relating to the safeguarding of assets, the operation of adequate and effective systems and control processes, and the preparation of fairly presented financial statements in compliance with all applicable legal and regulatory requirements and accounting standards.

## SPECIFIC RESPONSIBILITIES

The Committee supported the Trustees in fulfilling their governance and oversight responsibilities for:

- Financial reporting processes.
- Integrated and sustainability reporting processes.
- Internal financial controls.
- Monitoring the performance of internal and external audit processes.
- Monitoring the impact of information technology (IT) and IT-related matters on the financial results.
- Monitoring the sustainability of business strategy, risk management and good governance.
- Monitoring business conduct and compliance with laws, regulations and relevant codes of conduct.
- Evaluating the independence and objectivity of the Internal Audit and external audit functions.
- Monitoring matters relating to the sustainability of the Scheme to the extent that it has an impact on the financial results.
- Recommend for approval by the Board, the annual contribution increases.

The Annual Financial Statements start on **page 82**.

## Our Audit Committee Chairperson

### Mr Barry Stott

CA(SA)

Mr Stott commenced articles with PwC in February 1968 in the audit division. He was appointed partner in 1982, responsible for audits in the insurance and asset management industry. Mr Stott also led the financial services industry practice and financial services knowledge management division, and ensured that PwC staff were up to date on all issues in the industry, trained in industry specialisation and on all IFRS issues relating to the financial services industry. Since retiring from PwC in June 2009, Mr Stott has been a member of audit panels for Momentum Asset Management, Momentum Wealth, Rand Merchant Bank Asset Management and Advantage Asset Management. Since January 2010, Mr Stott has been an independent non-executive director of Clientèle Holdings Ltd, Clientèle Life Limited and Clientèle and General Limited. He is the Chairman of the Audit Committee, Risk Committee, and Remuneration Committee of the Clientele Group, as well as a member of the Clientèle Group Investment Committee and attends Actuarial Committee meetings.

Mr Stott serves on the Scheme's Investment Committee and Chairs the Audit and Risk Committees.

For more about the other Audit Committee members, see **pages 22 – 25**.

## Audit Committee *continued*

### HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

Read the Audit Committee's report on **pages 85 – 86**, and more about non-compliance matters on **pages 70 – 71**.

### COMPOSITION AND MEETINGS IN 2016

The Audit Committee comprises highly skilled and experienced members with extensive actuarial, financial and IT skills. Most of the Committee members, including the Chairperson, are independent and are not Trustees.

| Audit Committee attendance in 2016 | | 16 Mar | 16 Aug | 23 Aug | 31 Oct |
|---|---|---|---|---|---|
| Independent member/ Chairperson | Mr Barry Stott | ✓ | ✓ | ✓ | ✓ |
| Trustees | Ms Daisy Naidoo#* | ✓ | ✓ | ✓ | ✓ |
| | Mr Giles Waugh | ✓ | ✓ | ✓ | ✓ |
| | Mr Neil Morrison* | – | ✓ | ✓ | ✓ |
| Independent members | Ms Susan Ludolph◊ | × | ✓ | ✓ | ✓ |
| | Mr Steven Green | ✓ | ✓ | ✓ | ✓ |
| | Ms Phillile Maphumulo◊ | ✓ | ✓ | ✓ | ✓ |
| | Mr Dave King◆ | ✓ | – | – | – |

*# Term as a Trustee ended on 23 June 2016.*

** Elected as a Trustee on 23 June 2016.*

*◊ Appointed to the Committee on 20 January 2016.*

*◆ Elected as a Trustee on 23 June 2016 and subsequently resigned as member of the Audit Committee.*

The Committee meets at least four times a year and schedules additional meetings as necessary. The external and internal auditors meet regularly with the Committee without the Administrator and Scheme management present.

The members of the Committee may consult any expert or specialist to assist the Committee in performing its duties. The external auditors and the Principal Officer, as well as the internal auditors and the heads of the outsourced administration functions attend all Committee meetings by invitation and have unrestricted access to the Chairperson of the Audit Committee.

# Clinical Governance Committee

This Committee assists the Trustees in the general oversight of funding policies and practices, clinical governance and providing access to evidence-based, clinically appropriate, cost-effective, affordable, quality healthcare in a consistent and equitable manner. The Committee comprises members with the requisite skills to consider the clinical complexities in healthcare funding.

Clinical governance is integral to the funded healthcare environment, in ensuring that high-quality and affordable clinical care is offered to members. The Scheme operates according to a clinical governance structure that employs internationally recognised clinical best practice to account for clinical performance, and adheres to the following principles:

- Transparency;
- Accountability;
- Responsibility;
- Fairness;
- Independence;
- Ethical behaviour; and
- Social responsibility.

### SPECIFIC RESPONSIBILITIES

The Committee oversees the functions performed by Discovery Health in terms of the managed care agreement. In this regard it has insight into clinical risk management, clinical policies and protocols, ex-gratia requests and decisions, clinical pilot projects, member queries, research and development of clinical best practice, and health benefit formulation.

**The Committee's responsibilities are to:**

- Ensure healthcare benefits as prescribed by the Act and the Scheme Rules are upheld.
- Oversee the design and implementation of pilot projects that inform health benefit formulation.
- Ensure the Scheme's managed care mandate to offer members the highest level of appropriate, affordable quality care is complied with, taking into account the balance between cost-effective quality healthcare, effective clinical risk management, and affordability.
- Consider the member experience through monitoring and evaluating complaints, queries and disputes lodged by members with the Scheme or the CMS.

The Scheme's approach to ensuring the quality of care received by its members considers the Donabedian model as a framework for evaluating quality of care. The complexity of the healthcare model requires that the member is placed at the centre of this journey, and that different stakeholders in the provision of care collectively take responsibility for a sustainable healthcare funding model.

The Committee reviews and monitors all initiatives to reduce unnecessary healthcare costs without negatively impacting on the quality of care, and to support superior member experience and value-based care. The Committee also oversees the engagement strategies with healthcare professionals facilitated by Discovery Health, which foster shared purpose by re-engineering the delivery of care according to a team-based approach.

Read more about Discovery Health's initiatives for the Scheme on **pages 74 – 81**.

Health Quality Assessment is an industry body that performs an annual assessment of clinical quality offered by medical schemes according to specific quality indicators. As a participating scheme, DHMS receives an annual Scheme-specific report that assists the Committee in fulfilling its mandate to oversee and improve the quality of healthcare received by Scheme members. Overall, the Scheme performed better than the industry average for the chronic disease process indicators. The process scores, when tracked over time, indicate an improvement in care and a reduction in costs.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

The Committee considered the risk posed to the Scheme by the significantly higher than expected hospital admissions rate, which was a feature of the year. The strong correlation between the high utilisation rates and the increase in hospital beds in regions where new hospitals were opened were noted. The Committee ensured that key risk interventions were designed and implemented to manage the utilisation risk effectively, while also mitigating the impact of these measures on healthcare provider sentiment.

The cost of pharmaceuticals, especially new cancer medications, has continued to increase steadily since 2008, by as much as 325%. The Committee ensured the implementation of multiple strategies to mitigate this risk.

The introduction of new technology in healthcare can have unintended consequences, an example being increased utilisation and healthcare inflation. The Health Technology Assessment model is a systematic evaluation of the effects and impacts of health technologies and interventions, and determines the value of interventions to inform policy and decision-making in healthcare. The Committee oversaw the adoption of the process, which begins with scanning the horizon for new technologies and extends to determining the value of these and then linking them to benefits, managed care and implementation in a way that maximises value in relation to cost.

In September 2015, the World Health Organisation recommended that Pre-Exposure Prophylaxis (PreP) for HIV be offered as an additional prevention choice for people at substantial risk of HIV infection. South Africa has been recognised as the first country in Africa to translate this recommendation into national policy. The Committee considered the various challenges of implementing this policy within the Scheme environment and endorsed the funding approach to be adopted.

The NHI White Paper was released on 11 December 2015. The Scheme and Discovery Health submitted a joint response on the White Paper to the Department of Health, guided by the Clinical Governance Committee. Our response indicated support for the successful implementation of the NHI and encouraged a collaborative approach in further technical work to be conducted. It also noted certain inaccuracies that impact the private medical schemes industry and made a case for the industry to exist in parallel to the NHI system as is the case in many other health systems in the world.

## COMPOSITION AND MEETINGS IN 2016

The members included one Trustee who is the Chairperson of the Committee, three independent members and the Chief Medical Officer of the Scheme.

**Clinical Governance** attendance in 2016

| | | 17 Mar | 20 Jul | 03 Nov |
|---|---|---|---|---|
| Trustee/Chairperson | Dr Dhesan Moodley* | – | ✓ | ✓ |
| Independent member | Prof Zephne van der Spuy◊ | ✓ | ✓ | ✓ |
| | Prof Mike Sathekge | ✓ | ✓ | ✓ |
| | Prof Selma Smith | × | ✓ | ✓ |
| Scheme management: Chief Medical Officer | Dr Nozipho Sangweni | ✓ | ✓ | ✓ |

* *Elected as a Trustee on 23 June 2016.*

◊ *Prof Zephne van der Spuy chaired the Committee for the first meeting held on 17 March 2016 and was appointed as an independent member on 04 July 2016 after her term as a Trustee ended on 23 June 2016, whereafter Dr Dhesan Moodley was appointed as Chairperson.*

For more about the Committee members, see **pages 22 – 25**.

The Committee obtains regular reports and presentations from Discovery Health, and the relevant individuals are regularly invited to Committee meetings for this purpose.

# Disputes Committee

Section 29 (j) of the Act requires the rules of a scheme to provide for 'the settlement of any complaint or dispute'. Rule 27 of the Scheme Rules outlines the process for resolving complaints and disputes, in terms of which the Board has established an independent Disputes Committee which hears and rules on all member disputes in an open, transparent and equitable manner.

The Committee consists of three members drawn from a panel of experts, each of whom have either legal or medical expertise. All Committee meetings held must be attended by at least one legal expert and at least one medical expert. The Chairperson of all Committee meetings is always a practicing attorney. While not employed by the Scheme, Committee members are remunerated for their time and input in objectively hearing and adjudicating cases, regardless of the outcome of the hearings.

The Committee's purpose is to make consistent and fair decisions, carefully considering the provisions of the Act, all applicable laws, the Scheme Rules and the needs of all stakeholders. The Committee is bound by the provisions of all applicable legislation and the latest registered Scheme Rules. It is not empowered to make rulings that are discretionary in nature or that contravene applicable legislation and/or the latest registered Scheme Rules in any way.

In the event of a member being dissatisfied with a ruling made by the Committee, they can lodge a complaint with the CMS in terms of Section 47 of the Act.

Read more about how to lodge disputes on **page 155**.

## SPECIFIC RESPONSIBILITIES

- Hear member submissions and those of the Scheme's representative, which may be verbal and/or in writing, in line with relevant legislation and the Scheme Rules.
- Ensure that it has sufficient information regarding the dispute to adjudicate the case objectively.
- Determine an outcome for the dispute and draft a ruling with due regard for all facts presented at the hearing.
- Ensure that the process of hearing and adjudicating on disputes is handled as efficiently as possible and without undue delay.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

The Committee heard a total of 76 disputes. Although 392 disputes were lodged in 2016, 316 of these were resolved prior to a hearing, indicating the efficacy of the dispute resolution process.

## COMPOSITION AND MEETINGS IN 2016

Dispute Committee hearings are scheduled as and when required, and draw from the legal and medical panellists available at the time. The Committee can be constituted several times a week to attend to the caseload. Due to the frequency of meetings and variation of Committee members, an attendance register is not shown. During 2016, the Committee was properly constituted each time it met.

# 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 in respect of investing the Scheme's reserves, to ensure the investments made are in the best interest of members and within the risk appetite of the Scheme, as determined by the Board from time to time.

## SPECIFIC RESPONSIBILITIES

- Review the investment policy, and monitor its implementation and effectiveness.
- Make recommendations to the Trustees regarding the asset allocation principles of the Scheme's investment portfolio and the investment policy and strategy.
- Review investment strategies, capital and equity market assumptions, performance of the overall investment portfolio and performance of asset managers against established benchmarks, and report to the Trustees quarterly on the performance of the portfolio.
- Monitor the performance of each asset class with a view to maximising the total return, keeping in mind the risk appetite of the Scheme.
- Report to the Trustees annually on the overall performance of the asset managers and asset consultants.
- Make recommendations to the Trustees on the appointment of asset consultants and asset managers, including the fees payable and other terms on which the appointments are made and, if appropriate, tender for the appointment of asset consultants and asset managers.
- Assist the Trustees in deciding whether to withdraw funds from portfolios to support daily operations.
- Supervise the safekeeping and handling of the Scheme's investments.
- Monitor all reported investment activities in line with the Scheme's investment policy and statutory requirements, and where there is deviation from the investment policy investigate the reasons and recommend corrective action to the Trustees.
- Assist the Trustees in preparing their annual report on investment performance and compliance.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

- Considered the Scheme's investment strategy given the difficult market conditions, which led to the tactical decision to reduce overall risk.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across all its asset managers, which included on-site visits. No specific concerns were identified.
- Reviewed quarterly credit risk reports in terms of the Scheme Credit Risk Policy, to ensure credit risk was being appropriately managed.
- Reviewed the performance of asset managers after which certain portfolio re-allocations were made.

## COMPOSITION AND MEETINGS IN 2016

The Investment Committee comprised three Trustees and two independent Committee members during 2016.

| **Investment Committee** attendance in 2016 | | 01 Mar | 29 Mar | 01 Jun | 07 Nov |
|---|---|---|---|---|---|
| Independent member/ Chairperson | Mr Imtiaz Ahmed∞ | ✓ | ✓ | ✓ | ✓ |
| Trustees | Mr Puke Maserumule#◊ | ✓ | ✓ | ✓ | – |
| | Mr Noel Graves SC# | × | × | × | – |
| | Ms Daisy Naidoo#* | ✓ | ✓ | ✓ | ✓ |
| | Mr Neil Morrison* | – | – | – | ✓ |
| | Dr Dhesan Moodley* | – | – | – | ✓ |
| Independent member | Mr Barry Stott | ✓ | ✓ | ✓ | ✓ |

∞ *Appointed as a member of the Committee on 20 January 2016 and elected Chairperson on 07 November 2016.*

\# *Term as a Trustee ended on 23 June 2016.*

* *Elected as a Trustee on 23 June 2016.*

◊ *Mr Puke Maserumule chaired the Committee for the first three meetings held on 1 March 2016, 29 March 2016 and 1 June 2016. After his term as a Trustee ended on 23 June 2016, Mr Imtiaz Ahmed was appointed Chairperson of the Committee on 7 November 2016.*

The Committee receives investment advice and quarterly reports from its asset consultants, RisCura, who attend all Committee meetings. Asset managers are invited to attend Committee meetings on a rotational basis to report on their performance.

For more about the Committee members, see **pages 22 – 25**.

# Non-healthcare Expenses Committee

**The Committee's responsibilities are to:**

- Review and recommend the proposed contracted administration and managed care fees to the Trustees for consideration and approval.
- Review service level agreements and assist the Board to ensure that these have been complied with.
- Monitor the value the Scheme and its members receive from Discovery Health.
- Recommend the non-healthcare budget to the Board for consideration and approval, and monitor actual non-healthcare expenses incurred against the approved budget.

## SPECIFIC RESPONSIBILITIES

The Committee monitored the ongoing optimisation of the Vested outsourcing business model in line with its usual responsibilities, and to inform the terms of the agreements to be entered into with Discovery Health from 1 January 2018.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

- Assessed the value added to DHMS by Discovery Health in the provision of the administration and managed care services.
- Monitored developments and considered proposals to optimise the Vested® outsourcing business model, which included workshops with Scheme Office executives and Vested consultants to consider the effectiveness of the model.
- Reviewed reports on the service levels achieved by Discovery Health and approved changes to them in line with the operating environment.
- Assessed innovations by Discovery Health.
- Reviewed reports on the Scheme's non-healthcare expenses against budget and recommended the 2017 budget to the Trustees for approval.
- Considered and recommended a new Scheme Procurement Policy to the Trustees for approval.

Read more on how we conduct our operations on **pages 16 – 17** and more about the Committee members on **pages 22 – 25**.

## Non-healthcare Expenses Committee *continued*

### COMPOSITION AND MEETINGS IN 2016

The Committee comprised four Trustees, an independent member and the Principal Officer.

| Non-healthcare Expenses Committee attendance in 2016 | | 07 Mar | 06 Jun | 18 Aug[1] | 10 Oct |
|---|---|---|---|---|---|
| Trustee/ Chairperson | Mr Giles Waugh | ✓ | ✓ | ✓ | ✓ |
| Trustees | Mr Noel Graves SC#◊ | ✓ | ✓ | – | – |
| | Ms Daisy Naidoo#* | ✓ | ✓ | ✓ | ✓ |
| | Mr Dave King* | – | – | ✓ | ✓ |
| | Mr Neil Morrison* | – | – | ✓ | × |
| Independent member | Mr Johan Human◆ | – | – | – | ✓ |
| Scheme management: Principal Officer | Mr Milton Streak | ✓ | ✓ | ✓ | ✓ |

*1 The meeting on 18 August was a workshop.*

*# Term as a Trustee ended 23 June 2016.*

*◊ Mr Noel Graves chaired the Committee for the first two meetings held on 17 March 2016 and 06 June 2016. After his term as a Trustee ended on 23 June 2016, Mr Giles Waugh was appointed as Chairperson.*

** Elected as a Trustee on 23 June 2016.*

*◆ Appointed to the Committee on 05 September 2016.*

Where appropriate, executives from Discovery Health attend the meeting. The Committee also has access to a Vested outsourcing business model expert.

For more about the Committee members, see **page 22 – 25**.

# Nomination Committee

**The Committee's responsibilities are to:**

- Oversee the nomination process of suitably fit and proper persons for election and their appointment as Trustees;
- Consider diversity, demographics and skills required by the Board; and
- Oversee the nominations process implemented by an independent electoral body (IEB).

The Committee is independent of the Board and comprises significantly experienced independent members who are not Trustees.

### HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

The 2016 Trustee election process required the following activities:

- Considered the appointment of PwC's Forensic Services division to act as the IEB for the Scheme in its 2016 Trustee elections.
- Reviewed and approved the communication to Scheme members regarding the nominations process for the 2016 Trustee elections.
- Oversaw the governance of the nominations, proxy appointment and elections processes.

### COMPOSITION AND MEETINGS IN 2016

| Nomination Committee attendance in 2016 | | 04 Apr | 05 Apr | 06 Apr | 12 Apr | 18 Apr | 25 Apr | 09 June | 22 Sept | 07 Dec |
|---|---|---|---|---|---|---|---|---|---|---|
| Independent member/ Chairperson | Peter Goss | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Independent member | Roy Shough | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ |
| Independent member | Tom Wixley | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

The Committee is attended by the IEB and its representatives.

For more about the Committee members, see **pages 22 – 25**.

# Product Committee

The Committee oversees product development, amendments to benefits, proposed benefit plans and the development of annual product communication and marketing materials.

## SPECIFIC RESPONSIBILITIES

Every year, the Committee ensures that benefit proposals are assessed against the following factors:

- Clinical appropriateness and best practice;
- Financial affordability and sustainability;
- The best interest of members and fairness;
- Value and appropriateness to members; and
- The Scheme's Marketing and Communication Policies.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

- Reviewed the performance of all benefit plans based on specific performance metrics.
- Reviewed and recommended the 2017 benefit plan amendments to the Trustees for approval.
- Considered changes to the Scheme Rules.

## PRODUCT COMMITTEE COMPOSITION AND MEETINGS IN 2016

The Committee comprised three Trustees, an independent member and the Principal Officer.

| **Product Committee** attendance in 2016 | | 17 Mar | 27 Jul | 19 Aug | 23 Aug |
|---|---|---|---|---|---|
| Trustee/ Chairperson | Mr Giles Waugh | ✓ | ✓ | ✓ | ✓ |
| Trustees | Prof Zephne van der Spuy# | ✓ | – | – | – |
| | Mr Noel Graves SC# | × | – | – | – |
| | Dr Dhesan Moodley* | – | ✓ | ✓ | ✓ |
| | Ms Daisy Naidoo#* | – | ✓ | ✓ | ✓ |
| Independent member | Mr Johan Human◊ | – | – | – | ✓ |
| Scheme management: Principal Officer | Mr Milton Streak | ✓ | × | × | ✓ |

*# Term as a Trustee ended 23 June 2016.*
** Elected as a Trustee on 23 June 2016.*
*◊ Appointed to the Committee on 05 September 2016.*

The Committee obtains regular reports and presentations from Discovery Health, and the relevant individuals are regularly invited to Committee meetings for this purpose.

The Committee invited the Audit Committee, the Scheme external auditors, PwC, and the independent actuaries of the Scheme, Insight Actuaries & Consultants, to discuss the actuarial evaluation and consider contribution increases.

For more about the Committee members, see **pages 22 – 25**.

# Remuneration Committee

The Committee assists the Trustees to oversee the Scheme's remuneration and other human resources strategies and policies, and ensure compliance with these policies. It also ensures that reporting disclosures relating to remuneration are made according to the Board's objectives, and that a formal, rigorous and transparent process for appointing senior staff members is followed.

## SPECIFIC RESPONSIBILITIES

- Review staff remuneration, including that of senior executives, Trustees and Board Committee members, as well as any retirement and termination payments.
- Ensure that the Scheme's remuneration policies are established and administered in the Scheme's long-term interests.
- Ensure that succession plans are in place, where possible[1], to maintain an appropriate balance of skills in the Scheme's management and governance structures.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

- Recommended the Trustee, Committee member and Scheme Office senior staff remuneration to the Trustees for approval, based on market benchmarking conducted by independent remuneration practice experts and considering the non-profit status of the Scheme.
- Reviewed and recommended to the Trustees for approval amendments to the Scheme's human resources policies, to ensure alignment with legislation.
- Coordinated the executive search and recruitment process for the Scheme's new Principal Officer[2].
- Reviewed training and development requirements for Scheme staff and recommended the approval of the appropriate training and development initiatives to the Trustees.

*1 At least 50% of Trustees must be elected by members at any time, which means that succession planning is not possible for these positions.*
*2 Mr Milton Streak resigned as Principal Officer effective 31 December 2016, and his successor, Dr Nozipho Sangweni, was appointed to the role of Principal Officer with effect from 1 January 2017.*

### Remuneration Committee *continued*

With the support of the Committee, the Scheme presented its Trustee Remuneration Policy to members at its 2016 Annual General Meeting for a non-binding advisory vote, which received 96% approval. The formal approval of Trustee remuneration by members is a standing agenda item at each Annual General Meeting (AGM).

For more about the Committee members, see **pages 22 – 25**.

## COMPOSITION AND MEETINGS IN 2016

The Committee comprised two Trustees and an independent member, who Chairs the Committee. The Principal Officer attends Committee meetings by invitation.

| **Remuneration Committee** attendance in 2016 | | 26 May | 02 Nov |
|---|---|---|---|
| Independent member/ Chairperson | Mr Don Eriksson | ✓ | ✓ |
| Trustees | Mr Michael van der Nest SC | ✓ | ✓ |
| | Mr Noel Graves SC# | ✓ | – |
| | Mr Dave King* | – | ✓ |

*# Term as a Trustee ended 23 June 2016.*
** Elected as a Trustee on 23 June 2016.*

The Committee makes regular use of independent remuneration experts from PwC, and engaged Spencer Stuart to recruit for the Scheme Office during 2016. Individuals from these organisations are occasionally invited to Committee meetings.

For more about the Committee members, see **pages 22 – 25**.

# Risk Committee

The Trustees established the Risk Committee to ensure good governance and best practice, in line with King III's principles on the governance of risk.

The Scheme operates according to a best practice risk management framework that covers all its activities, protects its members and underpins its sustainability. In addition to risk management, the Risk Committee oversees compliance, combined assurance, IT governance, fraud, ethics, forensics and whistleblowing, legal and regulatory matters and litigation.

The role of the Committee in no way reduces the responsibility of the Trustees under relevant laws and regulations in respect of governance and oversight of the Scheme.

**The principal purpose and objectives of the Risk Committee are to:**

- Provide independent and objective oversight of the strategic, financial, insurance, operational, business and regulatory risks faced by the Scheme.
- Consider the risk management policy, processes, appetite and tolerance, and monitor the risk management process and mitigation plans.
- Review the compliance policy, plan and universe, and the adequacy and effectiveness of the system for monitoring compliance with laws and regulations, as well as management's response to operational compliance incidents.
- Monitor the effectiveness and appropriateness of the Scheme's combined assurance model, ensuring that it satisfactorily addresses all the significant risks facing the Scheme.
- Review the adequacy and effectiveness of the IT control framework and governance structure, ensuring that the risk management process covers the IT environment, and review the Scheme's disaster recovery and business continuity plans.
- Review anti-fraud programmes, controls, procedures and reports, including identification of fraud risks and implementation of anti-fraud measures.
- Review significant cases of conflict of interest, misconduct or fraud, or any other unethical activity by officials of the Scheme, its Administrator and Managed Care Provider and any other third-party service provider to the Scheme.

Further detail on key functions follows.

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

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

## COMBINED ASSURANCE

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

- Scheme management;
- Internal assurance providers (Discovery Group Risk Management, Compliance and Forensics functions); and
- External assurance providers (Internal Audit, external audit and an independent actuarial firm).

The combined assurance assessment showed that overall, adequate assurance was provided and received in respect of all significant risks for the 2016 benefit year. The Trustees are comfortable with the level and type of assurance the Scheme obtains.

## 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 Risk and Operations Officer who ensures that risk management is embedded into daily management activities. The Scheme outsources certain risk management activities to the Discovery Group Risk Management function.

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

The Trustees appoint the members of the Committee on an annual basis, with members consisting of Trustees, independent members and Scheme management.

## SPECIFIC RESPONSIBILITIES

In addition to its usual responsibilities, the Committee carefully monitored the risks, processes and controls relating to the election of new Trustees in June 2016.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

- Conducted the annual risk assessment, which included representatives of the Committee, the Scheme Office and the Administrator. The amended risk register was subsequently presented to the Trustees to provide them with sufficient oversight of the Scheme's risk management profile and allow them to discharge their accountability in respect of risk management.
- Reviewed regular risk management reports and key risk indicators, and performed its annual review of the risk management framework, risk appetite framework and risk appetite statement. The Committee approved the frameworks and risk appetite statement and subsequently recommended them to the Trustees for approval.
- Considered regular compliance reports and monitored exposure and actions taken to mitigate compliance risks, as well as performed its annual review of the Compliance Policy. The Committee approved the policy and subsequently recommended it to the Trustees for approval.
- Approved a combined assurance model and subsequent assessments, which meet the requirements of King III and support the Audit Committee in making their control statements in the Integrated Annual Report.
- Received reports to assist in delivering the Scheme's IT governance obligations.
- Approved the Scheme's fraud risk management strategy.

**Risk Committee** *continued*

## COMPOSITION AND MEETINGS IN 2016

The Committee comprised three Trustees and five independent members, one of whom Chairs the Committee. In accordance with the principles of King III, membership of the Risk Committee also includes the members of Scheme Office executive management.

| **Risk Committee** attendance in 2016 | | 16 Mar | 16 Aug | 06 Oct[1] | 31 Oct |
|---|---|---|---|---|---|
| Independent member/ Chairperson | Mr Barry Stott | ✓ | ✓ | ✓ | ✓ |
| Trustees | Ms Daisy Naidoo#* | ✓ | ✓ | ✓ | ✓ |
| | Mr Giles Waugh | ✓ | ✓ | ✓ | ✓ |
| | Mr Neil Morrison* | – | ✓ | × | ✓ |
| Independent members | Ms Susan Ludolph∞ | × | ✓ | × | ✓ |
| | Mr Steven Green | ✓ | ✓ | ✓ | ✓ |
| | Ms Philile Maphumulo∞ | ✓ | ✓ | ✓ | ✓ |
| | Mr Dave King◊ | ✓ | – | – | – |
| Scheme management | Mr Milton Streak | ✓ | ✓ | × | ✓ |
| | Dr Nozipho Sangweni | ✓ | × | ✓ | × |
| | Mr Selwyn Kahlberg | ✓ | ✓ | ✓ | ✓ |
| | Ms Yashmita Mistry | ✓ | ✓ | – | – |
| | Mr Howard Snoyman | ✓ | ✓ | ✓ | ✓ |
| | Mr Jan van Staden | ✓ | ✓ | ✓ | ✓ |
| | Ms Michelle Culverwell | ✓ | ✓ | ✓ | ✓ |

*1 The meeting on 06 October was a workshop.*
*# Term as a Trustee ended 23 June 2016.*
** Elected as a Trustee on 23 June 2016.*
*∞ Appointed to the Committee on 20 January 2016.*
*◊ Elected as a Trustee on 23 June 2016 and resigned as member of the Risk Committee on 04 July 2016.*

The external auditors, PwC, as well as the Discovery Group Risk Management function and Group Compliance function attend every Committee meeting. Representatives from Discovery Health also attend to provide detailed operational insight.

For more about the Committee members, see **pages 22 – 25**.

# Stakeholder Relations Committee

The Committee assists the Trustees to identify important stakeholder groups and their legitimate interests and expectations. The Committee also oversees the development and implementation of adequate processes and procedures for stakeholder engagement, ensuring that all legitimate interests of stakeholders are balanced in the best interests of the Scheme as a whole.

## SPECIFIC RESPONSIBILITIES

- Monitor and evaluate engagement plans for relevant stakeholders, ensuring adequate risk management.
- Ensure that stakeholder engagement plans are implemented timeously.
- Ensure that the objectives of the engagement plans are achieved.
- Report to the Trustees on how the Scheme is managing its relationships with key stakeholders.

## HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2016

- Reviewed member engagement, communication approaches and activities undertaken by the Scheme and Discovery Health in relation to the Competition Commission's market inquiry into the private healthcare sector, the Scheme's AGM, and other regulatory activity.
- Reviewed health professional engagement strategies to encourage participation in quality of care and centres of excellence initiatives in development by Discovery Health, as well as to engage providers on network changes due to increased utilisation.
- Monitored the Scheme's engagement with the CMS, the Competition Commission, and work streams relating to the NHI.
- Provided regular reports to the Trustees on its activities.

## COMPOSITION AND MEETINGS IN 2016

During 2016, the Committee comprised three Trustees, an independent member and the Principal Officer. The Committee requires that one of its members is a member of the medical profession.

| **Stakeholder Relations** attendance in 2016 | | 30 May | 04 Nov |
|---|---|---|---|
| Trustee/ Chairperson | Mr Michael van der Nest SC | ✓ | ✓ |
| Trustees | Mr Puke Maserumule# | × | – |
| | Dr Dhesan Moodley* | – | – |
| | Mr Dave King∞ | ✓ | ✓ |
| Independent member | Mr John Butler SC◊ | – | ✓ |
| Scheme management: Principal Officer | Mr Milton Streak | ✓ | ✓ |

*# Term as a Trustee ended on 23 June 2016.*

** Elected as a Trustee on 23 June 2016, and appointed to the Committee on 10 November 2016.*

*∞ Served as an independent member until elected as a Trustee on 23 June 2016.*

*◊ Appointed as an independent member on 05 September 2016 and appointed as Chairperson on 04 November 2016, and chaired that meeting.*

Only two separate meetings were held by the Committee during 2016 as, due to Committee member travel the first meeting was combined with a Board meeting in February 2016.

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

For more about the Committee members, see **pages 22 – 25**, and to read more about how the Scheme engages with its stakeholders, see **pages 26 – 35**.

# TRUSTEE AND COMMITTEE MEMBER REMUNERATION

The Board of Trustees is responsible for the development and implementation of a Remuneration Policy for Scheme employees as well as the Trustees and Board Committee members. The Board has delegated the responsibility of Scheme remuneration oversight to a Remuneration Committee (REMCO).

REMCO makes use of independent experts and market benchmarking to assist the Committee in terms of best remuneration practices. King III and its Remuneration Practice Notes are also used as additional guidance in determining the Remuneration Policy and methodology.

## REMUNERATION METHODOLOGY

The CMS advised schemes through Circular 41 of 2014 not to use the remuneration benchmarking of non-executive directors of listed companies. The Scheme's market benchmarking methodology (developed by PwC) is therefore as follows:

- Professional fees/rates charged in the fields of law, actuarial science, medicine, accounting and commerce.
- Professional fees will be discounted at an applicable rate (30%) to take into account the non-profit status of the Scheme.
- The new market benchmarking methodology was submitted to the CMS on 28 November 2014.

In 2015, the Scheme implemented the new remuneration methodology following its approval by members at the Scheme's 2015 Annual General Meeting. The methodology is being implemented over three years, with fees paid to Trustees incrementally adjusted to the benchmark level.

## ADOPTION AND APPROVAL OF REMUNERATION

The remuneration of Trustees is presented at each AGM for a majority vote by members, after it is approved by the Board on recommendation of REMCO.

## APPROVAL OF REMUNERATION POLICY

The Trustee Remuneration Policy was tabled at the 2016 AGM for a non-binding advisory vote as per King III, and was approved by 96% of the members present.

For more information on the remuneration of Trustees see Note 15 of the Annual Financial Statements on **page 109**, and for more information about REMCO see **pages 49 – 50**.

# DISCOVERY HEALTH MEDICAL SCHEME REMUNERATION POLICY

The main objective of the Scheme is to create long-term value for its members and stakeholders. An appropriate system of corporate governance is one of the mainstays of creating and sustaining such value. Elements of good corporate governance include fairness, accountability, responsibility and transparency, and the King III Report on Governance for South Africa requires corporations to develop astute protocols with respect to ensuring that the principles of corporate governance are engendered into the governance and management practices of the Scheme.

Long-term and sustainable stakeholder value is created via the Scheme's human capital contingent, and so the co-ordination and control of this element of corporate governance constitutes one of the most important strategic focus areas for the Scheme on an ongoing basis.

Through its remuneration policies, the Scheme strives to provide an ethical business framework for the establishment of protocols to attract, motivate and retain high-calibre people, with above-average industry ability and leadership potential to effectively manage the Scheme's interests and take care of members' interests, while also ensuring that they are remunerated fairly and responsibly in accordance with the recommended remuneration practices of King III.

## LEGISLATIVE FRAMEWORK FOR REMUNERATION POLICIES

The Scheme's remuneration policies, applicable to the Trustees and employees, uphold the obligations of the following legislation and regulations:

i. King III Code of Governance Principles and the DHMS Code of Ethics.

ii. Medical Schemes Act 131 of 1998, as amended (the Act), and the Discovery Health Medical Scheme Rules.

iii. Council for Medical Schemes Guidelines for Trustee Remuneration.

iv. The Companies Act 71 of 2008.

v. The Promotion of Equality and Unfair Discrimination Act 4 of 2000.

vi. The Labour Relations Act 66 of 1995.

vii. The Basic Conditions of Employment Act 75 of 1997.

viii. The Employment Equity Act 55 of 1998.

The Scheme defers to the provisions of King III and the DHMS Code of Ethics on all matters that are not in the scope of or are addressed by the Medical Schemes Act 131 of 1998, as amended, and the Discovery Health Medical Scheme Rules.

The provisions relating to remuneration and reward in the Basic Conditions of Employment Act, the Labour Relations Act and the Employment Equity Act are only applicable to persons employed by the Scheme and not to the Trustees who are appointed/elected on a non-executive basis and as such are not employees of the Scheme.

## DISCOVERY HEALTH MEDICAL SCHEME REMUNERATION POLICY *continued*

### REMUNERATION GOVERNANCE

A sound governance culture addresses many items including conflicts of interest, risk management and fiduciary duties.

The primary objective of the King III Code of Good Governance is to provide best practice recommendations to enable entities in South Africa to improve their corporate governance practices, which includes and has bearing on the remuneration practices of corporations. The following are the over-riding principles contained in the King III Code of Good Governance that promote sound and effective remuneration governance practices:

i. Principle 2.25. Companies should remunerate directors and executives fairly and responsibly

ii. Principle 2.26. Companies should disclose the remuneration of each individual director and prescribed officer.

iii. Principle 2.27.1 Shareholders should pass a non-binding advisory vote on the company's remuneration policy.

### THE SCHEME'S REMUNERATION GOVERNANCE MODEL

The Scheme adheres to the principles and practices espoused in the King III Code of Good Governance in order to protect all its stakeholders. The objective of the Scheme's Remuneration Governance Model espoused in its Remuneration Policies, is to stipulate the measures and or practices that must be implemented by the Scheme in order to ensure that the efforts and performance of the employees of the Medical Scheme are aligned with the long-term performance of the Scheme and the enhancement of sustainable stakeholder value. Therefore a significant portion of the Scheme's executive employees' total potential remuneration is performance-related.

Furthermore in line with the recommended practices in the King III Code of Good Governance, the Scheme has put in place the necessary governance structures, measures and procedures to ensure that those charged with the fiduciary responsibility of formulating and upholding the provisions of these policies, discharge their duties with due care and skill and are accountable to the Scheme in this regard.

### DELEGATION OF RESPONSIBILITY OF OVERSIGHT OF SCHEME REMUNERATION

The Board of Trustees of the Scheme is responsible for the development and implementation of a Remuneration Policy for the employees of the Scheme, and a Remuneration Policy for the Board of Trustees and Board Committee members of the Scheme. The Board of Trustees shall in turn delegate responsibility for oversight of the Scheme's remuneration practices to the Remuneration Committee.

### THE REMUNERATION COMMITTEE

Remuneration Committees play an important role in ensuring an objective approach to the management of remuneration more specifically executive pay practices. Executive Management is responsible for the day-to-day running of the Scheme with the aim of maximising value for members and stakeholders. One of the key functions of the Board of Trustees is strategic oversight and to review the implementation of strategy by executive management of the Scheme and to ensure that effective mechanisms and controls are in place to protect the interests of the members of the Scheme.

These functions are particularly important where there is potential for unfair influence or conflicts of interest in the setting of executive remuneration.

The Remuneration Committee acts under the delegated authority of the Board of Trustees of the Scheme. The role of the Remuneration Committee is to provide an independent influence on remuneration decisions made in respect of the Board of Trustees and Board Committee members and Employees of the Scheme.

This Committee is constituted of Trustees and independent Board Committee members, which ensures that the work of this Committee is free from conflict, which in turn provides a substantial degree of security for members. The Committee is also assisted by independent remuneration advisors and experts. The role of the Remuneration Committee is to make recommendations to the Board of Trustees regarding the remuneration strategy, policies and practices of the Scheme.

## ADOPTION AND APPROVAL OF THE SCHEME'S REMUNERATION POLICIES

The Scheme has established remuneration policies for the employees, the Board of Trustees and Board Committees.

The objective of the remuneration policies is to provide a legal and policy framework against which all remuneration decisions are made, validated, implemented, approved and reported by the Scheme.

To enable Scheme members to express their views on the Scheme's Remuneration Policy for Trustees, the Trustee Remuneration Policy will be tabled at the Scheme's AGM for a non-binding advisory vote.

The Remuneration policy for employees must be approved by the Board of Trustees, based on the recommendation by the Remuneration Committee.

## MITIGATION OF CONFLICT OF INTERESTS

The King III Code of Corporate Governance advises that the Board of an entity should reflect a balance of power, represented by a majority of Non-Executive Directors. In the case of the Scheme all Trustees are non-executives and therefore 'Independent Trustees'. In accordance with best corporate remuneration governance practices, Trustees hold non-executive status within the Scheme and are therefore in terms of the Scheme's Remuneration Policy not permitted to be paid consulting fees for consulting services rendered or to participate in the Scheme's incentive programme. This ensures that Trustees are able to act independently of any personal interest when making a fiduciary decision for or on behalf of the Scheme.

## MARKET BENCHMARKING

In accordance with the King III Code of Corporate Governance the remuneration of the Board of Trustees, Board Committee members and Employees of the Scheme are benchmarked periodically through independent review. The Scheme's Remuneration Committee uses market trends in professional fees/rates for professionals in the field of law, actuarial science, medicine and commerce for determining Trustee fees and market trends and independent benchmarking of remuneration of positions in the financial services industry, for employees. This provides the Scheme with information relating to market trends in remuneration practices and ensures that the Scheme compensates Trustees and employees in accordance with appropriate market norms.

## DISCLOSURE OF INFORMATION REGARDING REMUNERATION

In accordance with recommended practice in the King III Code of Corporate Governance the remuneration policies for the Board of Trustees of the Scheme shall be disclosed to members at the Annual General Meeting of the Scheme. Also in accordance with recommended practice in the King III Code of Corporate Governance the remuneration of the Board of Trustees shall also be disclosed to the members at the Annual General Meeting of the Scheme and shall be reported on in the Discovery Health Medical Scheme Integrated Report.

This information shall be disclosed at least 21 days prior to the AGM. Furthermore, members and the Council for Medical Schemes are provided with details of how the proposed Trustees and Board Committee member fees were determined as well as the details of the independent external advisors who provided advice to the Remuneration Committee on the structuring of Trustees and Board Committee member fees. These practices have been implemented to increase the Board of Trustees' accountability to members of the Scheme in respect to the decisions that they make on the remuneration policies and practices of the Scheme.

# REMUNERATION POLICY:
## trustees of the Discovery Health Medical Scheme

### PURPOSE OF POLICY

This policy contains a description of the core principles of the Scheme's Remuneration Policy for the Trustees and members of the Board Committees.

This policy also includes the provisions asserted in the Remuneration Guidelines published by the Council for Medical Schemes (Circular 41 of 2014).

### SCOPE OF POLICY

The provisions of this policy are binding on the Board of Trustees and Board Committees.

### POLICY STATEMENT

Significant responsibilities and fiduciary risks are borne by Trustees throughout the year, as well as the fact that all the Trustees and Board Committee members are independent professionals who are required to give up substantial amounts of their time to serve the needs of the Scheme and its members. The Scheme therefore strives to remunerate Trustees and Board Committee members appropriately to ensure that the appropriate skills are attracted and retained in a complex industry.

### THE ROLE OF THE REMUNERATION COMMITTEE

The Remuneration Committee of the Scheme is responsible for recommending to the Board of Trustees and the members of the Scheme the Remuneration Policy, structure and/or fees which the Trustees and Board Committee members are due.

### REMUNERATION OF THE BOARD OF TRUSTEES OF THE SCHEME

Trustees are entitled to remuneration in respect of services rendered in their capacity as members of the Board as determined and recommended by the Scheme's Remuneration Committee, which is reviewed on an annual basis. Trustees are compensated a market-related professional fee commensurate with the level of skill and expertise required in relation to the nature of the duties and concomitant responsibility attributed to the specific role and function of Trustees. The fees take into account the fact that the Scheme is a non-profit entity. Trustees hold non-executive status within the Scheme and are, therefore, in terms of the Scheme's Remuneration Policy not permitted to be paid consulting fees for consulting services rendered. The remuneration of Trustees is limited to a fee and does not include any additional benefits such as participation in the Scheme's incentive programme. This ensures that Trustees are able to act independently of any personal interest in terms of their fiduciary duties.

The total annual fees payable to Trustees is split into an annual base fee (70%) and a fee per meeting (30%). This recognises the ongoing responsibility of Trustees for the efficient control of the Scheme. The annual base fee is paid quarterly in arrears. The Scheme does not pay Trustees any remuneration or fees for attending conferences or training events over and above the training provider's fees and travel, accommodation and subsistence costs. It is the view of the Scheme that attending a conference or training event is sufficient reward.

### REMUNERATION OF BOARD COMMITTEE MEMBERS

Board Committee members shall be compensated a market-related fee commensurate with the level of skill and expertise required in relation to the nature of the duties and concomitant responsibility attributed to the specific role and function of the Board Committee of which he/she is a member, taking into account the fact that the Scheme is a non-profit entity.

## CALCULATION OF THE REMUNERATION OF TRUSTEES AND BOARD COMMITTEE MEMBERS

The Trustees' and Board Committee members' remuneration is based on a professional fee (based on an hourly rate paid) for professionals who are suitably skilled and qualified to serve as Trustees, discounted at an applicable rate to take into account the fact that the Scheme is a non-profit entity. Professional fees are based on the market-related fees charged by professionals in the field of law, actuarial science, medicine and commerce and will be benchmarked and adjusted annually. The total remuneration paid to Trustees and Board Committee members are determined by the following elements:

- Number of meetings per year.
- Preparation time for each meeting.
- Duration of meetings.
- Ad-hoc time required by the Chairperson of the Board of Trustees or Board Committees in the execution of his/her duties.
- A discount applied to the professional fee for being a non-profit entity.

## PARTICIPATION IN INCENTIVE PROGRAMMES

Trustees and Board Committee members are not permitted to participate in the Scheme's incentive reward programmes.

## REIMBURSEMENTS

Members of the Board of Trustees may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as a Trustee, which shall include but not be limited to travel outside of the Johannesburg Metropolis or Gauteng. In order to be reimbursed for travel expenses the Trustee must complete a Reimbursement Claim Form and submit the original tax invoices of the travel expenses he/she is claiming.

## MARKET BENCHMARKING

In accordance with the King III Code of Corporate Governance the remuneration of Trustees and Board Committee members are benchmarked periodically through independent review. The Scheme's Remuneration Committee uses market trends in professional fees/rates for professionals in the field of law, actuarial science, medicine and commerce for determining Trustee and Board Committee member fees. This provides the Scheme with information relating to market trends in remuneration practices and ensures that the Scheme compensates Trustees and Board Committee members in accordance with appropriate market norms. The benchmarked professional fees will be discounted to recognise the non-profit status of medical schemes.

## APPROVAL OF TRUSTEES' AND BOARD COMMITTEE MEMBERS' REMUNERATION

The Scheme's Trustee remuneration for each financial year going forward is reviewed and recommended by the Remuneration Committee to the Board of Trustees for provisional approval and thereafter should be approved through a vote by members at the AGM of the Scheme. The Scheme's members and the Council for Medical Schemes shall be provided with the required information pertaining to the proposed remuneration of the Board of Trustees and Board Committee members at least 21 days prior to the AGM.

## DISCLOSURE OF TRUSTEES' AND BOARD COMMITTEE MEMBERS' REMUNERATION

The principles of maximum transparency and disclosure regarding remuneration are endorsed by the Scheme. The members of the Board of Trustees shall disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the Scheme. Furthermore, the remuneration of the Trustees and Board Committee members shall also be disclosed to members of the Scheme and shall be reported on in the Discovery Health Medical Scheme Integrated Annual Report.

The CMS and members shall also be provided with details of how the proposed Trustees' and Board Committee members' fees were determined, as well as the details of the independent advisers who provided advice to the Remuneration Committee on the structuring of Trustees' and Board Committee members' fees.

## REMUNERATION PAYMENT PROCEDURES

All fees shall be paid directly to the Trustee into his/her bank account, the details of which are to be provided by the Trustee to the Scheme Secretary.

## APPLICATION OF TRUSTEE LIABILITY INSURANCE

The Scheme must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

# REGULATORY AND INDUSTRY MATTERS DEALT WITH IN 2016

## → CIRCULAR 68 OF 2015

*The review of the solvency framework.*

The CMS has commenced research into the design and potential impact of a new risk-based solvency framework. During 2016, DHMS provided comment to the CMS on the proposed Risk Based Capital Framework, as set out in Circular 68 of 2015. In November 2016, the CMS held two workshops in this regard, and subsequently invited stakeholders to participate in any of four working groups established to deal with business risk, asset risk, operational risk and the implementation of the new framework. The Scheme has identified and proposed participants to the CMS, and awaits confirmation.

## → CIRCULARS 20 OF 2015 AND 59 OF 2016

*Notice of intention to publish undesirable business practice declaration in terms of section 61 (2) of the Medical Schemes Act, 1998 (Act No 131 of 1998).*

The CMS issued Circular 20 of 2015 on 13 March 2015 which notified medical schemes that the Registrar had published a notice in the Government Gazette of his intention to declare certain business practices undesirable, and requested written representations in response. The practices described in the Circular related to the manner of use of branding, logos and names of medical schemes. The Scheme submitted comments to the CMS on 28 April 2015, and the CMS subsequently issued Circular 59 of 2016 regarding schemes and administrators that share some degree of branding. The Scheme's submitted comments on this Circular on 13 September 2016 and awaits a response from the CMS.

## → CIRCULARS 29 AND 36 OF 2015 AND CIRCULAR 37 OF 2016

*Draft Undesirable Business Practice Declaration in terms of Section 61 (2) of the Medical Schemes Act, 1998 (Act No 131 of 1998).*

Circular 29 of 2015 was issued by the CMS on 17 April 2015 and notified that the Registrar had published a notice in the Government Gazette of his intention to declare certain business practices undesirable. The practices discussed in the Circular relate to the election and voting processes followed by schemes. In response to requests from the industry, the CMS subsequently published Circular 36 of 2015 on 10 April 2015. In 2016 the CMS issued Circular 37 of 2016 in which it referred to Notice 305 of 2016 published in Government Gazette 40022. This 2016 notice replaced the 2015 notices. The Scheme submitted its representations in this regard on 8 July 2016 and awaits a response from the CMS.

## → CIRCULAR 47 OF 2016

*Ministerial Directive on the Establishment of a Beneficiary Registry.*

Circular 47 of 2016 issued by the CMS on 15 July 2016 set out that the CMS had been tasked, in the form of a directive from the Minister of Health, with the responsibility of collecting medical scheme member information for the purposes of monitoring the impact of current policies and identifying medical scheme members who access services in the public sector. The directive requires all medical schemes, administrators and regulated private healthcare funding entities to furnish the CMS with regular updated records pertaining to the basic and demographic details of all members and their beneficiaries.

The CMS subsequently held industry workshops for the purpose of presenting and discussing the data specification and collection process, and to address security concerns relating to the collection and storage of data. The Scheme was represented at these forums.

An Information Technology Advisory Group (ITAG) consisting of four work streams was constituted to examine processes required with regards to IT security, data collection, data specification and legal and governance relating to the Beneficiary Registry. The Health Funders Association (HFA) a body representing the industry, and of which the Scheme is a member, participates in the ITAG.

## → CMS INSPECTION

As detailed in the CMS Annual Report 2013-2014, the CMS in December 2013 appointed an Inspector to conduct an investigation into the DHMS Trustee election process conducted in 2013. The Scheme cooperated fully with the Inspector during the process, which commenced in 2013 and continued into 2014. In 2016, the inspection matter was resolved to the satisfaction of all parties and was closed by the CMS.

## → COMPETITION COMMISSION MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

The Competition Commission Health Market Inquiry (HMI) seeks to determine whether there are aspects of the South African private healthcare sector market which distort, restrict or prevent competition. The Scheme supports the inquiry and cooperates fully and extensively with the HMI Panel. The date for publishing the HMI report and its recommendations has been extended to December 2017.

The CMS' Circulars are available at **www.medicalschemes.com/Publications.aspx**.

## → NATIONAL HEALTH INSURANCE

The South African Constitution, in Chapter 2 of the Bill of Rights, Section 27, provides that all citizens have the right of access to healthcare. In accordance with this principle, the Department of Health published a Green Paper on National Health Insurance (NHI) in 2011, and received comments from all stakeholders including the Scheme. The paper is based on the premise that a central NHI Fund will be established that will procure healthcare services from both the public and private sectors. In December 2015, the NHI White Paper was released and the Scheme submitted its comments by the deadline of 31 May 2016. The Scheme has subsequently been engaging in work streams regarding the NHI where invited to do so.

## → SCHEME RULES AND NON-DISCLOSURE

The 2016 Scheme Rules were submitted to the CMS at a meeting held for this purpose on 17 September 2015. The CMS did not approve certain sections of the Rules, being Rule 11, Rule 14.7, and the income definition as contained in Rule 4.39. The definition of income was amended in accordance with CMS requirements and as a result, the KeyCare 290 income band was closed for new membership in July 2016, and the plan option closed permanently in December 2016.

During the course of 2016, the Scheme appealed the non-registration of Rule 11 in terms of Section 49 and subsequently Section 50 of the Medical Schemes Act (the Act). Rule 11 deals with the prevention of members re-joining the Scheme immediately after committing fraud or deliberate non-disclosure against the Scheme; the Scheme believes that in order to protect the greater membership, such members should be prohibited from re-joining the Scheme for a certain time period. The Scheme was unsuccessful in both appeals, and is currently reviewing its options in this regard.

Scheme Rule 14.7 remains unregistered by the CMS, pending an appeal in terms of Section 49 of the Act. Rule 14.7 deals with the rejection of claims from providers where they have placed the Scheme at risk. In this regard the concern of the Scheme relates to fraudulent or illegal behaviour.

The registration of the proposed 2017 Scheme Rules by the CMS, which were submitted to the CMS on 15 September 2016, is awaited.

The Scheme Rules are available to registered users at **www.discovery.co.za/medical-aid/scheme-rules.**

## → REVIEW OF PMB BENEFITS AND CARE

When the Prescribed Minimum Benefits (PMB) Code was established in 2010, it was acknowledged that a coordinated, consultative process to develop benefit definitions to improve the clarity of the entitlement that members have, and the liabilities that schemes face, in respect of the PMB provisions in the Act and regulations would need to take place.

Circulars 83 of 2016 and 1 of 2017, issued by the CMS, propose a review of the PMBs. The Scheme has submitted a response that includes suggestions on the design of the review process, entailing broader representation and participation of stakeholders to obtain a more robust formulation and greater clarity of the healthcare reforms and their impact.

A key consideration in this process is the coordination and alignment of various regulatory processes that impact reform in the healthcare sector. It is important that there be more certainty for all participating stakeholders on the intended purpose of the PMB review in relation to, for example, the NHI and the HMI processes. This will enable a more robust formulation, and provide more clarity of the healthcare reforms and their impact on medical schemes. The Scheme will continue to participate actively in relevant forums.

## → WAITING PERIODS IN RESPECT OF RELATED CONDITIONS

During the course of 2016, two cases relating to the Scheme's right to apply waiting periods for conditions related to a condition that has been disclosed when a new member applies to join the Scheme, were heard by the Appeal Board in accordance with Section 50 of the Act. The outcome of both cases was that a medical scheme is permitted to apply waiting periods relating to both the conditions disclosed by the incoming member, and also those which are directly related to them. This ruling has implications for the underwriting processes of the Scheme.

# 05 Performance

# OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR

"In 2016, the Discovery Health Medical Scheme demonstrated its ability to weather difficult conditions and manage unexpected events. As the largest and most innovative open medical scheme in South Africa, I believe the Scheme is best placed to continue providing access to affordable, equitable and quality healthcare that meets the needs of our members now and into the future."

The economic and industry challenges of 2016, experienced during the last of my eight-year tenure as Principal Officer, tested the agility and resilience of the Scheme's highly innovative Vested outsourcing business model. The Scheme responded effectively and timeously to the confluence of tough local economic conditions and industry-specific adverse events and challenges, which threatened the long-term sustainability of the private healthcare funding industry.

The global context for the Scheme's challenges included extreme economic volatility and significant socio-political shifts felt worldwide. From Brexit in the UK to the US presidential elections, the implications of rising nationalism, protectionism and intolerance promise to be far-reaching.

While at times South Africa feels remote, our relatively small formal economy and developing society are highly sensitive to this global turbulence. Moreover, slow economic growth, the implications of the downgrades in the country's credit rating and policy inconsistency, added to the intractable social problems of inequality and poverty, make for an exceptionally tough domestic economic environment.

Looking back at the year, besides the economic indicators, from the first quarter of 2016, the Scheme experienced significant increases in the utilisation of healthcare services, especially in terms of hospital admission rates and benefits. As medical schemes price their contributions in August of every benefit year for the coming year, based on projected and expected funding requirements, there is limited scope for schemes to respond to such unexpected deviations within a benefit year.

In the context of the Scheme's Vested outsourcing business model, which entails active innovation and collaboration between the Scheme and Discovery Health, its Administrator and Managed Care Provider, this potential threat was effectively mitigated and managed without compromising access to or quality of care. Any possible implications for our members were extensively communicated and individual members were assisted in ensuring optimal cover for their care.

Discovery Health, through their world-class analytics capabilities and big data informatics, performed extensive early root cause analyses and mapped the unprecedented increase in utilisation of healthcare services to specific drivers. One of the major contributors was a significant increase in hospital admission rates emanating from several new private hospitals, as well as increases in admission rates at certain established hospitals. The effect on the Scheme, and the industry as a whole, was a significant increase in costly hospital claims.

This impact was felt across open and closed medical schemes in the industry, resulting in some media coverage on the financial state and sustainability of the private healthcare funding industry. The Scheme and Discovery Health also interacted with the Council for Medical Schemes (CMS) and the Competition Commission's Healthcare Market Inquiry (HMI) Panel on the matter.

Against this backdrop, management expected an operating loss compared to budget for the 2016 benefit year. However, the thorough measures put in place by Discovery Health, on behalf of the Scheme, to contain costs while ensuring quality of care and managing the utilisation of healthcare services, were highly effective in protecting members' funds and the financial performance of the Scheme.

That we were able to report a positive operating result of R102 million, investment income (net of return on savings trust assets) of R1 201 million, and a net surplus of R1 305 million for the 2016 year demonstrated that the Scheme has the scale, agility and resilience necessary to manage and withstand unpredictable market conditions. This justifies the trust that our 2.7 million beneficiaries place in the Scheme to fund and facilitate their access to affordable, equitable and quality private healthcare.

Ultimately, it is the quality of the Scheme's relationship with all its stakeholders that supports its ability to fulfil its value proposition and promise to members, while remaining sustainable in the long term. This, in turn, underpins effectiveness, efficiency and viability of the private healthcare ecosystem of which the Scheme is a significant part and contributor. As such, the Scheme will remain committed to balancing the needs and expectations of all its stakeholders in line with its primary objective of providing sustained high value to its members.

It has been a real privilege serving the members of the Discovery Health Medical Scheme over the last eight years. I leave the management of the Scheme in the capable hands of Dr Nozipho Sangweni, who has been a member of the Scheme's governing body and a colleague for several years. Dr Sangweni takes the helm as Principal Officer from 1 January 2017. She does so in challenging times for the Scheme and the industry, as the focus on accessibility, affordability, quality and sustainability of private healthcare becomes ever more important in South Africa. I believe the Scheme has the leadership, the partnerships and the track record to ensure continued value for our members, our other stakeholders and society in general.

My sincere gratitude and thanks are due to the Chairman of the Board of Trustees, Mr Michael van der Nest; the Board of Trustees; the Board Committees; the executive management team; and our counterparts at Discovery Health for their support over the years in what has been an incredibly exciting and meaningful journey in my healthcare career.

MILTON STREAK
**PRINCIPAL OFFICER**

## A word from our new Principal Officer

I am honoured and excited to be taking the helm at Discovery Health Medical Scheme and look forward to a new era, where we are able to leverage the solid market position, resilience, agility and adaptive capabilities of DHMS to continue to withstand economic uncertainty and pressures, for the health and wellness of our members.

The world-class governance structures and practices of the Scheme, combined with the extensive capabilities of Discovery Health, provide me with a solid foundation.
I look forward to working with the industry through the Health Funders Association, the industry representative body of which the Scheme is a member, and to continuing and growing the positive and cooperative working relationships we have with our regulators, most importantly the CMS, to the benefit of the South African healthcare system.

> I am honoured and excited to be taking the helm at **Discovery Health Medical Scheme**

In line with our statements of purpose and vision, and the values that guide our conduct and interactions as a matter of course, we will continue to focus on our most important stakeholders, our members, by understanding their economic and health challenges. We must take a significant step forward to deepen our competitive advantage, through innovation and in the continued pursuit of excellence, in order to generate value for our members and safeguard their continued access to quality, outcomes-based healthcare.

My thanks to Mr Milton Streak for his many years of dedication to the Scheme, and together with my colleagues, we wish him well in his future endeavours.

DR NOZIPHO SANGWENI
**PRINCIPAL OFFICER AS OF 01 JANUARY 2017**

# Overview

Discovery Health Medical Scheme delivered a positive net healthcare result of R102 million for the year ended 31 December 2016 (2015: R507 million). The year-on-year decrease in the operating result was mainly attributable to medical inflation and increased utilisation of benefits. Despite difficult investment markets, the Scheme generated healthy investment income of R1 257 million (2015: 1 019 million) contributing to the net surplus for the year of R1 305 million (2015: R1 276 million).

This solid financial performance increased members' funds to R14.2 billion (2015: R12.9 billion) with a solvency level of 26.33% (2015: 25.98%). The Scheme's financial strength and ability to pay claims was once again confirmed with a credit rating of AA+, the highest possible rating in the industry, from independent credit rating agency, Global Credit Rating Co (GCR).

**16** Benefit options (2015: 15)

**6** Network efficiency discount options* (2015: 6)

**EXECUTIVE SERIES**
- Executive

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

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

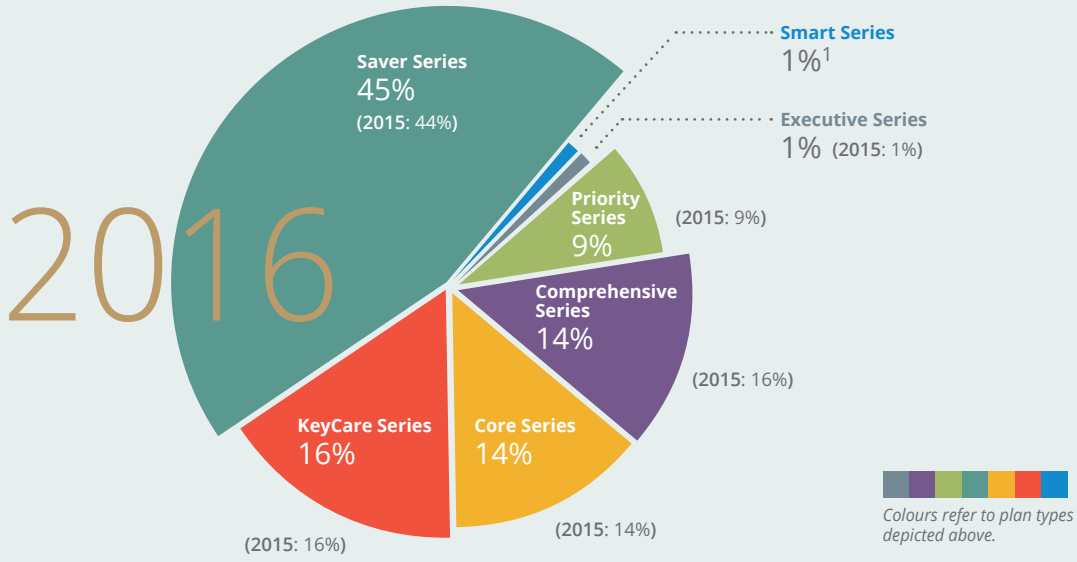
**SAVER SERIES**
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta* Saver
- Essential Delta* Saver

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

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

**SMART SERIES**
- Smart

## Distribution of scheme beneficiaries on various plans




1 *Launched in 2016.*

# Gross contribution income

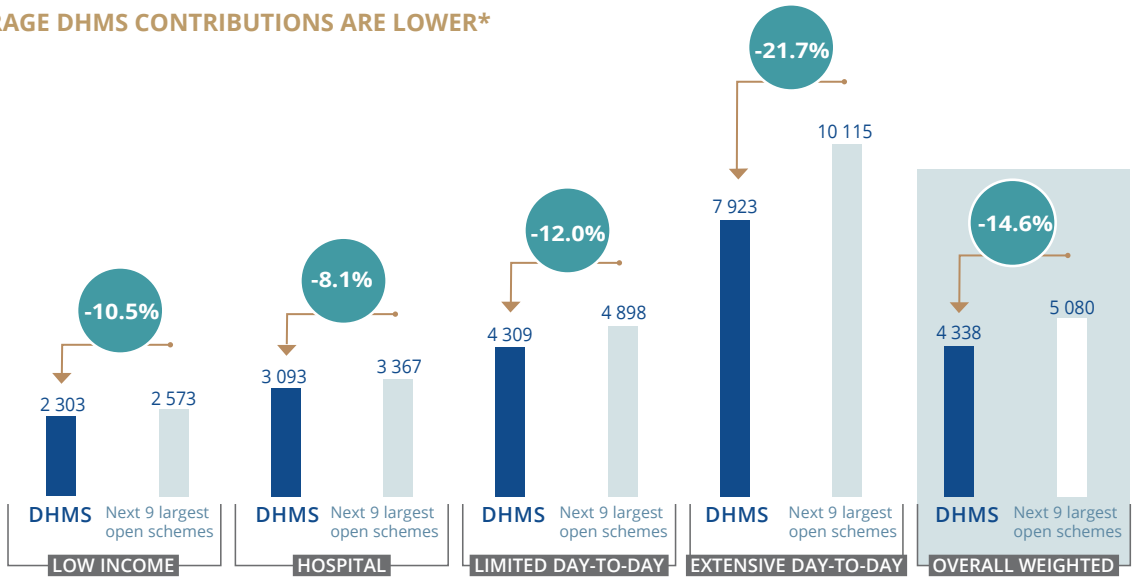
Maintaining the balance between competitive contributions, providing affordable quality healthcare to our members and meeting regulatory reserve requirements remains a challenge.

However, the Scheme remained competitive with average contributions in 2016 being 14.6% lower* (based on the rate for a principal member plus one adult beneficiary and one child beneficiary) than the next nine open schemes by size, largely due to its ability to contain the impact of medical inflation. The Scheme's competitiveness was reflected in average net membership and beneficiary growth of 2.45% and 1.71% respectively.

That 87% of contributions received are used for members' direct benefit by funding claims and reserves (to meet regulatory solvency requirements) demonstrates the Scheme's commitment to its members and its high levels of efficiency. The remainder is utilised to fund activities for the support and benefit of members such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

Gross contribution income rose 8.63% to R54.1 billion (2015: R49.8 billion), driven by the 8.6% headline increase in 2016 contributions and net growth in average Scheme membership of 2.45%. The most significant net membership growth was recorded in the mid to low tier options, where the Saver series and newly launched Smart plan recorded net membership growth of 27 321 and 11 807 respectively. The Comprehensive series experienced the largest decline in principal membership of 12 439.

## AVERAGE DHMS CONTRIBUTIONS ARE LOWER*



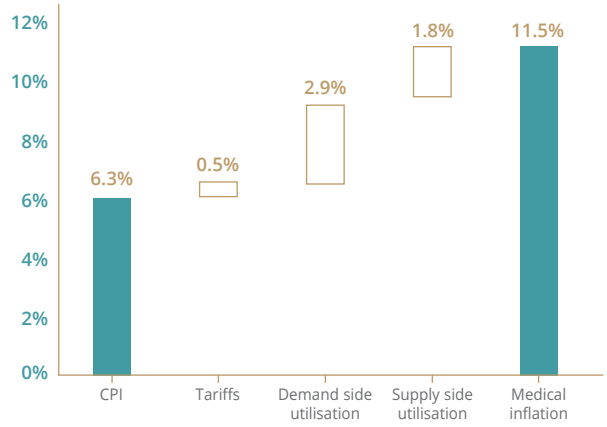

* *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a family unit comprising one principal member, one adult and one child dependant (a family of three). These average contributions are then weighted (for DHMS and the next nine largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the discount that a typical member of another scheme would earn by moving to DHMS.*

# Net claims incurred

Net claims incurred increased 10.4% to R36.6 billion (2015: R33.2 billion).

Escalating healthcare costs remain of concern to medical schemes with healthcare inflation consistently well above CPI. The main drivers of healthcare inflation are tariff increases and higher utilisation of healthcare services due to demand side and supply side effects. Supply side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare; and demand side utilisation pertains to the deterioration in the demographic profile of beneficiaries, specifically a higher ratio of older and ailing members who need more, higher priced healthcare services. A summary of the composition of medical inflation (annualised over the period 2008 to 2016) is illustrated in the diagram alongside.

**Average annualised inflation rate (2008 – 2016)**




Despite these cost pressures, the Scheme was able to contain the gross claims ratio to 87% (2015: 86%) due to robust risk management interventions implemented by the Administrator.

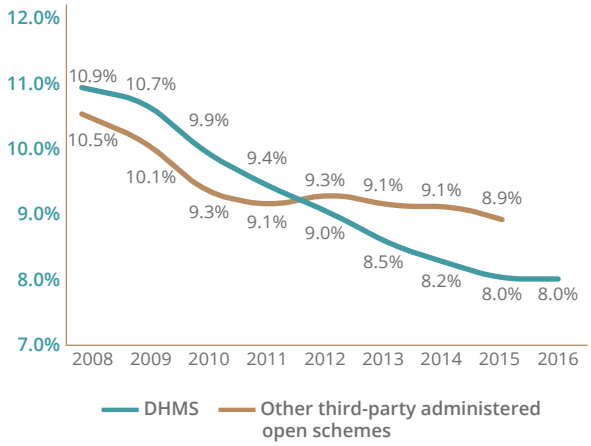
# Gross administration expenditure

Gross administration expenditure consists of administration fees paid to the Administrator and other operational Scheme expenditure.

The most significant component of gross administration expenditure is administration fees paid to the Scheme's Administrator, Discovery Health. The gross increase in administration fees of 7.1% to R4.2 billion (2015: R3.9 billion) was attributable to the administration fee per member rate increase and net growth in average Scheme membership of 2.45%. The administration fee per average member per month (pampm) increased by only 4.5% from R258.73 to R270.49, as significant scale-related administration fee discounts continued to contain increases to below CPI.

The graph alongside depicts the continued decrease in gross administration expenses as a percentage of gross contribution income, compared to the average third-party administered open scheme competitor.

**Gross administration expenditure as % of gross contribution income**




A Scheme analysis of the CMS Annual Report 2015–2016 shows that at R125.23 for 2015, DHMS continued to rank below the average gross administration expenditure per average beneficiary per month (pabpm) for open schemes, which was R127.54 (or R130.27 excluding the Scheme). This ranks the Scheme 9th lowest out of 23 open schemes.

# Accredited managed care services costs

The increase in accredited managed care services costs of 7.8% to R1.4 billion (2015: R1.3 billion) was attributable to both the accredited managed care costs per member per month rate increase, and growth in average Scheme membership of 2.45%.

Managed care costs pampm increased, at a rate below CPI, by 5.2% from R87.19 to R91.72. However, managed care costs as a percentage of gross contribution income continued to decline with the 2016 ratio at 2.60% (2015: 2.62%).

The Scheme analysis of the CMS Annual Report 2015–2016 shows that DHMS had a managed care cost pabpm of R40.86 compared to the average of R37.53 among open schemes (average of R33.52 when the Scheme is excluded). Although the pabpm managed care costs may appear more expensive relative to other open schemes, it does not consider the breadth of managed care services offered, or the claims cost savings generated by the managed care services. In 2015, claims cost savings of R136.29 pabpm were realised through claims review processes, implemented protocols, price negotiations and drug utilisation reviews. This equates to a saving of R3.33 for every Rand paid in managed care costs – an exceptional return on investment of 233%.

# Investment results

The Scheme's investment portfolio is suitably diversified and managed with the aim of optimising returns within its approved risk appetite. Asset allocation is managed and monitored from an asset/liability perspective, 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 Scheme assets are invested in money market and cash investments, with smaller allocations to bonds (local and foreign) and equities.

The volatility in the 2016 year, precipitated by shock results in both the Brexit referendum and the US election, challenged the local equity market with the FTSE/JSE All Share Index returning a mere 2.6% for the year (2015: 5.1%). The Rand bucked its historic trend, appreciating 11.5% against the US Dollar (2015: 35% depreciation against the US Dollar). The bond market (ALBI JSE All Bond Composite Index) redeemed itself with a 15.5% return in 2016 from a dismal showing in 2015 (negative 3.9% return). Cash (STeFI Index) returned around 7.4% for 2016.

Despite the difficult market conditions, the Scheme managed an overall investment return of 8.79% for 2016 (2015: 6.01%).

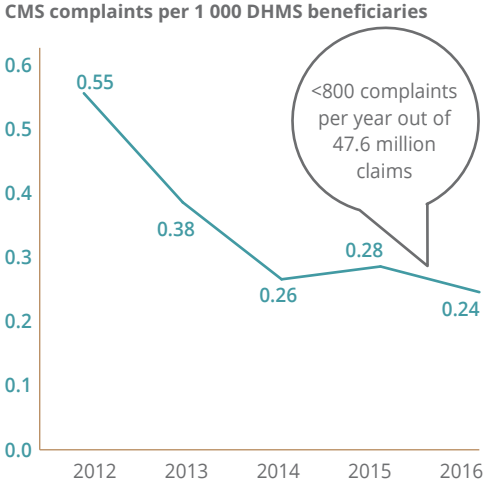
# Member disputes and appeals

Given the Scheme's approximately 55% market share (covering more than 2.7 million beneficiaries), the reduction in complaints received is a source of great pride for the Scheme. We believe our strong focus on our members as the Scheme's primary stakeholders supported this achievement.

In 2016, the CMS received an average of 0.24 complaints per 1000 lives covered by the Scheme, an improvement from the 0.28 complaints per 1000 lives recorded during 2015, shown in the graph alongside. In an effort to deal with member disputes in a prompt and equitable manner, the Scheme expanded its Disputes Committee to comprise four practicing attorneys and three medical doctors. This additional capacity allowed it to convene more than once a week, which it had previously been limited to. During the year, 773 (2015: 738) complaints were lodged with the CMS in terms of Section 47 of the Medical Schemes Act (the Act).

See more about how to lodge complaints or disputes on **page 155**.

**CMS complaints per 1 000 DHMS beneficiaries**




# Solvency

The Medical Scheme Act (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) of the Act.

At 31 December 2016, the Scheme's solvency level of 26.33% (2015: 25.98%) of gross annual contributions was R719 million (2015: R488 million) more than the statutory solvency requirement.

| Calculation of regulatory capital requirement | 31 December 2016 R'000 | 31 December 2015 R'000 |
|---|---|---|
| Total members' funds | **14 234 461** | 12 929 011 |
| Less cumulative net gain on re-measurement of investments | **–** | – |
| Total net assets (Regulation 29) | **14 234 461** | 12 929 011 |
| Gross annual contributions | **54 056 212** | 49 759 756 |
| Solvency ratio | **26.33%** | 25.98% |
| Average accumulated funds per member at year end | **R10 971** | R10 360 |

# Prudent financial management

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

| | 31 December 2016 R'000 | 31 December 2015 R'000 |
|---|---|---|
| Gross annual contributions | **54 056 212** | 49 759 756 |
| Total outstanding contributions, excluding December | **24 258** | 16 378 |
| % outstanding | **0.04%** | 0.03% |

# Due application of the Scheme Rules

The Board of Trustees keeps a constant check on appropriate and consistent application of the Scheme Rules in relation to beneficiary entitlement and healthcare provider reimbursements. This check is an integral component of the Board's fiduciary responsibility.

# Ensuring statutory and regulatory compliance

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

# Matters of non-compliance for the year ended 31 December 2016

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

During the year, the Scheme did not comply with the following Sections and Regulations of the Act.

### ▶ STATUTORY SCHEME SOLVENCY

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

During 2016, the Scheme's solvency level dropped below 25% during January and November. In January, the drop was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year). In November, the drop was due to a negative claims experience in line with historic trends.

At 31 December 2016, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 26.33% (2015: 25.98%), exceeding the statutory solvency requirement of 25%.

### ▶ SUSTAINABILITY OF BENEFIT PLANS

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

For the year ended 31 December 2016 the following plans did not comply with Section 33 (2):

| Benefit plan | Net healthcare result (R'000) | Net surplus/ (deficit) (R'000) |
|---|---|---|
| Executive | (350 528) | (341 248) |
| Classic Comprehensive | (872 500) | (741 888) |
| Classic Comprehensive Zero MSA | (2 040) | (1 072) |
| Coastal Saver | (184 640) | (31 011) |
| Coastal Core | (32 915) | 67 366 |
| KeyCare Plus | (579 629) | (314 518) |

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

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

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

### ▶ INVESTMENT IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a) and (c) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs across the industry. The CMS granted DHMS an exemption from these sections of the Act up to 21 April 2018.

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

### ▶ INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE SOUTH AFRICA

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

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

During August and September, a breach of the Scheme's foreign derivative exemption (Category 7 (b) of Annexure B) occurred when the Investec Target Return Bond Fund (collective investment scheme) derivative exposure was greater than 2.5% due to large foreign exchange fluctuations that occurred because of Brexit. The breach was rectified on 21 September 2016. This was duly reported to the CMS on 26 October 2016. It should be noted that despite the recorded breach at the individual fund level, the fair value of the Scheme's total offshore derivative exposures was only 0.19% of the aggregate fair value of Scheme liabilities and minimum accumulated funds at 31 August 2016.

### ▶ CONTRIBUTIONS RECEIVED AFTER DUE DATE

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

The Scheme applies robust credit control processes to deal with the collection of outstanding contributions, including the suspension of membership for non-payment.

### ▶ BROKER FEES PAID

In terms of Regulation 28 (5) of the Act, broker fees shall be paid monthly 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 0.02% 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.

### ▶ CLAIMS PAID IN EXCESS OF 30 DAYS AFTER RECEIPT

Section 59 (2) of the Act requires a medical scheme to pay a member or a supplier of a service any benefit owing to them within 30 days after the day on which the claim in respect of the benefit is received by the medical scheme.

During the process of transitioning to a new claims administration platform, quality assurance processes were significantly extended to ensure valid, accurate and complete processing of claims on the new claims administration platform. This process resulted in a delay in the processing of claims payments. A total number of 34 claims were identified that were paid later than 30 days after the claims notification date. The value of exceptions should be considered in the context of net claims incurred of R36.6 billion during 2016. Exceptions identified pertained to a specific event i.e. the transition to the new claims administration platform and thus no further action is required. The claims administration platform is set up to ensure payments occur within regulatory requirements.

## Reserve accounts

Movements in reserve accounts are set out in the Statement of Changes in Funds and Reserves on **page 92**.

## Outstanding claims

Movements in the outstanding claims provision are set out in Note 6 to the Annual Financial Statements on **page 104**.

## Personal Medical Savings Accounts

The Personal Medical Savings Account (PMSA) enables members to manage day-to-day healthcare expenses. Members pay an agreed sum of 0%, 15% or 25% of the gross contributions, depending on their plan choice, into this savings account. The Scheme advances the full annual amount to members for immediate use, although members only contribute monthly. The PMSA provides a variety of benefits to members for medical expenses outside hospital, such as day-to-day medicines, visits to GPs and specialists, dental care and optometry.

The balance remaining in the PMSA at the end of each calendar year is carried over to the following year for the benefit of the member.

The Scheme's liability to members in respect of the PMSA is reflected as a current liability in the Annual Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act. These funds are invested separately from the Scheme's assets and are managed by two independent asset managers, Taquanta and Aluwani. The average interest earned on these funds was 7.64% in 2016 (2015: 6.91%).

## Going concern

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

## Auditor independence

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

# Operational statistics per benefit plan

for the year ended 31 December 2016

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

| 2015 | Executive | Classic Comp | Classic Core | Classic Saver | Classic Priority | Essential Comp | Essential Core | Essential Saver | Essential Priority | Coastal Saver | Coastal Core | KeyCare Plus | KeyCare Core | KeyCare Access | Classic Comp Zero MSA | Smart** | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of members at the end of the accounting period | 11 262 | 163 889 | 54 057 | 258 175 | 100 080 | 20 388 | 35 434 | 97 816 | 8 344 | 181 052 | 87 022 | 229 510 | 14 854 | 5 241 | 753 | | **1 267 877** |
| Number of beneficiaries at the end of the accounting period | 25 149 | 376 774 | 115 775 | 565 252 | 230 166 | 40 810 | 74 106 | 205 605 | 17 651 | 412 879 | 191 498 | 403 636 | 23 320 | 7 531 | 1 700 | | **2 691 852** |
| Average number of members for the accounting period | 11 468 | 167 127 | 53 274 | 255 914 | 101 008 | 20 783 | 33 075 | 93 255 | 8 444 | 179 275 | 85 046 | 219 615 | 14 083 | 4 913 | 751 | | **1 248 031** |
| Average number of beneficiaries for the accounting period | 25 698 | 385 422 | 114 418 | 559 621 | 231 898 | 41 770 | 69 820 | 197 093 | 17 798 | 409 467 | 187 726 | 387 746 | 22 132 | 7 152 | 1 685 | | **2 659 446** |
| Average risk contributions per member per month (R') | 6 037 | 4 800 | 2 759 | 2 633 | 3 308 | 4 182 | 2 192 | 2 203 | 2 990 | 2 224 | 2 136 | 1 443 | 1 219 | 872 | 4 805 | | **2 675** |
| Average risk contributions per beneficiary per month (R') | 2 694 | 2 081 | 1 285 | 1 204 | 1 441 | 2 081 | 1 039 | 1 042 | 1 419 | 974 | 968 | 818 | 776 | 599 | 2 141 | | **1 255** |
| Average net claims incurred per member per month (R')* | 7 927 | 4 660 | 1 915 | 1 902 | 2 617 | 3 353 | 1 457 | 1 355 | 1 843 | 1 820 | 1 679 | 1 360 | 541 | 425 | 4 406 | | **2 214** |
| Average net claims incurred per beneficiary per month (R')* | 3 538 | 2 021 | 892 | 870 | 1 140 | 1 668 | 690 | 641 | 874 | 797 | 760 | 771 | 344 | 292 | 1 963 | | **1 039** |
| Average administration costs per member per month (R') | 285 | 285 | 285 | 285 | 285 | 285 | 285 | 285 | 285 | 285 | 285 | 153 | 82 | 98 | 285 | | **259** |
| Average administration costs per beneficiary per month (R') | 127 | 124 | 133 | 130 | 124 | 142 | 135 | 135 | 135 | 125 | 129 | 87 | 52 | 68 | 127 | | **121** |
| Average managed care: Management services per member per month (R') | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | | **87** |
| Average managed care: Management services per beneficiary per month (R') | 39 | 38 | 41 | 40 | 38 | 43 | 41 | 41 | 41 | 38 | 40 | 49 | 55 | 60 | 39 | | **41** |
| Average family size at 31 December | 2.23 | 2.30 | 2.14 | 2.19 | 2.30 | 2.00 | 2.09 | 2.10 | 2.12 | 2.28 | 2.20 | 1.76 | 1.57 | 1.44 | 2.26 | | **2.12** |
| Loss ratio (%) | 133% | 99% | 73% | 76% | 82% | 83% | 70% | 65% | 65% | 86% | 83% | 99% | 52% | 64% | 95% | | **86%** |
| Total non-healthcare expenses as a percentage of risk contributions (%) | 6% | 8% | 13% | 14% | 11% | 9% | 16% | 16% | 12% | 17% | 17% | 14% | 11% | 16% | 8% | | **13%** |
| Average non-healthcare expenses per member per month (R') | 377 | 378 | 362 | 371 | 377 | 378 | 356 | 362 | 372 | 368 | 357 | 208 | 131 | 139 | 374 | | **338** |
| Average non-healthcare expenses per beneficiary per month (R') | 168 | 164 | 168 | 170 | 164 | 188 | 169 | 171 | 177 | 161 | 162 | 118 | 83 | 95 | 167 | | **158** |
| Average age of beneficiaries (years) | 42.49 | 39.74 | 38.54 | 32.19 | 35.94 | 44.59 | 35.93 | 30.71 | 35.20 | 32.98 | 36.78 | 28.68 | 34.17 | 30.43 | 38.15 | | **33.86** |
| Pensioner ratio (beneficiaries over 65 years) | 19% | 15% | 14% | 6% | 10% | 24% | 10% | 5% | 10% | 6% | 11% | 5% | 10% | 5% | 12% | | **9%** |
| Average relevant health care expenses per member per month (R') | 8 043 | 4 774 | 2 002 | 1 989 | 2 704 | 3 464 | 1 544 | 1 442 | 1 930 | 1 907 | 1 766 | 1 436 | 628 | 560 | 4 543 | | **2 304** |
| Average relevant health care expenses per beneficiary per month (R') | 3 590 | 2 070 | 932 | 910 | 1 178 | 1 724 | 731 | 682 | 916 | 835 | 800 | 813 | 400 | 385 | 2 024 | | **1 081** |
| Net surplus/(deficit) per benefit plan (R'000) | (320 737) | (601 499) | 285 423 | 993 912 | 336 804 | 97 722 | 136 190 | 504 202 | 74 927 | (84) | 65 198 | (394 861) | 86 251 | 13 236 | (544) | | **1 276 140** |

* *See note 13 to the Annual Financial Statements for explanatory note on change of disclosure.*
** *The Smart Plan was introduced in 2016.*

# DISCOVERY HEALTH'S INITIATIVES FOR THE SCHEME

Discovery Health's vision of an integrated, value-driven healthcare system, centred on the needs of members, has led to the development of its business model that integrates wellness, quality of care and technology into a cohesive and sustainable healthcare system.

## Discovery Health's business model


Discovery Health's vision for the Scheme is that current and potential members see the Scheme as providing far more than commoditised medical scheme benefits, and as delivering an integrated healthcare system that ensures that Scheme members obtain the best quality of care available in South Africa, as well as outstanding value.

Discovery Health provides services that go well beyond traditional administration and managed care services, including ongoing product innovation, best-in-class service excellence, effective claims risk management, fraud management as well as coordination and management of the quality of clinical services accessed by the Scheme's members. Discovery Health employs more than 4 000 people and deploys world-class actuarial, analytic, clinical and research and development capabilities at every point in the medical scheme product cycle.

# A DAY IN THE LIFE OF THE SCHEME

Every day* on average in 2016, Discovery Health facilitated the following for the Scheme's members:

Paid out in claims:
R142 million

Calls handled:
36 600

Babies born:
117

New lives:
1 350

Claims processed:
250 900

Hospital admissions authorised:
2 900

* *258 working days in a year.*

# Improving wellness

At the heart of Discovery Health's drive to make people healthier is Vitality, the world's leading science-based wellness programme. Through Vitality, the Scheme's members can benefit from innovative solutions that address their health risks and make them healthier. Increased engagement in the programme over time leads to substantially improved health outcomes. Externally verified research clearly indicates that patients with chronic conditions who are highly engaged in the Vitality programme have between 10% and 30% lower healthcare costs, fewer admissions to hospital and shorter stays in hospital. Vitality members who exercise twice a week are 13% less likely to be admitted to hospital than those who rarely exercise. The greatest benefit is evident in the impact on mortality. Members on the two highest Vitality statuses have a life expectancy (at age 65) that is eight years longer than members who are not on Vitality or who are on the lowest status.

## VITALITY STATISTICS FOR DHMS MEMBERS IN 2016

Vitality Health Checks
255 000

Gym visits
26 million

HealthyFood Baskets bought
20 million

Flights booked
1.25 million

Movies watched
2.8 million

Discovery Miles earned
1.7 billion

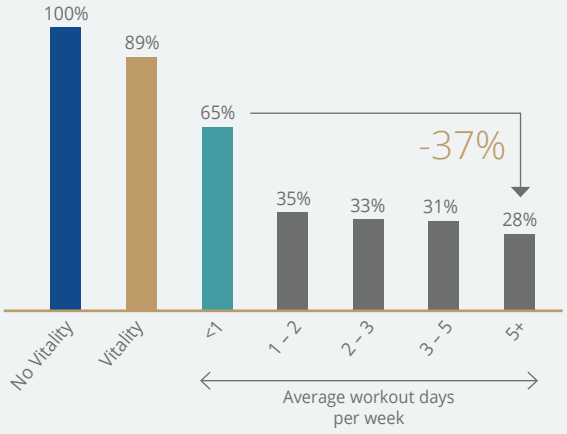
In 2016, over 53% of the Scheme's members were on Vitality and 43% were actively engaged, a steady increase from the previous year due to the introduction of Vitality Active Rewards. This enables members to set weekly exercise goals to access more immediate rewards and feedback. Vitality also collaborated with Apple to launch Vitality Active Rewards with Apple Watch, which combined the functionality and appeal of the Apple Watch with frequent incentives to encourage healthy behaviour. The more than 290 000 members who signed up for Vitality Active Rewards have demonstrated an increase of 25% in their physical activity, and those who use the Apple Watch have shown an 81% increase.

Supporting these ongoing healthy behaviours has enabled the Scheme to benefit from savings of R1 billion in 2015[1], through Vitality.

*1 2016 figures not available at time of printing.*

## VITALITY ACTIVE REWARDS USING WEARABLES AND ANALYTICS TO DRIVE BEHAVIOUR CHANGE

### Physical activity reduces mortality risk



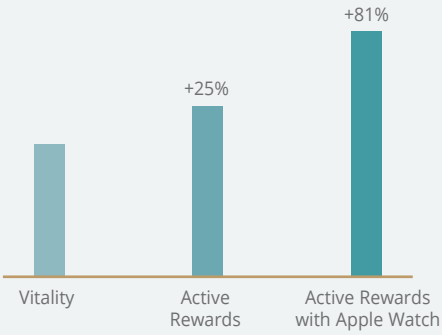

### Unprecedented engagement

More than
25%
increase in physical activity

More than
290 000
active members

More than
3 500 000
weekly rewards

### Incentive-driven behaviour change



# Ensuring higher quality healthcare

Discovery Health actively works to improve the quality of healthcare available to the Scheme's members. It enables a cohesive healthcare system in which healthcare professionals work in integrated teams better able to share patient information, and are paid using innovative alternatives to current fee-for-service models, such as value-based reimbursement models.

Discovery Health has developed best-in-class disease management and care coordination programmes to improve member's access to and quality of care. These include chronic disease programmes for diabetes, renal failure, HIV, mental health, and care coordination programmes aimed at complex patients with multiple conditions, such as the ElderCare programme. Some examples of these programmes are:

- The **Coordinated Care Programme**, which provides high-quality coordinated care to the Scheme's sickest members. The programme has been extended to more than 6 300 patients across five regions, 16 facilities and five home-based care companies. The programme has shown improved quality (67% increase in mobility and cognitive functions), a 34% reduction in cost per event and more than 33% less hospital admissions. From 2017, the programme will be extended to KeyCare members with complex medical conditions.
- The **KidneyCare Programme** in 2008, which has shown improved clinical outcomes for members and lower overall healthcare costs.

Read more about this programme and other initiatives for the Scheme's members on **pages 30 – 33**.

- The Scheme launched targeted benefits for at risk members including an individualised approach to screening, a comprehensive **DiabetesCare Programme** and an external medical items extender benefit.
- As part of the focus on improving the quality of healthcare delivered to members, **Centres of Excellence for major joint replacements and in-hospital psychiatry** have been introduced. Our data along with international data shows that clinical outcomes (mortality and readmission rates) are significantly improved where there is a higher volume of cases, due to the skills and experience that the practising healthcare teams develop.
- Discovery Health's **HealthID** application (app) for health professionals is South Africa's first and most comprehensive electronic health record (EHR), which provides doctors and other health professionals with a complete view of their patient's health history and test results. This improves patient care and reduces the likelihood of serious medical errors, as well as reducing duplicate or unnecessary pathology tests. The app also reduces the administrative burden for doctors and simplifies their engagement in managed care initiatives by, for instance, making it quick and easy to fill in chronic illness benefit applications, and providing them with the relevant scheme formulary list. Discovery Health is consistently enhancing the functionality of HealthID to ensure increasing relevance to health professionals treating the Scheme's members. The app is now in regular use by more than 2 780 doctors and has more than 1 200 000 member consents.

## TARGETED ENHANCEMENTS FOR IMPROVED QUALITY OF CARE

### Centres of Excellence

**Major joint replacements**

National network of hospitals and specialists

Contracted on quality measures

Co-payment on voluntary out-of-network admissions

**In-hospital psychiatry**

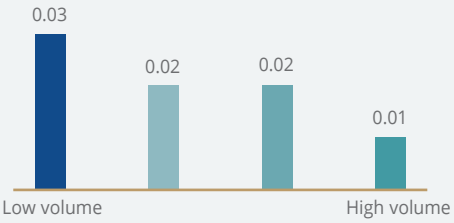
National network of accredited facilities

Specialised facilities for patients with mental health conditions

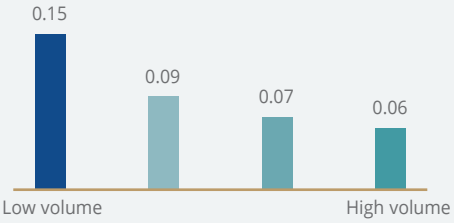
Co-payment on voluntary out-of-network admissions

### Outcomes in Centres of Excellence

Risk adjusted **mortality** rate




Risk adjusted **readmission** rate



# Lowering the cost of healthcare

Discovery Health actively manages the cost of healthcare through an integrated operating model and various health innovations and assets. Some of the strategies Discovery Health employs on behalf of the Scheme include a move away from fee-for-service reimbursement to value-based contracting with providers. This type of contracting includes measures of quality of care and clinical outcomes. Discovery Health has already developed and implemented several value-based contracts with doctors, and is engaging with the industry on identifying other means to reduce healthcare costs. Discovery Health continues to grow and maintain provider networks that are efficient, drive adoption of cost-effective generic medicines, and incorporate technology into the healthcare system – measures that together help to counteract medical inflation without compromising access to and quality of healthcare.

The turnaround in the Scheme's loss ratio is evidence of Discovery Health's capabilities and value added to members. In May 2016, the Scheme was projecting an operating loss of R600 million for the full year. However, Discovery Health's risk management and utilisation interventions supported a turnaround of R700 million, which allowed the Scheme to end the year with a R102 million operating surplus, and net surplus after investment income of R1 305 million.

The turnaround was effected mainly by a reduction in inappropriate admissions to hospital, as well as through the impact of the Scheme's risk sharing contracts with hospital groups. This reversal in the utilisation trend will underpin the Scheme's ability to continue offering lower contribution increases than its competitors in the future, as well as the Scheme's longer-term sustainability.

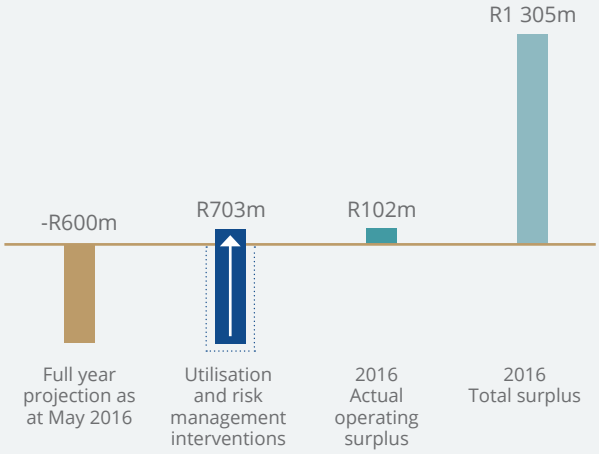
Discovery Health's managed care processes and intervention resulted in savings of R4.54 billion for the Scheme in 2015. Achieved through tariff and alternative reimbursement mechanism (ARM) savings, medicine savings, benefit design and funding policy, forensics and billing rules and surgical devices management, these savings amounted to a 12% reduction in risk claims, equivalent to a return of 3.5 times on the Scheme's investment in managed care fees; i.e. for every R1 the Scheme paid in managed healthcare fees, it received R3.50 in return[1].

By addressing the increasing costs of healthcare holistically and adopting an approach that combines Vitality engagement with an integrated healthcare system offering, the Scheme can offer substantially lower healthcare premium contributions than the rest of the market. In 2016, the Scheme's premiums were 14.6%[2] lower than the average for the next nine largest open medical schemes, on a plan-for-plan basis.

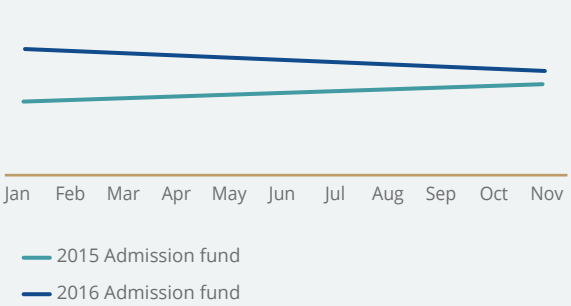
*1 2016 figures not available at time of printing.*
*2 Based on the rate for a principal member plus one adult beneficiary and one child beneficiary.*

**DRAMATIC TURNAROUND IN DISCOVERY HEALTH MEDICAL SCHEME LOSS RATIO DUE TO EFFECTIVE INTERVENTIONS**

**R700 million turnaround in projected DHMS claims – equivalent to 2% of total premiums**

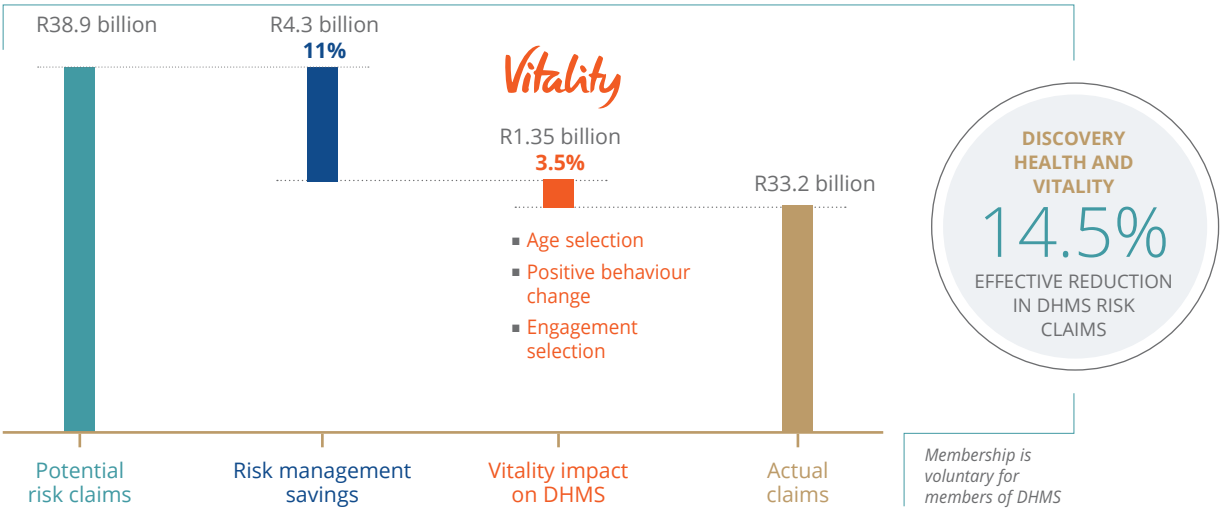



**DHMS Medical admission trend**



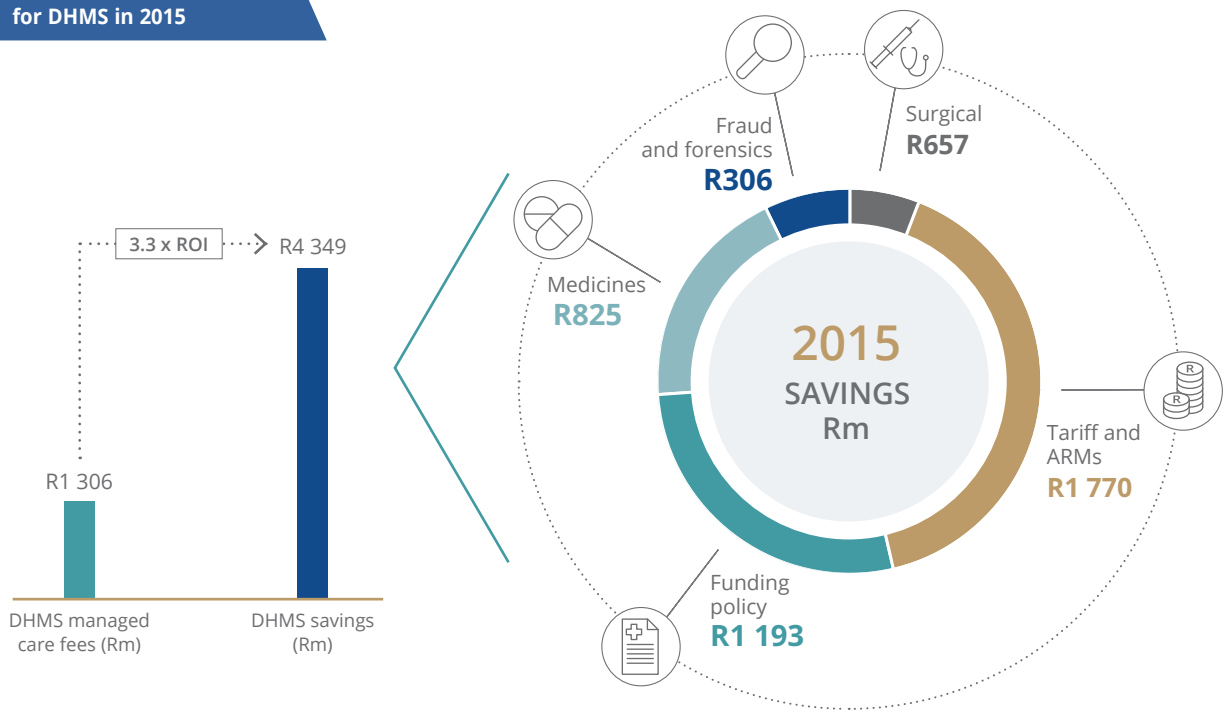
## DISCOVERY HEALTH AND VITALITY GENERATES SUBSTANTIAL SAVINGS FOR DHMS

**Discovery Health and Vitality had a R5.7 billion positive impact on DHMS risk claims in 2015**




## DISCOVERY HEALTH'S MANAGED CARE INTERVENTIONS

**Achieved R4.3 billion savings for DHMS in 2015**




**11% effective reduction in DHMS risk claims**

# Enabling personalised healthcare and service benefits through technology

Mobile and digital technologies such as wearable technologies and big data are driving significant change in global healthcare systems. They empower members and their doctors to manage their health and health plans more proactively, and improve coordination, quality of care and overall experience. Staying abreast of these emerging technologies and applying data analytics to gain deep insights is critical for new and unique product designs.

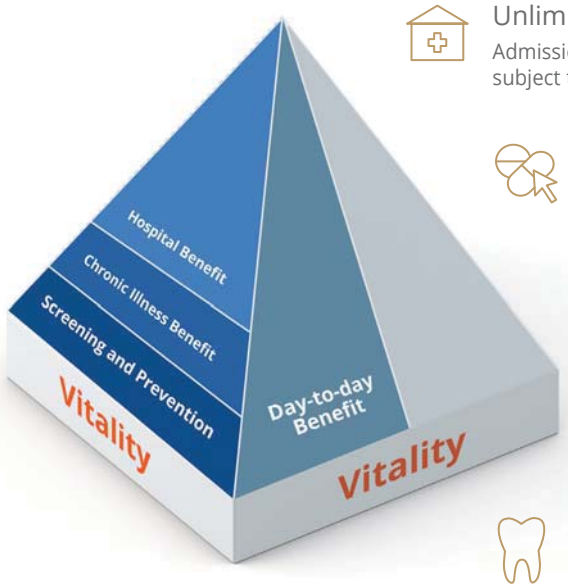
Discovery Health invests substantially in new technology and innovation to improve its value proposition and that of its client schemes to attract more members, an investment that amounted to more than R800 million in 2016. This included:

**Smart Advisor App**
– an iPad app to make it easier for financial advisers to engage with members and sign on new clients.

**Direct to Consumer Channel (D2C)**
– an online application channel for new members.

**The Discovery Member App**
has been extremely successful channel to engage with our members. There are currently more than 236 000 users, with more than 2.6 million logins a month.

**The Smart Plan** – integrates digital platforms, network providers and medical services in a seamless member journey. The plan offers the best value for money in the South African open medical scheme market, due to its use of digital technology and smart networks to significantly reduce healthcare costs. Its premium contributions are 23% lower than the average contributions of comparable health plans from other medical schemes. By incorporating technology, the Scheme can attract a tech-savvy, younger generation of members who are empowered to manage their own health plans and spending. Launched in January 2016, the plan now has approximately 36 000 members. It has been particularly helpful in supporting the Scheme's efforts to attract new members with a younger demographic profile. The launch of The Essential Smart Plan for 2017 extended The Smart Plan range.




### Unlimited hospital cover @ 100%
Admissions outside the Smart Hospital Network are subject to a fixed deduction of R8 200.

### Full cover for chronic medicine
Through MedXpress, MedXpress partner pharmacies, Clicks or Dis-Chem.

### Screening and prevention benefits
Extensive screening and prevention benefits when done at any of our wellness providers.

### Unlimited GP consultations
R100 per consultation

### Dental check-up
One dental check-up a year, with a R150 payment.

### Eye test
One eye test a year in the Smart Optometry Network, with a R100 payment.

**Discovery Health is investing over R800 million per annum in technology and digital innovation**

Discovery Member App

**236 000+** users

**59%** year-on-year user growth

**2.6 million+**
monthly logins

**First EHR** in SA

**2 780+** doctors

**1.2 million+**
member consents

AI Virtual Agent

**1st** in SA healthcare Science Hub

**94%** of queries answered with 93% accuracy

**5 – 10% reduction**
in general calls and emails once fully operational

**Big Data** and Data Science Hub

**2 Peta Bytes** of data

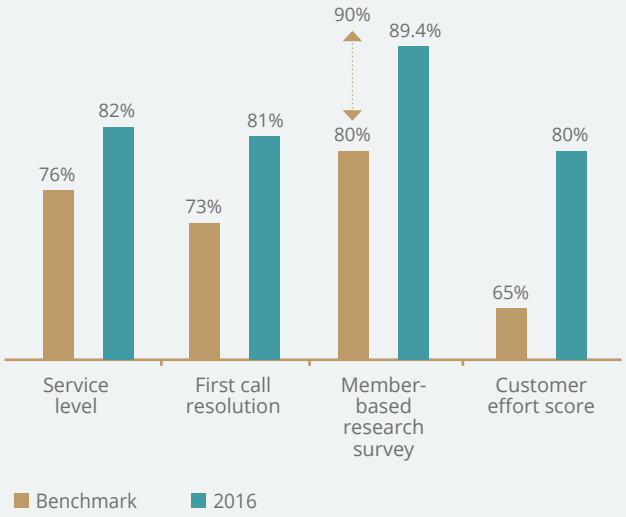
**Predictive analytics**
for health risk, mortality risk, fraud risk, lifestyle choices, etc.

# Maintaining world-class service levels

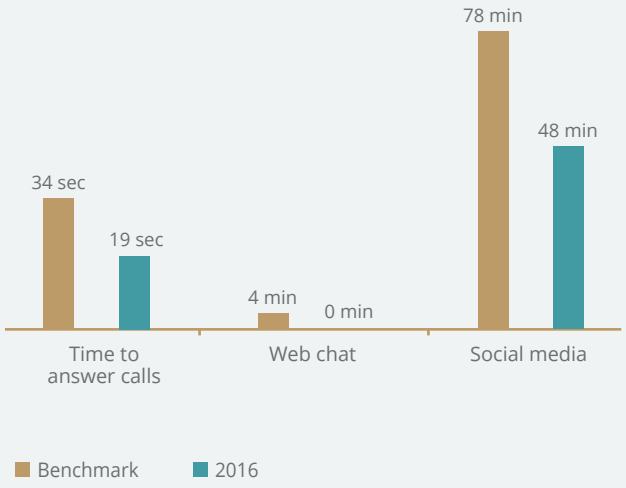
In 2016, Discovery Health enhanced its model to ensure the continued delivery of quality healthcare in an environment of high medical inflation. Its service metrics improved and are considered above international benchmarks.

## SERVICE QUALITY EXCEEDS BEST INTERNATIONAL BENCHMARKS

### Leading service metrics




### Quickest response time




*Independent benchmarking: McKinsey Service Comparison; 2016 Dimension Data's Global Contact Centre Benchmarking.*

# 06 Financials

# STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

## for the year ended 31 December 2016

The Board of Trustees is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the Annual Financial Statements of Discovery Health Medical Scheme (the Scheme). The Annual Financial Statements comprise the Statement of Financial Position at 31 December 2016, and the Statements of Comprehensive Income, Changes in Funds and Reserves and Cash Flows for the year then ended, and the Notes, comprising a summary of significant accounting policies and other explanatory information. 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 also reviewed the other information included in the integrated report and are responsible for both its accuracy and its consistency with the Annual Financial Statements.

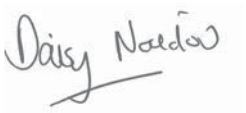
The Trustees are responsible for the Scheme's systems of internal control and incorporate risk management and internal control procedures, which are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being controlled. Reliance 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 Annual 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 have occurred during the year under review.

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2017. 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 Annual Financial Statements and these financial statements support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Annual Financial Statements and their unqualified report is presented on pages 87 to 89. The Annual Financial Statements, which are presented on pages 90 to 153 were approved by the Board of Trustees on 6 April 2017 and are signed on its behalf by:

M VAN DER NEST
**CHAIRPERSON**



D NAIDOO
**TRUSTEE**

M STREAK[1]
**PRINCIPAL OFFICER**

*1 Mr Streak was the Principal Officer during 2016, and resigned with effect from 31 December 2016.*

# REPORT OF THE AUDIT COMMITTEE

for the year ended 31 December 2016

We are pleased to present our report for the financial year ended 31 December 2016. 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

The Committee has adopted formal terms of reference that have been approved by the Board of Trustees and are reviewed at least annually. The Committee has conducted its affairs in compliance with its terms of reference and has discharged the responsibilities contained therein.

## Audit Committee members, meeting attendance and assessment

The Committee consists of four independent members and three Trustee members and meets at least four times per year. The Committee met four times during 2016.

The executive officers of the Scheme and representatives of the Administrator attend meetings or parts of meetings by invitation. Internal Audit and the External Auditor attend meetings or parts of meetings by invitation. Internal Audit and the External Auditor are also afforded the opportunity to meet with the Committee, after each meeting, without the Administrator present.

Members of the Committee collectively keep up to date with key developments affecting their required skill set. The effectiveness of the Committee and its individual members is assessed annually. The last assessment was performed at the end of 2016. Based on the result of the assessment, the Committee is satisfied with its effectiveness.

### Role and responsibilities

The Committee's role and responsibilities include statutory duties as per the Act and further responsibilities assigned to it by the Board. The Committee executed its duties in accordance with its terms of reference and applicable laws and regulations in force during the financial year.

The membership and attendance of the members of the Committee are as follows:

| | | 16 Mar | 16 Aug | 23 Aug | 31 Oct |
|---|---|---|---|---|---|
| **Independent Member/Chair** | Mr Barry Stott | ✓ | ✓ | ✓ | ✓ |
| **Trustees** | Ms Daisy Naidoo[1] | ✓ | ✓ | ✓ | ✓ |
| | Mr Giles Waugh | ✓ | ✓ | ✓ | ✓ |
| | Mr Neil Morrison[2] | – | ✓ | ✓ | ✓ |
| **Independent Members** | Ms Susan Ludolph[3] | ✓ | ✓ | ✓ | ✓ |
| | Mr Steven Green | ✓ | ✓ | ✓ | ✓ |
| | Ms Phililе Maphumulo[3] | ✓ | ✓ | ✓ | ✓ |
| | Mr Dave King[4] | ✓ | – | – | – |

*1 Term as a Trustee ended on 23 June 2016.*

*2 Elected as a Trustee on 23 June 2016.*

*3 Appointed to the Committee on 20 January 2016.*

*4 Elected as a Trustee on 23 June 2016 and subsequently resigned as member of the Audit Committee.*

### 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. Corlia Volschenk was approved by the Council for Medical Schemes as the statutory auditor of the Scheme for the financial period 1 January 2016 to 31 December 2016 in accordance with section 36(2) of the Medical Schemes Act 131 of 1998 on 11 October 2016.

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

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

The Committee, following consultation with the Scheme's executive officers, approved the engagement letter, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2016. The Committee approved the actual audit fees for the year ended 31 December 2015.

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 15 to the Annual Financial Statements.

# REPORT OF THE AUDIT COMMITTEE *continued*

for the year ended 31 December 2016

## Financial statements and accounting practices

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 Medical Schemes Act 131 of 1998 and circulars issued by the Council for Medical Schemes.

## Internal financial controls

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, among other things, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board of Trustees. This included a formal documented review by the Internal Audit function of the design, implementation and effectiveness of the Administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that Reasonable Assurance* can be placed on the internal controls and risk management and High Assurance** can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Annual 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 Internal Audit 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 the relevant Scheme charters, codes and relevant legal, regulatory and other obligations. The Committee is satisfied that there has been no material breach of these standards or material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 34 to the Annual Financial Statements.

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

## Going concern

The Committee has reviewed the Scheme's financial position as at 31 December 2016, as well as the budget for the year ending 31 December 2017. Total members' funds exceeded R14.2 billion with a solvency level of 26.33% as at 31 December 2016. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) investments as at 31 December 2016 to cover its monthly claims expenditure 4.79 times.

On the basis of this review and taking note of the current net surplus of R1.3 billion, the Committee considers that:

- The Scheme's assets currently exceeds its liabilities; and
- 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 B STOTT
**Chairperson: Audit Committee**
6 April 2017

# INDEPENDENT AUDITOR'S REPORT

To the members of Discovery Health Medical Scheme

## Report on the audit of financial statements

### Opinion

We have audited the financial statements of Discovery Health Medical Scheme (the Scheme), set out on pages 90 to 153, which comprise the statement of financial position as at 31 December 2016, 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 Discovery Health Medical Scheme as at 31 December 2016, 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 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 *Code of Ethics for Professional Accountants* (Parts A and B).

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

### Key audit matters

Key audit matters are those matters that, in our professional judgment, 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*<br>The outstanding claims provision of R1,121 million at year-end, described in Notes 6 and 31 to the financial statements, is a provision recognised for claims incurred by members prior to year-end but only reported to the Scheme after year-end.<br><br>The outstanding claims provision is calculated by the Scheme's actuaries using an actuarial model based on the Scheme's actual claim development patterns throughout the year to project the year-end provision. This model applies a combination of the Basic Chain Ladder (BCL) and Cost Per Event (CPE) methods. The claim treatment date, processing date and amount are used to derive claim development patterns that are used to project claims to an ultimate position which is subsequently used to estimate the outstanding claims provision.<br><br>We identified this as a matter of most significance in our audit because of the impact of estimation uncertainty on the projected claim development pattern. A material change in the actual claims pattern or a change in timing or value can cause a material change in the provision. | For a sample of actual claims received in the 2016 financial year, we tested the accuracy of the service and process dates and no inconsistencies were identified during our testing.<br><br>We made use of various data analytics to substantively test the different relevant claim rules against which the actual claims received by the Scheme are assessed for completeness and validity of actual claims data.<br><br>The claims data that was included in the Scheme's actuarial model was agreed to the actual claims data that was tested above in the member administration system with no material difference noted.<br><br>We obtained an understanding from the Scheme's actuaries regarding the process to calculate the outstanding claims provision. The Scheme applied a combination of BCL and CPE methods, which is generally applied within the medical scheme industry.<br><br>To test the reasonableness of the Scheme's estimation process we compared actual claim results in the current year to the prior year provision and no material difference was noted.<br><br>Our actuarial specialist independently calculated the Scheme's outstanding claims provision, taking into account the method applied by the Scheme and the claim data tested above. We compared our results with those of the Scheme and based on the outcome of the procedures described above, we accepted the reasonability of Scheme's provision. |

# INDEPENDENT AUDITOR'S REPORT *continued*

## Other information

The Scheme's trustees are responsible for the other information. The other information comprises the Statement of Responsibility by the Board of Trustees, the Audit Committee's Report and the Integrated Annual Report. 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 identified above 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 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 required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa as amended that have come to our attention during the course of our audit:

Section 33(2)(b) of the Medical Schemes Act of South Africa: Certain benefit options were not self-supporting in terms of financial performance, as disclosed in note 34 of the financial statements; and

Regulation 29(2) of the Medical Schemes Act of South Africa: The Scheme's accumulated funds expressed as a percentage of gross annual contributions was below the statutory solvency requirement of 25% at the end of January and November 2016. However, at 31 December 2016, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 26.33% which exceeds the statutory solvency requirement of 25%, as disclosed in note 34 of the financial statements.

**PricewaterhouseCoopers Inc.**
Director: C Volschenk
Registered Auditor
Johannesburg
6 April 2017

# STATEMENT OF FINANCIAL POSITION

as at 31 December 2016

| R'000 | Notes | 2016 | 2015 |
|---|---|---|---|
| **ASSETS** | | | |
| *Non-current assets* | | **5 614** | 1 071 |
| Long Term Employee Benefit Plan asset | 27 | **5 614** | 1 071 |
| *Current assets* | | **20 864 905** | 18 897 501 |
| Financial assets at fair value through profit or loss | 2 | **12 211 677** | 11 399 332 |
| Derivative financial instruments | 7 | **54 760** | – |
| Trade and other receivables | 3 | **2 058 008** | 1 632 586 |
| Cash and cash equivalents | | | |
| – Personal Medical Savings Account trust assets | 4 | **4 142 672** | 3 667 456 |
| – Medical Scheme assets | 5 | **2 397 788** | 2 198 127 |
| **Total assets** | | **20 870 519** | 18 898 572 |
| **FUNDS AND LIABILITIES** | | | |
| *Members' funds* | | **14 234 461** | 12 929 011 |
| Accumulated funds | | **14 234 461** | 12 929 011 |
| *Current liabilities* | | **6 636 058** | 5 969 561 |
| Outstanding claims provision | 6 | **1 121 394** | 985 087 |
| Derivative financial instruments | 7 | **4 376** | 65 210 |
| Personal Medical Savings Account trust liabilities | 8 | **4 204 043** | 3 736 659 |
| Trade and other payables | 9 | **1 306 245** | 1 182 605 |
| **Total funds and liabilities** | | **20 870 519** | 18 898 572 |

# STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2016

| R'000 | Notes | 2016 | Restated 2015 |
|---|---|---|---|
| **Risk contribution income** | 10 | **43 626 398** | 40 066 741 |
| **Relevant healthcare expenditure** | | **(38 035 898)** | (34 503 627) |
| Net claims incurred* | 11 | **(36 613 210)** | (33 160 818) |
| Claims incurred* | 11 | **(36 772 332)** | (33 231 554) |
| Third party claim recoveries | 11 | **159 122** | 70 736 |
| Accredited managed healthcare services (no risk transfer) | 12 | **(1 407 267)** | (1 305 790) |
| Net (loss) on risk transfer arrangements* | 13 | **(15 421)** | (37 019) |
| Risk transfer arrangement fees | | **(366 344)** | (344 093) |
| Recoveries from risk transfer arrangements* | | **350 923** | 307 074 |
| **Gross healthcare result** | | **5 590 500** | 5 563 114 |
| Broker service fees | 14 | **(1 101 648)** | (982 874) |
| Expenses for administration | 27 | **(4 150 194)** | (3 874 896) |
| Other operating expenses | 15 | **(236 206)** | (198 387) |
| **Net healthcare result** | | **102 452** | 506 957 |
| **Other income** | | **1 524 116** | 1 033 020 |
| Investment income | 21 | **1 257 479** | 1 018 998 |
| Net gains on financial assets at fair value through profit or loss | 22 | **264 278** | 6 504 |
| Sundry income | 23 | **2 359** | 7 518 |
| **Other expenditure** | | **(321 118)** | (263 837) |
| Expenses for asset management services rendered | | **(31 076)** | (31 578) |
| Interest paid | 24 | **(290 042)** | (232 259) |
| **Net surplus for the year** | | **1 305 450** | 1 276 140 |
| **Other comprehensive income** | | **–** | – |
| **Total comprehensive income for the year** | | **1 305 450** | 1 276 140 |

* *See note 13 to the Annual Financial Statements for explanatory note on change of disclosure.*

# STATEMENT OF CHANGES IN FUNDS AND RESERVES

for the year ended 31 December 2016

| R'000 | Note | **2016 Accumulated funds** | 2015 Accumulated funds |
|---|---|---|---|
| Balance at beginning of the year | | **12 929 011** | 11 652 804 |
| Total comprehensive income for the year | | **1 305 450** | 1 276 140 |
| Reserves transferred from other medical schemes | 25 | **–** | 67 |
| Total member funds end of the year | | **14 234 461** | 12 929 011 |

# STATEMENT OF CASH FLOWS

for the year ended 31 December 2016

| R'000 | Notes | **2016** | 2015 |
|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| Cash flows generated from operations before working capital changes | 29 | **151 902** | 555 793 |
| Working capital changes: | | | |
| (Increase) in trade and other receivables | 29.1 | **(500 589)** | (99 229) |
| Increase in outstanding claims provision | | **136 307** | 139 292 |
| Increase in Personal Medical Savings Accounts | | **467 384** | 485 916 |
| Increase in trade and other payables | 29.2 | **123 640** | 151 366 |
| **Cash generated by operations** | | **378 644** | 1 233 138 |
| Purchases of financial instruments | 29.3 | **(1 922 170)** | (6 176 902) |
| Proceeds from sale of financial instruments | 29.4 | **1 258 510** | 4 339 081 |
| (Increase) in Long Term Employee Plan Asset | | **(7 544)** | – |
| Cash transferred from other medical scheme | | **–** | 67 |
| Interest received | 21 | **1 206 486** | 981 460 |
| Dividend income | 21 | **50 993** | 37 729 |
| Interest paid | 24 | **(290 042)** | (232 259) |
| **Net cash flows from operating activities** | | **674 877** | 182 314 |
| **NET INCREASE IN CASH AND CASH EQUIVALENTS** | | **674 877** | 182 314 |
| Cash and cash equivalents at beginning of year | | **5 865 583** | 5 683 269 |
| **CASH AND CASH EQUIVALENTS AT END OF YEAR** | | **6 540 460** | 5 865 583 |
| **Cash and cash equivalents comprise** | | | |
| Personal Medical Savings Accounts trust assets | 4 | **4 142 672** | 3 667 456 |
| Medical Scheme assets | 5 | **2 397 788** | 2 198 127 |
| | | **6 540 460** | 5 865 583 |

# ACCOUNTING POLICIES

for the year ended 31 December 2016

## General information

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

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

These Annual Financial Statements were authorised for issue by the Board of Trustees on 6 April 2017.

## 1 Basis of preparation

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

The accounting policies applied in the preparation of these Annual Financial Statements are set out below. These policies have been consistently applied to all years presented, except for changes required by the mandatory adoption of new and revised IFRS, discussed in the table 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 Annual Financial Statements, are disclosed in Note 33.

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

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

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

**New standards, amendments and interpretations effective in 2016 and relevant to the Scheme:**
The following standards and amendments for the current accounting period have been adopted. These new accounting standards and amendments have not had any material impact on the Scheme's financial results or disclosure in the financial statements.

| Standard | Scope | Effective date |
|---|---|---|
| IAS 1 (Amendment): Presentation of financial statements | The amendments clarify guidance on materiality and aggregation, the presentation of subtotals, the structure of financial statements and the disclosure of accounting policies. | 1 January 2016 |
| IAS 19 (Amendment): Employee Benefits | Discount rate: regional market issue – This amendment clarifies that market depth of high-quality corporate bonds is assessed based on the currency in which the obligation is denominated, rather than the country where the obligation is located. When there is no deep market for high-quality corporate bonds in that currency, government bond rates must be used. | 1 January 2016 |

# ACCOUNTING POLICIES *continued*

for the year ended 31 December 2016

## 1 Basis of preparation *continued*

**New standards, amendments and interpretations effective in 2016 and not relevant to the Scheme:**

| Standard | Scope | Effective date |
|---|---|---|
| IAS 16 (Amendment): Property, plant and equipment and IAS 38 (Amendment): Intangible assets | This amendment clarifies that the use of revenue-based methods to calculate the depreciation of an asset is not appropriate because revenue generated by an activity that includes the use of an asset generally reflects factors other than the consumption of the economic benefits embodied in the asset. The amendment also clarifies that revenue is generally presumed to be an inappropriate basis for measuring the consumption of the economic benefits embodied in an intangible asset. | 1 January 2016 |
| IAS 27 (Amendment): Separate financial statements | This amendment restores the option to use the equity method to account for investments in subsidiaries, joint ventures and associates in an entity's separate financial statements. | 1 January 2016 |
| IAS 34 (Amendment): Interim Financial Reporting | This amendment states that the required interim disclosures must either be in the interim financial statements or incorporated by cross-reference between the interim financial statements and wherever they are included within the greater interim financial report. Other information within the interim financial report must be available to users on the same terms as the interim financial statements and at the same time. | 1 January 2016 |
| IFRS 5 (Amendment): Non-current Assets Held for Sale and Discontinued Operations | This is an amendment to the changes in methods of disposal. Assets (or disposal groups) are generally disposed of either through sale or through distribution to owners. The amendment to IFRS 5 clarifies that changing from one of these disposal methods to the other should not be considered to be a new plan of disposal, rather it is a continuation of the original plan. There is therefore no interruption of the application of the requirements in IFRS 5. The amendment also clarifies that changing the disposal method does not change the date of classification. | 1 January 2016 |
| IFRS 7 (Amendment): Financial Instruments: Disclosures | Applicability of the offsetting disclosures to condensed interim financial statements – The amendment removes the phrase 'and interim periods within those annual periods' from paragraph 44R, clarifying that these IFRS 7 disclosures are not required in the condensed interim financial report. However, IAS 34 requires an entity to disclose an explanation of events and transactions that are significant to an understanding of the changes in financial position and performance of the entity since the end of the last annual reporting period.<br><br>Servicing contracts – The amendment clarifies that a servicing contract that includes a fee can constitute continuing involvement in a financial asset. An entity must assess the nature of the fee and arrangement against the guidance for continuing involvement in paragraphs IFRS 7.B30 and IFRS 7.42C in order to assess whether the disclosures are required. | 1 January 2016 |
| IFRS 11 (Amendment): Joint arrangements | This amendment adds new guidance on how to account for the acquisition of an interest in a joint operation that constitutes a business. The amendments specify the appropriate accounting treatment for such acquisitions. | 1 January 2016 |

## 1 Basis of preparation *continued*

**New standards, amendments and interpretations effective in 2016 and not relevant to the Scheme:**

| Standard | Scope | Effective date |
|---|---|---|
| IFRS 10 (Amendment): Consolidated financial statements and IAS 28 (Amendment): Investments in associates and joint ventures | This amendment eliminates the inconsistency between IFRS 10 and IAS 28. If the non-monetary assets sold or contributed to an associate or joint venture constitute a 'business', then the full gain or loss will be recognised by the investor. A partial gain or loss is recognised when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary. The amendment also clarifies the application of the consolidation exception for investment entities and their subsidiaries. | 1 January 2016 |
| IFRS 14: Regulatory deferral accounts | This is an interim standard on the accounting for certain balances that arise from rate-regulated activities. Rate regulation is a framework where the price that an entity charges to its customers for goods and services is subject to oversight and/or approval by an authorised body. | 1 January 2016 |
| IAS 16 (Amendment): Property, plant and equipment and IAS 41 (Amendment): Agriculture | This amendment to IAS 16 has scoped in bearer plants, but not the produce on bearer plants. It further explains that a bearer plant not yet in the location and condition necessary to bear produce is treated as a self-constructed asset. The amendment to IAS 41 has adjusted the definition of a bearer plant, include examples of non-bearer plants and remove current examples of bearer plants from IAS 41. | 1 January 2016 |

**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 to the Scheme's results but may result in additional disclosure in the financial statements.

| Standard | Scope | Effective date |
|---|---|---|
| IFRS 16: Leases<br><br>IFRS 16 supersedes IAS 17: Leases, IFRIC 4: Determining whether an arrangement contains a lease, SIC 15: Operating lease – Incentives, and SIC 27: Evaluating the substance of transactions involving legal form of a lease | The new standard requires lessees to recognise assets and liabilities arising from all leases in the statement of financial position. Lessor accounting has not substantially changed in the new standard.<br><br>A lessee will measure the lease liabilities at the present value of future lease payments. The lease asset will initially be the same amount as lease liabilities, including costs directly related to entering into the lease. Lease assets will be amortised in a similar way to other assets such as property, plant and equipment.<br><br>A lessee will not be required to recognise assets and liabilities for short-term leases (less than 12 months), and leases for which the underlying asset is of low value (such as laptops and office furniture.) | 1 January 2019 |
| IFRS 15: Revenue from contracts with customers | Establishes principles for accounting the nature, amount, timing and uncertainty of revenue arising from an entity's contracts with customers. | 1 January 2018 |
| IFRS 9 (Amendment): Financial instruments | This standard introduces new requirements for the classification and measurement of financial assets by introducing a fair value through other comprehensive income category for certain debt instruments. It also contains a new impairment model which will result in earlier recognition of losses. No changes were introduced for the classification and measurement of financial liabilities, except for the recognition of changes in own credit risk in other comprehensive income for liabilities designated at fair value through profit or loss. | 1 January 2018 |

# ACCOUNTING POLICIES *continued*

for the year ended 31 December 2016

## 2 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, and loans and 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 transfers the asset, while transferring substantially all the risks and rewards of ownership.
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

## 3 Financial assets

### Financial assets at fair value through profit or loss

The Scheme recognises a financial asset at fair value through profit or loss when any of the following conditions are met:

- The asset is acquired principally for the purpose of selling in the near term.
- The portfolio of assets are traded for short-term profit.
- A derivative that is not designated as an effective hedge.
- Upon initial recognition the Scheme designated the asset as fair value through profit or loss.

A group of financial assets is designated as at fair value through profit or loss if it is managed and its performance is evaluated on a fair value basis, in accordance with the Scheme's documented risk management strategy, and information about the group of assets is provided internally on that basis to the Scheme's key management personnel.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the profit or loss 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.

### Trade and other receivables

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 and subsequently measured at amortised cost using the effective interest rate method, less provision for impairment.

## 4 Foreign currency translation

### Functional and presentation currency

Items included in the Annual 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.

## 5 Scheme amalgamations

Scheme amalgamations are accounted for by applying the acquisition method.

The cost of an amalgamation is measured as the fair value of the assets transferred and liabilities incurred or assumed at the date of exchange.

When an entity is amalgamated into the Scheme, all identifiable assets, liabilities and members' funds are accounted for at their fair values at the acquisition date. No consideration is paid for these transactions and they are recognised as from the transaction date.

The Scheme recognises the net assets from amalgamated schemes as a direct addition to reserves in its Statement of Financial Position.

Section 63(14) of the Act, prescribes that assets and liabilities of the parties to amalgamations shall vest and become binding upon the party to which the transfer effected.

No goodwill is recognised on the amalgamation of schemes

## 6 Cash and cash equivalents

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value.

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

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

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

## 7 Impairment of financial assets

### Financial assets carried at amortised cost

The Scheme assesses at each reporting date whether there is objective evidence that a financial asset is impaired. A financial asset or group of financial assets 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 asset (a "loss event") and that loss event (or events) has an adverse impact on the estimated future cash flows of the financial asset that can be reliably estimated.

Objective evidence that a financial asset or group of financial assets is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service provider or member debtors.
- Breach of contract, such as non-payment of member contributions when due and if these remain unpaid for extended periods.
- Default or delinquency in payments due by service providers and other debtors.
- Observable data indicating that there is a measurable decrease in the estimated future cash flows from other Scheme assets since the initial recognition of those assets, although the decrease cannot yet be attributed to the individual financial assets in the Scheme.
- 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 financial assets that are individually significant, such as service provider debtors. In the case of assets which are not individually significant, such as contribution debtors, financial assets are grouped on the basis of similar credit characteristics, such as asset type 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 a financial asset has been incurred, the amount of the loss is measured as the difference between the assets' carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. The carrying amount of the asset 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. 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.

# ACCOUNTING POLICIES *continued*

for the year ended 31 December 2016

## 8 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.

## 9 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.

Derivative liabilities include liabilities that exist at year end as a result of marked-to-market losses accrued on derivative instruments.

### Trade payables

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.

### Personal Medical Savings Accounts trust liabilities

Members' Personal Medical Savings Accounts, which are managed by the Scheme on behalf of its members, 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 that Act.

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

Interest payable on members' Personal Medical Savings Accounts is expensed when incurred.

## 10 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.

### Outstanding claims provision

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

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

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

## 11 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.

## 12 Member insurance contracts

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

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 31.

## 13 Contribution income

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.

## 14 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.

### 14.1 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.

### 14.2 Risk transfer arrangements

Risk transfer arrangements are contractual arrangements entered into by the Scheme with a third party which undertakes 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, but the arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees (including Managed care: healthcare services) are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for financial assets held at amortised cost. The impairment loss is also calculated following the same method used for these financial assets. These processes are described in Accounting Policy Note 7.

# ACCOUNTING POLICIES *continued*

for the year ended 31 December 2016

## 14 Relevant healthcare expenditure *continued*

### 14.3 Accredited managed healthcare services (no risk transfer)

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.

## 15 Liability adequacy test

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

## 16 Broker service fees

Broker service fees are fees paid as acquisition costs for the introduction and provision of ongoing services to members and are expensed as incurred.

## 17 Expenses for administration and other operating expenses

Fees paid to the Scheme Administrator are included in Expenses for administration and are expensed as incurred. Other operating expenses include expenses other than administration fees and are expensed as incurred.

## 18 Investment income

Investment income comprises dividends and interest received and accrued on investments at fair value through profit or loss and interest on cash and cash equivalents.

Interest income is recognised using the effective interest method, taking into account the principal amount outstanding and the effective interest rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income from investments is recognised when the right to receive payment is established – this is on the "last day to trade" for listed shares and on the "date of declaration" for unlisted shares.

## 19 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 and recognises them as a reduction of net claims incurred.

## 20 Unallocated funds

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and are included under sundry income on the face of the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under Trade and other payables. The liability is measured at amortised cost using the effective interest rate method.

## 21 Employee benefits

### 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.

## 21 Employee benefits *continued*

### 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.

## 22 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.

## 23 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, excluding interest income on Personal Medical Savings Accounts;
  - 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.

## 24 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 32 to the Annual Financial Statements. The objectives include achieving medium to long-term capital growth and the investment strategy does not include the use of leverage.

These funds are managed by unrelated asset managers who apply various investment strategies to accomplish their respective investment objectives. The investment strategy does not include the use of leverage.

The change in fair value of each fund is included in the Statement of Comprehensive Income in 'Net fair value gains/ (losses) on financial assets at fair value through profit or loss'.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

for the year ended 31 December 2016

| R'000 | 2016 | 2015 |
|---|---|---|
| **1 Accounting policies** | | |
| The accounting policies of the Scheme are set out on pages 93 to 101. | | |
| **2 Financial assets at fair value through profit or loss** | | |
| **The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:** | | |
| Current assets | **12 211 677** | 11 399 332 |
| – Offshore bonds | **1 245 709** | 1 335 137 |
| – Equities | **2 049 834** | 1 415 647 |
| – Yield-enhanced bonds | **3 413 740** | 3 058 012 |
| – Inflation-linked bonds | **610 476** | 464 574 |
| – Money market instruments | **4 891 918** | 5 125 962 |
| | **12 211 677** | 11 399 332 |
| Reconciliation of the balance at the beginning of the year to the balance at the end of the year: | | |
| At the beginning of the year | **11 399 332** | 9 474 520 |
| Acquisitions | **1 922 170** | 6 176 902 |
| Disposals | **(1 127 159)** | (4 465 329) |
| Net gains on revaluation of financial assets at fair value through profit or loss (Note 22) | **17 334** | 213 239 |
| **At the end of the year** | **12 211 677** | 11 399 332 |
| A register of investments is available for inspection at the registered office of the Scheme. | | |
| **3 Trade and other receivables** | | |
| **Insurance receivables** | | |
| Contribution receivables | **1 629 627** | 1 386 504 |
| Contributions outstanding | **1 639 386** | 1 396 137 |
| Less: Provision for impairment | **(9 759)** | (9 633) |
| Member and service provider claims receivables | **84 190** | 70 316 |
| Amount due | **341 473** | 278 845 |
| Less: Provision for impairment | **(257 283)** | (208 529) |
| Other risk transfer arrangements | **24 426** | 7 520 |
| Recoveries due from other risk transfer arrangements | **6 718** | 5 051 |
| Share of outstanding claims provision (Note 6) | **17 708** | 2 469 |
| **Broker fee receivables** | **1 084** | 111 |
| Amounts due from brokers | **1 948** | 895 |
| Less: Provision for impairment | **(864)** | (784) |
| Other insurance receivables | **138 781** | 60 869 |
| **Total receivables arising from insurance contracts** | **1 878 108** | 1 525 320 |

| R'000 | 2016 | 2015 |
|---|---|---|
| **3 Trade and other receivables** *continued* | | |
| **Loans and receivables** | | |
| Balance due by related party | **20 540** | 12 024 |
| Discovery Third Party Recovery Services (Pty) Ltd (Note 27) | **20 540** | 12 024 |
| Sundry accounts receivable | **157 670** | 93 797 |
| Interest receivable | **1 690** | 1 445 |
| **Total receivables arising from loans and receivables** | **179 900** | 107 266 |
| | **2 058 008** | 1 632 586 |
| At 31 December 2016 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. | | |
| **4 Cash and cash equivalents – Personal Medical Savings Account trust assets** | | |
| (Monies managed by the Scheme on behalf of members) | | |
| **PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO** (Managed by Aluwani Capital Partners (Pty) Ltd) (previously Momentum Asset Management) | | |
| **Balance at beginning of the year** | **1 832 987** | 1 594 575 |
| Net additional Investments | **82 668** | 120 220 |
| Interest Income | **154 364** | 118 267 |
| Amortised cost adjustments | **1 372** | (75) |
| **Balance at the end of the year** | **2 071 391** | 1 832 987 |
| **PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO** (Managed by Taquanta Asset Managers (Pty) Ltd) | | |
| **Balance at beginning of the year** | **1 834 469** | 1 594 214 |
| Net additional Investments | **86 660** | 127 524 |
| Interest Income | **150 152** | 112 731 |
| **Balance at the end of the year** | **2 071 281** | 1 834 469 |
| **Total Personal Medical Savings Account trust assets** | **4 142 672** | 3 667 456 |

These funds represent members' Personal Medical Savings Account assets managed by the Scheme on behalf of its members. As required by Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes, these assets have been invested separately from the Scheme's assets. The difference between total Personal Medical Savings Account trust assets and Personal Medical Savings Account trust liabilities (Note 8) is reconciled monthly and arises from timing of cash flows to and from the portfolios. For the year under review the average rate earned on the Personal Medical Savings Account Trust assets was 7.64% (2015: 6.91%).

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

| R'000 | 2016 | 2015 |
|---|---|---|
| **5 Cash and cash equivalents – medical scheme assets** | | |
| Current accounts | **940 981** | 842 123 |
| Money market instruments | **1 456 807** | 1 356 004 |
| | **2 397 788** | 2 198 127 |
| At 31 December 2016 cash and cash equivalents are carried at amortised cost, which approximates fair value. | | |
| **6 Outstanding claims provision** | | |
| Outstanding claims provision – not covered by risk transfer arrangements | **1 103 686** | 982 618 |
| Outstanding claims provision – covered by risk transfer arrangements | **17 708** | 2 469 |
| | **1 121 394** | 985 087 |
| *Analysis of movement in outstanding claims* | | |
| Balance at beginning of the year | **985 087** | 845 795 |
| Payments in respect of prior year | **(951 858)** | (872 043) |
| Over/(under) provision in prior year (Note 11) | **33 229** | (26 248) |
| Outstanding claims provision raised in current year | **1 088 165** | 1 011 335 |
| Not covered by risk transfer arrangements | **1 070 457** | 1 008 866 |
| Covered by risk transfer arrangements (Note 3) | **17 708** | 2 469 |
| **Balance at end of the year** | **1 121 394** | 985 087 |
| *Analysis of outstanding claims provision* | | |
| Estimated gross claims | **1 192 494** | 1 059 065 |
| Less: | | |
| Estimated recoveries from savings plan accounts (Note 8) | **(71 100)** | (73 978) |
| **Balance at end of the year** | **1 121 394** | 985 087 |

| R'000 | 2016 | 2015 |
|---|---|---|
| **7 Derivative financial instruments** | | |
| **Financial assets held at fair value through profit or loss** | | |
| Current assets | | |
| – Derivative financial instruments | **54 760** | – |
| **Financial liabilities held at fair value through profit or loss** | | |
| Current liabilities | | |
| – Derivative financial instruments | **(4 376)** | (65 210) |
| **Derivative financial asset/(liability) at the end of the year** | **50 384** | (65 210) |
| **Reconciliation of the balance at beginning of the year to the balance at the end of the year:** | | |
| **Derivative financial (liability)/asset at the beginning of the year** | **(65 210)** | 16 731 |
| **Net realised (gains)/losses on derivative financial instruments (Note 29.4)** | **(131 351)** | 126 248 |
| Realised gains on derivative financial instruments | **(136 710)** | (36 137) |
| – Equity portfolio derivatives | **(693)** | (2 852) |
| – Zero-cost equity collars | **–** | (785) |
| – Zero-cost currency collars | **(136 017)** | (32 500) |
| Realised losses on derivative financial instruments | **5 359** | 162 385 |
| – Bond portfolio derivatives | **3 719** | – |
| – Zero-cost currency collars | **1 640** | 162 385 |
| **Net fair value gains/(losses) on derivative financial instruments (Note 22)** | **246 944** | (208 189) |
| Gains on revaluation of derivative financial instruments to fair value | **255 039** | 8 823 |
| – Equity portfolio derivatives | **9 138** | 8 823 |
| – Zero-cost equity collars | **91 072** | – |
| – Zero-cost currency collars | **154 829** | – |
| Losses on revaluation of derivative financial instruments to fair value | **(8 095)** | (217 012) |
| – Equity portfolio derivatives | **–** | (5 738) |
| – Zero-cost equity collars | **–** | (63 629) |
| – Zero-cost currency collars | **–** | (147 645) |
| – Bond portfolio derivatives | **(8 095)** | – |
| **Derivative financial asset/(liability) at the end of the year** | **50 384** | (65 210) |

**Derivative Instruments**

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

The Scheme's equity managers entered into All Shareholder Index (ALSI) and SWIX 40 futures contracts to generate an equity-related return on cash held in the equity portfolios.

The Scheme's bond managers entered into bond futures to hedge the bond portfolios and provide protection against market risk.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 32).

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

| R'000 | 2016 | 2015 |
|---|---|---|
| **8 Personal Medical Savings Account trust liabilities** | | |
| (Personal Medical Savings Account trust monies managed by the Scheme on behalf of its members) | | |
| Balance on Personal Medical Savings Accounts at the beginning of the year | **3 736 659** | 3 250 743 |
| Add: | | |
| Personal Medical Savings Accounts contributions received or receivable | **10 429 814** | 9 693 015 |
| For the current year (Note 10) | **10 429 814** | 9 693 015 |
| Interest on Personal Medical Savings Accounts (Note 24) | **287 923** | 232 141 |
| Transfers received from other medical schemes | **13 691** | 19 815 |
| Less: | | |
| Claims paid to or on behalf of members (Note 11) | **(9 942 225)** | (9 199 956) |
| Refunds on death or resignation | **(321 819)** | (259 099) |
| **Balance due to members on Personal Medical Savings Accounts held in trust at the end of the year** | **4 204 043** | 3 736 659 |
| It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2016 but not reported will amount to approximately R71 100 056 (2015: R73 978 313) (Note 6). | | |
| As at 31 December 2016 the carrying amount of the members' Personal Medical Savings Accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature. | | |
| Interest is allocated on these Personal Medical Savings Account balances monthly in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes. The Scheme does not charge interest on negative (overdrawn) Personal Medical Savings Account balances. | | |
| **9 Trade and other payables** | | |
| **Insurance payables** | | |
| Contributions received in advance | **137 260** | 119 036 |
| Contribution refunds due to employers | **1 804** | 1 494 |
| Reported claims not yet paid | **548 257** | 506 752 |
| Balance at the beginning of the year | **506 752** | 334 519 |
| Net movement for the year | **41 505** | 172 233 |
| Broker fee creditors | **97 234** | 87 618 |
| Accredited brokers | **97 234** | 87 618 |
| **Total liabilities arising from insurance contracts** | **784 555** | 714 900 |
| **Financial liabilities** | | |
| Balance due to related parties | **469 924** | 437 982 |
| Discovery Health (Pty) Ltd (Note 27) | **469 924** | 437 982 |
| Unallocated funds | **2 438** | 11 727 |
| Total accruals | **49 328** | 17 996 |
| General accruals | **49 268** | 17 996 |
| Leave pay provision | **60** | – |
| **Total arising from financial liabilities** | **521 690** | 467 705 |
| | **1 306 245** | 1 182 605 |
| At 31 December 2016 the carrying amounts of insurance and other payables approximate their fair values due to the short term maturities of these liabilities. | | |

| R'000 | 2016 | Restated 2015 |
|---|---|---|
| **10 Risk contribution income** | | |
| Gross contributions per registered Scheme rules | **54 056 212** | 49 759 756 |
| Less: | | |
| Personal Medical Savings Account contributions (Note 8) | **(10 429 814)** | (9 693 015) |
| | **43 626 398** | 40 066 741 |
| **11 Net claims incurred** | | |
| Current year claims per registered Scheme rules | **46 578 250** | 42 292 218 |
| Claims not covered by risk transfer arrangements* | **46 227 327** | 41 985 144 |
| Claims covered by risk transfer arrangements (Note 13)* | **350 923** | 307 074 |
| Movement in outstanding claims provision | **136 307** | 139 292 |
| (Over)/under provision in prior year (Note 6) | **(33 229)** | 26 248 |
| Adjustment for current year | **169 536** | 113 044 |
| | **46 714 557** | 42 431 510 |
| Less: | | |
| Claims charged to members' Personal Medical Savings Accounts (Note 8) | **(9 942 225)** | (9 199 956) |
| Claims incurred | **36 772 332** | 33 231 554 |
| Third party claim recoveries | **(159 122)** | (70 736) |
| | **36 613 210** | 33 160 818 |

* *See note 13 to the Annual Financial Statements for explanatory note on change of disclosure.*

**Risk transfer arrangements**

During 2016 the Scheme had six (2015: four) risk transfer arrangements in place. The methodologies used to determine the claims covered by these arrangements are set out below.

1. Risk transfer arrangement covering in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans.

   The claims experience for members on the KeyCare Plus and KeyCare Access plans for the 2016 benefit year that were not part of this risk transfer agreement was used as the basis for determining the claims under this arrangement. These claim amounts are adjusted to include a provision for outstanding claims and then converted to a Per Life Per Month (PLPM) rate using the membership on the KeyCare Plus and KeyCare Access plans.

   In order to determine the value of claims under this arrangement, the average 2016 PLPM rate is multiplied by the lives exposure for this arrangement's membership.

2. Risk transfer arrangement providing optometry services to members on the KeyCare Plus and KeyCare Access plans.

   An analysis as to the expected costs of optometry benefits using the experience from other Scheme plans was conducted. These claim amounts are adjusted to include a provision for outstanding claims and converted to a PLPM rate. Generally the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

3. Risk transfer arrangement providing dentistry services to members on the KeyCare Plus and KeyCare Access plans.

   The cost of the dental group of procedure codes was isolated. Using claims data linked to this group, the overall PLPM cost of dental services on all plans excluding KeyCare Plus and KeyCare Access was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally, the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other benefit plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 11 Net claims incurred *continued*

4. Risk transfer arrangement covering treatment for Executive and Comprehensive Plan members diagnosed with diabetes (type I and II).

   For their diabetes-related treatment, members have a choice of using the managed care organisation under this risk transfer arrangement or not. As the risk profile of the two groups of members are similar, the claims experience of the Executive and Comprehensive Plan members who have not elected to use this provider, was used to estimate the members' fee-for-service cost for those who have elected to use this provider.

   As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

   - PLPM estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive Plan members who have not elected this provider.
   - The expected fee-for-service cost was calculated by multiplying the calculated PLPM costs by the number of members exposed for the period on this programme.

5. Risk transfer arrangement providing acute medication dispensing services to members on the Smart plan.

   The Scheme contracted with two providers as Designated Service Providers (DSP) to provide acute medication dispensing services for Smart plan (newly introduced benefit option in 2016) members. The Scheme remunerates the DSP's at the contracted monthly capitation fee.

   The estimated claims incurred under this arrangement is determined using the acute medicine claims experience for members not on the Smart plan and calculating a PLPM rate. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for Smart plan members.

| R'000 | 2016 | 2015 |
|---|---|---|
| **12 Accredited managed healthcare services (no risk transfer)** | | |
| 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 | **453 235** | 420 464 |
| Hospital Benefit Management Services | **420 400** | 390 431 |
| Managed Care Network Management Services and Risk Management Services | **390 788** | 363 010 |
| Pharmacy Benefit Management Services | **142 844** | 131 885 |
| | **1 407 267** | 1 305 790 |

| R'000 | 2016 | Restated 2015 |
|---|---|---|
| **13 Net (loss) on risk transfer arrangements*** | | |
| **The Scheme operated the following risk transfer arrangements during the year:** | | |
| Risk transfer arrangements fees | **(366 344)** | (344 093) |
| Recoveries under risk transfer arrangements (Note 11) | **350 923** | 307 074 |
| | **(15 421)** | (37 019) |

* *For certain of these arrangements, the Scheme settles claims on behalf of the risk transfer providers. These claims are subsequently recovered from these providers. In prior periods, these recoveries were disclosed as part of "Recoveries under risk transfer arrangements". During the year under review, this disclosure has been reviewed to only include the estimated recoveries under risk transfer arrangements in line with industry practice. This disclosure change has no impact on the Gross healthcare result, the Net healthcare result or the Net surplus previously presented. Total recoveries under risk transfer arrangements and net claims incurred during 2015 was previously presented as R95 million higher, representing the amount of actual recoveries under risk transfer arrangements.*

| R'000 | 2016 | Restated 2015 |
|---|---|---|
| **14 Broker service fees** | | |
| Brokers' fees | **1 101 648** | 982 874 |
| | **1 101 648** | 982 874 |
| **15 Other operating expenses** | | |
| Association fees | **1 616** | 240 |
| Audit fees | **11 594** | 5 432 |
| Audit services for the year ended 2016 | **1 661** | – |
| Audit services for the year ended 2015 | **2 462** | 2 015 |
| Audit services for the year ended 2014 | **–** | 2 550 |
| Other services | **7 471** | 867 |
| Audit and Risk Committee fees (Note 16)* | **1 755** | 1 246 |
| Audit Committee | **1 167** | 835 |
| Risk Committee | **588** | 411 |
| Bank charges | **10 681** | 10 379 |
| Clinical Governance Committee fees | **375** | 74 |
| Council for Medical Schemes | **40 631** | 38 202 |
| Debt collecting fees | **3 850** | 3 222 |
| Dispute Committee fees | **871** | 478 |
| Fidelity Guarantee Insurance | **226** | 224 |
| General meeting costs | **8 986** | 3 218 |
| Investment Committee fees | **323** | 125 |
| Investment reporting fees | **3 416** | 2 571 |
| Legal fees | **816** | 542 |
| Net impairment losses (Note 17) | **75 167** | 71 193 |
| Nomination Committee fees (Note 18) | **571** | 132 |
| Other expenses | **25 499** | 20 732 |
| Principal Officer fees – Remuneration | **5 706** | 5 126 |
| Principal Officer fees – Unvested Long Term Employee Benefit | **1 438** | 1 502 |
| Printing, postage and stationery | **735** | 550 |
| Product Committee fees | **–** | 66 |
| Professional fees | **9 548** | 10 877 |
| Remuneration Committee fees | **109** | 68 |
| Scheme office costs | **6 314** | 4 538 |
| Staff costs (Note 19) | **20 127** | 13 279 |
| Sundry amounts written off | **293** | 192 |
| Stakeholder Relations Committee fees | **129** | 142 |
| Trustees' remuneration and consideration expenses (Note 20) | **5 430** | 4 037 |
| | **236 206** | 198 387 |

* *Enhanced note disclosure has been presented as these committees are separately remunerated.*

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

| R'000 | 2016 | Restated 2015 |
|---|---|---|
| **16 Audit and Risk Committees fees*** | | |
| **Audit Committee fees** | **1 167** | 835 |
| B Stott – Independent Member (Chairperson)[1] | **603** | 468 |
| D Eriksson – Independent Member[2] | **–** | 54 |
| N Novick – Independent Member[3] | **–** | 132 |
| S Green – Independent Member | **158** | 121 |
| D King – Independent Member[4] | **64** | 60 |
| S Ludolph – Independent Member[5] | **163** | – |
| P Maphumulo – Independent Member[5] | **179** | – |
| **Risk Committee fees** | **588** | 411 |
| B Stott – Independent Member (Chairperson)[1] | **161** | 126 |
| D Eriksson – Independent Member[2] | **–** | 45 |
| N Novick – Independent Member[4] | **–** | 97 |
| S Green – Independent Member | **128** | 98 |
| D King – Independent Member[3] | **57** | 45 |
| S Ludolph – Independent Member[5] | **113** | – |
| P Maphumulo – Independent Member[5] | **129** | – |
| | **1 755** | 1 246 |

These are payments to independent members of the Audit and Risk Committees. These members are not Trustees of the Scheme. Amounts paid to Trustee members of these Committees are disclosed in Note 20.

1 *Ex Officio member of the Board of Trustees, as Audit and Risk Committee chairperson.*
2 *Resigned 1 July 2015.*
3 *Resigned 31 December 2015.*
4 *Resigned 23 June 2016.*
5 *Appointed 20 January 2016.*

* *Enhanced note disclosure has been presented as these committees are separately remunerated.*

| R'000 | 2016 | 2015 |
|---|---|---|
| **17 Net impairment losses** | | |
| **Insurance and other receivables** | | |
| Contributions that are not collectable | **126** | 2 527 |
| Movement in provision | **126** | 2 527 |
| Members' and service providers' portions that are not recoverable | **76 422** | 61 005 |
| Movement in provision | **76 422** | 61 005 |
| Amounts due by brokers that are not recoverable | **81** | 184 |
| Movement in provision | **81** | 184 |
| Payables/receivables written off | **(1 462)** | 7 505 |
| Less: | | |
| Previously written off receivables recovered | **–** | (28) |
| | **75 167** | 71 193 |
| **18 Other Committee fees** | | |
| **Nomination Committee fees** | | |
| P Goss – Independent Member (Chairperson) | **201** | 44 |
| T Wixley – Independent Member | **184** | 44 |
| R Shough – Independent Member | **186** | 44 |
| | **571** | 132 |
| **19 Staff costs** | | |
| Salaries and bonuses | **16 466** | 11 837 |
| Pension costs – defined contribution plans | **1 160** | 745 |
| Medical and other benefits | **699** | 499 |
| Long Term Employee Benefit Service Cost | **1 563** | 394 |
| Increase/(decrease) in leave pay accrual | **239** | (196) |
| | **20 127** | 13 279 |
| Number of employees at 31 December | **11** | 11 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 20 Trustees' remuneration and consideration expenses

The following table records the remuneration and consideration paid to Trustees during the year:

| 31 December 2016 | Services as Trustee R'000 | Committee fees: Audit Committee R'000 | Risk Committee R'000 | Investment Committee R'000 | Clinical Governance Committee R'000 | Product Committee R'000 | Committee fees: Non-Healthcare Expenditure Committee R'000 | Remuneration Committee R'000 | Stakeholder Relations Committee R'000 | Trustee Travel R'000 | Total R'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| M Van Der Nest SC (Chairperson) | **813** | **–** | **–** | **–** | **–** | **–** | **–** | **66** | **104** | **22** | **1 005** |
| P Maserumule | **206** | **–** | **–** | **95** | **–** | **–** | **–** | **–** | **35** | **–** | **336** |
| N Graves SC | **247** | **–** | **–** | **46** | **–** | **35** | **64** | **33** | **–** | **13** | **438** |
| Z van der Spuy | **260** | **–** | **–** | **–** | **71** | **45** | **–** | **–** | **–** | **69** | **445** |
| G Waugh | **441** | **129** | **132** | **–** | **–** | **121** | **102** | **–** | **–** | **–** | **925** |
| D Moodley | **207** | **5** | **-** | **56** | **86** | **52** | **–** | **–** | **–** | **24** | **430** |
| N Morrison | **220** | **66** | **71** | **56** | **–** | **5** | **32** | **–** | **–** | **2** | **452** |
| D King | **206** | **–** | **-** | **–** | **–** | **–** | **41** | **33** | **45** | **59** | **384** |
| D Naidoo | **469** | **127** | **133** | **132** | **–** | **52** | **91** | **–** | **–** | **11** | **1 015** |
| **Total** | **3 069** | **327** | **336** | **385** | **157** | **310** | **330** | **132** | **184** | **200** | **5 430** |

| 31 December 2015 | Services as Trustee R'000 | Committee fees: Audit Committee R'000 | Risk Committee R'000 | Investment Committee R'000 | Clinical Governance Committee R'000 | Product Committee R'000 | Committee fees: Non-Healthcare Expenditure Committee R'000 | Remuneration Committee R'000 | Stakeholder Relations Committee R'000 | Trustee Travel R'000 | Total R'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| M Van Der Nest SC (Chairperson) | 602 | – | – | – | – | – | – | 53 | 91 | – | 746 |
| P Maserumule | 314 | – | – | 155 | – | – | – | – | 71 | – | 540 |
| N Graves SC | 336 | – | – | 115 | – | 79 | 101 | 53 | – | – | 684 |
| Z van der Spuy | 324 | – | – | – | 122 | 79 | – | – | – | 86 | 611 |
| G Waugh | 306 | 113 | 98 | – | – | 102 | 79 | – | – | – | 698 |
| D Naidoo | 336 | 113 | 106 | 124 | – | – | 79 | – | – | – | 758 |
| **Total** | **2 218** | **226** | **204** | **394** | **122** | **260** | **259** | **106** | **162** | **86** | **4 037** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

| R'000 | 2016 | 2015 |
|---|---|---|
| **21 Investment income** | | |
| Financial assets at fair value through profit or loss: | **1 200 503** | 971 034 |
| Dividend income | **50 993** | 37 729 |
| Interest income | **1 149 510** | 933 305 |
| Cash and cash equivalents interest income | **56 976** | 47 964 |
| **Investment income per Statement of Comprehensive Income** | **1 257 479** | 1 018 998 |
| The Scheme's total interest income is summarised below. | | |
| **Financial assets not at fair value through profit or loss:** | | |
| | **56 976** | 48 155 |
| Interest received from Administrator (Note 23) | **–** | 191 |
| Cash and cash equivalents interest income | **56 976** | 47 964 |
| **Financial assets at fair value through profit or loss:** | | |
| Interest income | **1 149 510** | 933 305 |
| **Total interest income** | **1 206 486** | 981 460 |
| **22 Net gains on financial assets at fair value through profit or loss** | | |
| **Net fair value gains on financial assets at fair value through profit or loss :** | **17 334** | 213 239 |
| Fair value gains on financial assets at fair value through profit or loss: | **180 725** | 315 387 |
| – Equities | **126 213** | 23 368 |
| – Money market instruments | **598** | 671 |
| – Offshore bonds | **–** | 290 923 |
| – Inflation-linked bonds | **5 574** | 425 |
| – Yield-enhanced bonds | **48 340** | – |
| Fair value losses on financial assets at fair value through profit or loss : | **(163 391)** | (102 148) |
| – Equities | **(64 229)** | (58 738) |
| – Money market instruments | **(2 759)** | (539) |
| – Offshore bonds | **(88 161)** | (32 099) |
| – Inflation-linked bonds | **(7 845)** | (5 918) |
| – Yield-enhanced bonds | **(397)** | (4 854) |
| **Net fair value gains/(losses) on derivative financial instruments:** | **246 944** | (208 189) |
| Fair value gains on derivative financial instruments: | **255 039** | 8 823 |
| Fair value losses on derivative financial instruments: | **(8 095)** | (217 012) |
| **Net fair value gains on cash and cash equivalents** | **–** | 1 454 |
| | **264 278** | 6 504 |

| R'000 | 2016 | 2015 |
|---|---|---|
| **23 Sundry income** | | |
| Interest received from Administrator (Note 21) | **–** | 191 |
| Prescribed amounts written back | **2 433** | 3 678 |
| (Reversal of stale cheques written back)/Stale cheques written back | **(74)** | 3 649 |
| | **2 359** | 7 518 |
| **24 Interest paid** | | |
| Financial assets not at fair value through profit or loss: | | |
| Interest on Personal Medical Savings accounts (Note 8) | **287 923** | 232 141 |
| Interest paid to Administrator (Note 27) | **2 119** | 118 |
| | **290 042** | 232 259 |
| **25 Reserves transferred from other medical schemes** | | |
| Movement in and reserves transferred from amalgamated: | | |
| Altron Medical Scheme | **–** | 198 |
| PG Bison Medical Scheme | **–** | (131) |
| | **–** | 67 |

For further detail in respect of the above transfers, refer to note 26.

## 26 Amalgamations

The effective date of the amalgamations with Altron Medical Scheme and PG Bison Medical Scheme (refer note 25) was prior to 2015 and there have been no movements in these reserves during the year under review. The transactions recorded in 2015 are movements in reserves subsequent to the amalgamation date relating to contributions, claims and operating expenses adjustments.

## 27 Related party transactions

The Scheme is governed by the Board of Trustees who 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, broker services and wellness programmes.

Third party collection services are provided through Discovery Third Party Recovery Services (Pty) Ltd, specialist pharmaceutical services through Southern RX Distributors (Pty) Ltd and home-based care through Grove Nursing Services (Pty) Ltd, all wholly-owned subsidiaries of Discovery Health (Pty) Ltd.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 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 | 2016 | 2015 |
|---|---|---|
| **Statement of Comprehensive Income transactions** | | |
| *Compensation* | | |
| Short term employee benefits | **(26 381)** | (21 704) |
| Unvested Long Term Employee Benefit | **(3 000)** | (1 502) |
| *Contributions* and claims | | |
| Gross contributions received | **724** | 795 |
| Claims paid from the Scheme | **(281)** | (252) |
| Claims paid from the Personal Medical Savings Account | **(163)** | (202) |
| Interest paid on Personal Medical Savings Accounts | **1** | 2 |
| **Statement of Financial Position transactions** | | |
| Long Term Employee Benefit Plan asset | **5 614** | 1 071 |
| Plan asset | **9 738** | 5 136 |
| Plan liability | **(4 124)** | (4 065) |
| Contribution debtors | **35** | 17 |
| Personal Medical Savings Account balances | **(10)** | (28) |
| Trustee remuneration payable | **–** | (58) |

The terms and conditions of the related party transactions were as follows:

| Transactions | Nature of transactions and their terms and conditions |
|---|---|
| Compensation | This constitutes remuneration and consideration paid to Trustees and Executive Officers short term employee benefits and unvested long term employee benefits. |
| Contributions received | This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members. |
| Claims incurred | This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members. |
| Contribution debtors | This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts. |
| Personal Medical Savings Account balances | The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to third parties, the balances earn monthly interest on an accrual basis, at interest rates aligned to the rates earned within the Personal Medical Savings Account trust portfolios. The amounts are all current and would need to be payable on demand as applicable to other members. |

## 27 Related party transactions *continued*

### Transactions with entities that have significant influence over the Scheme

| R'000 | 2016 | 2015 |
|---|---|---|
| **Discovery Health (Pty) Ltd – Administrator** | | |
| **Statement of Comprehensive Income transactions** | | |
| Administration fees paid | **(4 150 194)** | (3 874 896) |
| Interest received on monthly balances (Note 23) | **–** | 191 |
| Interest paid on monthly balances (Note 24) | **(2 119)** | (118) |
| **Statement of Financial Position transactions** | | |
| Balance due to Discovery Health (Pty) Ltd (Note 9)* | **(351 510)** | (327 895) |
| **Discovery Health (Pty) Ltd – Managed care organisation** | | |
| **Statement of Comprehensive Income transactions** | | |
| Accredited managed healthcare services (no risk transfer ) (Note 12) | **(1 407 267)** | (1 305 790) |
| **Statement of Financial Position transactions** | | |
| Balance due to Discovery Health (Pty) Ltd at year end (Note 9)* | **(118 414)** | (110 087) |
| **Discovery Health (Pty) Ltd – Brokers** | | |
| **Statement of Comprehensive Income transactions** | | |
| Broker fees paid | **(14 135)** | – |
| **Discovery Health (Pty) Ltd – Wellness experiences** | | |
| **Statement of Comprehensive Income transactions** | | |
| Claims paid from the Scheme | **(9 541)** | (12 306) |
| **Statement of Financial Position transactions** | | |
| Claims due to provider | **(93)** | – |
| **Discovery Third Party Recovery Services (Pty) Ltd** | | |
| **Statement of Comprehensive Income transactions** | | |
| Third party collection fees | **(22 030)** | (17 695) |
| **Statement of Financial Position transactions** | | |
| Balance due to the Scheme at year end (Note 3) | **20 540** | 12 024 |
| **Southern RX Distributors (Pty) Ltd** | | |
| **Statement of Comprehensive Income transactions** | | |
| Claims paid from the Scheme | **(145 325)** | (71 392) |
| **Statement of Financial Position transactions** | | |
| Claims due to provider | **(1 837)** | (1 168) |
| **Grove Nursing Services (Pty) Ltd** | | |
| **Statement of Comprehensive Income transactions** | | |
| Claims paid from the Scheme | **(9 677)** | (3 686) |
| **Statement of Financial Position transactions** | | |
| Claims (due to)/from provider | **(35)** | 1 |

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R470 million (2015: R438 million), disclosed in Note 9.*

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 27 Related party transactions *continued*

### Transactions with entities that have significant influence over the Scheme *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 Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of the Administrator's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Act. The Scheme and the Administrator shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at a prime-linked rate and is due within 30 days.

The administration fees are an all-inclusive fee, calculated on a Per Member Per Month basis. The total expense for administration cost increases in line with membership growth, however, the Per Member Per Month fee has increased at a rate lower than inflation for a number of years.

The main categories of service provided can be broken down as follows:

- Member and provider servicing;
- Marketing and advertising;
- Financial and actuarial services; and
- Governance, risk, compliance and internal audit.

### Managed healthcare agreements

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.

### Accredited managed healthcare services (no risk transfer)

Managed healthcare services is the cost of managing healthcare expenditure, such as 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.

The managed care agreement is in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of Discovery Health (Pty) Ltd's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Act. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at a prime-linked rate and is due within 30 days.

## 27 Related party transactions *continued*

### Transactions with entities that have significant influence over the Scheme *continued*

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

### Third party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2016 to 31 December 2016 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R14 million (2015: 12 million).

### Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd to provide specialist pharmaceutical services to members of the Scheme.

### Wellness experiences

Discovery Health (Pty) Ltd provides wellness experiences through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

### Home-based nursing services

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare services, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based care to members of the Scheme in the comfort of their home.

### Broker service fees

The Scheme contracted with Discovery Health (Pty) Ltd to provide broker services direct to the consumer. The amounts were paid through the normal broker fee channels. This is a new agreement effective from 2016.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 28 Surplus/(deficit) from operations per benefit plan

| 2016 | Executive R'000 | Classic Comp R'000 | Classic Comp Zero MSA R'000 | Classic Core R'000 | Classic Saver R'000 | Classic Priority R'000 | Essential Comp R'000 | Essential Saver R'000 |
|---|---|---|---|---|---|---|---|---|
| **Risk contribution income** | **875 516** | **9 802 065** | **51 050** | **1 857 849** | **9 115 477** | **4 202 272** | **1 014 102** | **2 885 453** |
| Net claims incurred | (1 157 978) | (9 709 842) | (47 899) | (1 340 447) | (6 784 281) | (3 384 976) | (833 849) | (1 805 622) |
| Claims incurred | (1 159 318) | (9 728 653) | (48 001) | (1 346 843) | (6 817 367) | (3 396 783) | (836 103) | (1 818 786) |
| Third party claim recoveries | 1 340 | 18 811 | 102 | 6 396 | 33 086 | 11 807 | 2 254 | 13 164 |
| Net (loss)/income on risk transfer arrangements | (2 425) | (35 647) | (320) | – | – | – | (4 161) | – |
| Risk transfer arrangement fees | (9 914) | (131 482) | (938) | – | – | – | (13 673) | – |
| Recoveries from risk transfer arrangements | 7 489 | 95 835 | 618 | – | – | – | 9 512 | – |
| Accredited managed healthcare services (no risk transfer) | (12 280) | (172 806) | (915) | (57 064) | (294 412) | (107 268) | (20 650) | (112 847) |
| **Relevant healthcare expenditure** | **(1 172 683)** | **(9 918 295)** | **(49 134)** | **(1 397 511)** | **(7 078 693)** | **(3 492 244)** | **(858 660)** | **(1 918 469)** |
| **Gross healthcare result** | **(297 167)** | **(116 230)** | **1 916** | **460 338** | **2 036 784** | **710 028** | **155 442** | **966 984** |
| Broker service fees | (11 360) | (165 057) | (828) | (42 828) | (259 350) | (102 255) | (20 642) | (86 194) |
| Expenses for administration | (39 938) | (562 224) | (2 975) | (185 567) | (957 550) | (348 811) | (67 157) | (366 937) |
| Other operating expenses | (2 063) | (28 989) | (153) | (9 580) | (49 421) | (18 009) | (3 469) | (18 938) |
| **Net healthcare result** | **(350 528)** | **(872 500)** | **(2 040)** | **222 363** | **770 463** | **240 953** | **64 174** | **494 915** |
| Investment income | 10 968 | 154 294 | 818 | 50 982 | 263 050 | 95 799 | 18 438 | 100 903 |
| Net gains on financial assets at fair value through profit or loss | 2 370 | 33 385 | 174 | 10 798 | 55 540 | 20 560 | 3 986 | 20 697 |
| Sundry income | 20 | 308 | (1) | 95 | 498 | 184 | 33 | 184 |
| **Other income** | **13 358** | **187 987** | **991** | **61 875** | **319 088** | **116 543** | **22 457** | **121 784** |
| Expenses for asset management services rendered | (272) | (3 820) | (23) | (1 259) | (6 505) | (2 369) | (453) | (2 490) |
| Interest paid | (3 806) | (53 555) | – | (83) | (91 299) | (33 251) | (6 402) | (35 016) |
| **Other expenditure** | **(4 078)** | **(57 375)** | **(23)** | **(1 342)** | **(97 804)** | **(35 620)** | **(6 855)** | **(37 506)** |
| ***Net (deficit)/surplus for the year*** | **(341 248)** | **(741 888)** | **(1 072)** | **282 896** | **991 747** | **321 876** | **79 776** | **579 193** |

## 28 Surplus/(deficit) from operations per benefit plan *continued*

| 2016 | Essential Core R'000 | Essential Priority R'000 | Coastal Saver R'000 | Coastal Core R'000 | KeyCare Plus R'000 | KeyCare Core R'000 | KeyCare Access R'000 | Smart R'000 | Total R'000 |
|---|---|---|---|---|---|---|---|---|---|
| **Risk contribution income** | **1 013 633** | **297 133** | **5 385 228** | **2 413 696** | **4 207 970** | **220 866** | **57 055** | **227 033** | **43 626 398** |
| Net claims incurred | (660 685) | (205 856) | (4 491 692) | (1 962 720) | (3 964 639) | (127 085) | (22 924) | (112 715) | 36 613 210) |
| Claims incurred | (665 369) | (206 777) | (4 514 656) | (1 973 413) | (3 993 633) | (128 916) | (23 551) | (114 163) | (36 772 332) |
| Third party claim recoveries | 4 684 | 921 | 22 964 | 10 693 | 28 994 | 1 831 | 627 | 1 448 | 159 122 |
| Net income/(loss) on risk transfer arrangements | – | – | – | – | 31 190 | – | (2 923) | (1 135) | (15 421) |
| Risk transfer arrangement fees | – | – | – | – | (204 582) | – | (2 923) | (2 832) | (366 344) |
| Recoveries from risk transfer arrangements | – | – | – | – | 235 772 | – | – | 1 697 | 350 923 |
| Accredited managed healthcare services (no risk transfer) | (39 701) | (8 360) | (204 472) | (94 660) | (250 933) | (15 471) | (5 423) | (10 005) | (1 407 267) |
| **Relevant healthcare expenditure** | **(700 386)** | **(214 216)** | **(4 696 164)** | **(2 057 380)** | **(4 184 382)** | **(142 556)** | **(31 270)** | **(123 855)** | **(38 035 898)** |
| **Gross healthcare result** | **313 247** | **82 917** | **689 064** | **356 316** | **23 588** | **78 310** | **25 785** | **103 178** | **5 590 500** |
| Broker service fees | (26 669) | (7 510) | (174 400) | (65 440) | (124 596) | (6 517) | (1 794) | (6 208) | (1 101 648) |
| Expenses for administration | (129 091) | (27 182) | (664 984) | (307 902) | (436 502) | (14 540) | (6 115) | (32 719) | (4 150 194) |
| Other operating expenses | (6 662) | (1 404) | (34 320) | (15 889) | (42 119) | (2 598) | (908) | (1 684) | (236 206) |
| **Net healthcare result** | **150 825** | **46 821** | **(184 640)** | **(32 915)** | **(579 629)** | **54 655** | **16 968** | **62 567** | **102 452** |
| Investment income | 35 499 | 7 465 | 182 695 | 84 590 | 224 314 | 13 832 | 4 846 | 8 986 | 1 257 479 |
| Net gains on financial assets at fair value through profit or loss | 7 236 | 1 604 | 38 516 | 17 766 | 46 306 | 2 820 | 1 013 | 1 507 | 264 278 |
| Sundry income | 65 | 13 | 343 | 158 | 411 | 25 | 10 | 13 | 2 359 |
| **Other income** | **42 800** | **9 082** | **221 554** | **102 514** | **271 031** | **16 677** | **5 869** | **10 506** | **1 524 116** |
| Expenses for asset management services rendered | (874) | (184) | (4 516) | (2 090) | (5 540) | (342) | (119) | (220) | (31 076) |
| Interest paid | (57) | (2 591) | (63 409) | (143) | (380) | (23) | (11) | (16) | (290 042) |
| **Other expenditure** | **(931)** | **(2 775)** | **(67 925)** | **(2 233)** | **(5 920)** | **(365)** | **(130)** | **(236)** | **(321 118)** |
| ***Net surplus/(deficit) for the year*** | **192 694** | **53 128** | **(31 011)** | **67 366** | **(314 518)** | **70 967** | **22 707** | **72 837** | **1 305 450** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 28 Surplus/(deficit) from operations per benefit plan continued

| 2015 | Executive R'000 | Classic Comp R'000 | Classic Comp Zero MSA R'000 | Classic Core R'000 | Classic Saver R'000 | Classic Priority R'000 | Essential Comp R'000 | Essential Saver R'000 |
|---|---|---|---|---|---|---|---|---|
| **Risk contribution income** | **830 871** | **9 626 771** | **43 280** | **1 763 910** | **8 085 165** | **4 009 464** | **1 043 009** | **2 465 336** |
| Net claims incurred* | (1 090 864) | (9 344 752) | (39 684) | (1 224 311) | (5 841 078) | (3 172 290) | (836 186) | (1 516 002) |
| Claims incurred* | (1 091 535) | (9 354 646) | (39 725) | (1 227 405) | (5 855 182) | (3 178 190) | (837 485) | (1 521 065) |
| Third party claim recoveries | 671 | 9 894 | 41 | 3 094 | 14 104 | 5 900 | 1 299 | 5 063 |
| Net (loss)/income on risk transfer arrangements* | (4 040) | (54 466) | (450) | – | – | – | (5 969) | – |
| Risk transfer arrangement fees | (9 876) | (126 167) | (916) | – | – | – | (13 327) | – |
| Recoveries from risk transfer arrangements* | 5 836 | 71 701 | 466 | – | – | – | 7 358 | – |
| Accredited managed healthcare services (no risk transfer) | (11 999) | (174 863) | (785) | (55 739) | (267 757) | (105 682) | (21 745) | (97 571) |
| **Relevant healthcare expenditure** | **(1 106 903)** | **(9 574 081)** | **(40 919)** | **(1 280 050)** | **(6 108 835)** | **(3 277 972)** | **(863 900)** | **(1 613 573)** |
| **Gross healthcare result** | **(276 032)** | **52 690** | **2 361** | **483 860** | **1 976 330** | **731 492** | **179 109** | **851 763** |
| Broker service fees | (10 775) | (159 699) | (682) | (40 608) | (224 310) | (95 695) | (19 802) | (70 895) |
| Expenses for administration | (39 226) | (571 646) | (2 567) | (182 213) | (875 309) | (345 486) | (71 177) | (318 954) |
| Other operating expenses | (1 819) | (26 511) | (119) | (8 465) | (40 677) | (16 035) | (3 297) | (14 852) |
| **Net healthcare result** | **(327 852)** | **(705 166)** | **(1 007)** | **252 574** | **836 034** | **274 276** | **84 833** | **447 062** |
| Investment income | 10 405 | 151 633 | 473 | 33 587 | 232 309 | 91 660 | 18 856 | 84 714 |
| Net gains on financial assets at fair value through profit or loss | 106 | 1 529 | 6 | 294 | 1 481 | 800 | 188 | 154 |
| Sundry income | 69 | 1 002 | 3 | 321 | 1 542 | 606 | 124 | 564 |
| **Other income** | **10 580** | **154 164** | **482** | **34 202** | **235 332** | **93 066** | **19 168** | **85 432** |
| Expenses for asset management services rendered | (288) | (4 189) | (19) | (1 348) | (6 461) | (2 539) | (521) | (2 380) |
| Interest paid | (3 177) | (46 308) | – | (5) | (70 993) | (27 999) | (5 758) | (25 912) |
| Other expenditure | (3 465) | (50 497) | (19) | (1 353) | (77 454) | (30 538) | (6 279) | (28 292) |
| ***Net (deficit)/surplus for the year*** | **(320 737)** | **(601 499)** | **(544)** | **285 423** | **993 912** | **336 804** | **97 722** | **504 202** |

* *See note 13 to the Annual Financial Statements for explanatory note on change of disclosure.*

## 28 Surplus/(deficit) from operations per benefit plan *continued*

| 2015 | Essential Core R'000 | Essential Priority R'000 | Coastal Saver R'000 | Coastal Core R'000 | KeyCare Plus R'000 | KeyCare Core R'000 | KeyCare Access R'000 | Total R'000 |
|---|---|---|---|---|---|---|---|---|
| **Risk contribution income** | **870 164** | **302 973** | **4 784 988** | **2 179 506** | **3 803 900** | **205 967** | **51 437** | **40 066 741** |
| Net claims incurred* | (578 249) | (186 734) | (3 915 586) | (1 713 148) | (3 585 417) | (91 452) | (25 065) | (33 160 818) |
| Claims incurred* | (580 074) | (187 273) | (3 925 543) | (1 717 962) | (3 597 787) | (92 312) | (25 370) | (33 231 554) |
| Third party claim recoveries | 1 825 | 539 | 9 957 | 4 814 | 12 370 | 860 | 305 | 70 736 |
| Net income/(loss) on risk transfer arrangements* | – | – | – | – | 30 742 | – | (2 836) | (37 019) |
| Risk transfer arrangement fees | – | – | – | – | (190 971) | – | (2 836) | (344 093) |
| Recoveries from risk transfer arrangements* | – | – | – | – | 221 713 | – | – | 307 074 |
| Accredited managed healthcare services (no risk transfer) | (34 605) | (8 835) | (187 572) | (88 982) | (229 779) | (14 735) | (5 141) | (1 305 790) |
| **Relevant healthcare expenditure** | **(612 854)** | **(195 569)** | **(4 103 158)** | **(1 802 130)** | **(3 784 454)** | **(106 187)** | **(33 042)** | **(34 503 627)** |
| **Gross healthcare result** | **257 310** | **107 404** | **681 830** | **377 376** | **19 446** | **99 780** | **18 395** | **5 563 114** |
| Broker service fees | (22 914) | (7 483) | (150 846) | (60 125) | (111 395) | (6 056) | (1 589) | (982 874) |
| Expenses for administration | (113 121) | (28 882) | (613 181) | (290 883) | (402 605) | (13 849) | (5 797) | (3 874 896) |
| Other operating expenses | (5 271) | (1 340) | (28 489) | (13 523) | (34 964) | (2 243) | (782) | (198 387) |
| **Net healthcare result** | **116 004** | **69 699** | **(110 686)** | **12 845** | **(529 518)** | **77 632** | **10 227** | **506 957** |
| Investment income | 20 861 | 7 662 | 162 740 | 53 623 | 138 494 | 8 882 | 3 099 | 1 018 998 |
| Net losses on financial assets at fair value through profit or loss | (23) | 68 | 1 045 | 381 | 456 | 13 | 6 | 6 504 |
| Sundry income | 201 | 51 | 1 079 | 513 | 1 328 | 85 | 30 | 7 518 |
| **Other income** | **21 039** | **7 781** | **164 864** | **54 517** | **140 278** | **8 980** | **3 135** | **1 033 020** |
| Expenses for asset management services rendered | (850) | (212) | (4 529) | (2 156) | (5 600) | (360) | (126) | (31 578) |
| Interest paid | (3) | (2 341) | (49 733) | (8) | (21) | (1) | – | (232 259) |
| **Other expenditure** | **(853)** | **(2 553)** | **(54 262)** | **(2 164)** | **(5 621)** | **(361)** | **(126)** | **(263 837)** |
| ***Net surplus/(deficit) for the year*** | **136 190** | **74 927** | **(84)** | **65 198** | **(394 861)** | **86 251** | **13 236** | **1 276 140** |

* *See note 13 to the Annual Financial Statements for explanatory note on change of disclosure.*

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

| R'000 | 2016 | 2015 |
|---|---|---|
| **29 Cash flows from operations before working capital changes** | | |
| Net surplus for the year | **1 305 450** | 1 276 140 |
| Adjustments for: | | |
| Impairment losses (Note 15) | **75 167** | 71 193 |
| Interest received (Note 21) | **(1 206 486)** | (981 460) |
| Dividend income (Note 21) | **(50 993)** | (37 729) |
| Interest paid (Note 24) | **290 042** | 232 259 |
| Unvested Long Term Employee Benefit | **3 000** | 1 894 |
| Net gains on financial assets at fair value through profit or loss (Note 22) | **(264 278)** | (6 504) |
| | **151 902** | 555 793 |
| **Reconciliation of movements in the cash flow statement** | | |
| **29.1 Increase in trade and other receivables** | **(500 589)** | (99 229) |
| Opening balance | **1 632 586** | 1 604 550 |
| Closing balance | **(2 058 008)** | (1 632 586) |
| Impairment losses | **(75 167)** | (71 193) |
| **29.2 Increase in trade and other payables** | **123 640** | 151 366 |
| Opening balance | **(1 182 605)** | (1 031 239) |
| Closing balance (Note 9) | **1 306 245** | 1 182 605 |
| **29.3 Purchases of financial instruments** | **(1 922 170)** | (6 176 902) |
| Financial assets at Fair value (Note 2) | **(1 922 170)** | (6 176 902) |
| **29.4 Proceeds from sale of financial instruments** | **1 258 510** | 4 339 081 |
| Financial assets at Fair value (Note 2) | **1 127 159** | 4 465 329 |
| Derivative financial instruments (Note 7) | **131 351** | (126 248) |

## 30 Events after the reporting period

No significant events occurred between the reporting date and the date the financial statements were authorised for issue.

## 31 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.

The risks that the Scheme faces can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

### Hospital benefits

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional, medication, equipment and consumables.

### Day-to-day benefits

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the Personal Medical Savings Account (PMSA) and an insurance risk element. This includes the Insured Network 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 61 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions. These include conditions such as HIV/Aids, high blood pressure, cholesterol and asthma.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 31 Insurance risk management report *continued*

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

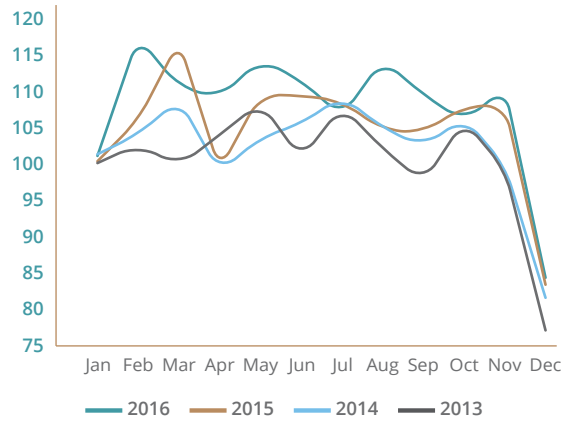
### Hospital benefit risk

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.

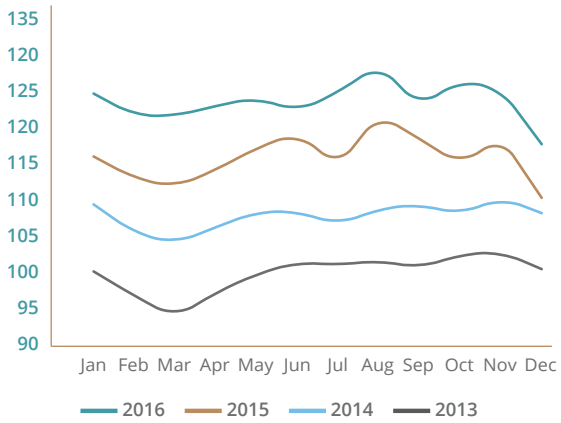
An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The following graphs indicate the change in the admission rate over the past four years as well as the impact on the cost per event. These graphs are indexed to a value of 100 as at January 2013.

**Hospital Admission Rate**
(Indexed to Jan 2013 = 100)




**Total Cost Per Event**
(Indexed to Jan 2013 = 100)

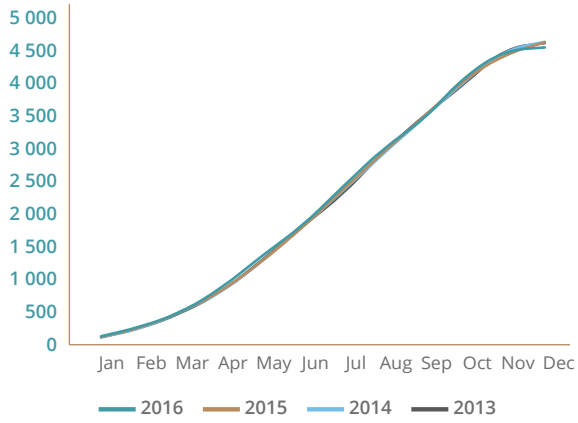



### Day-to-day benefits risk

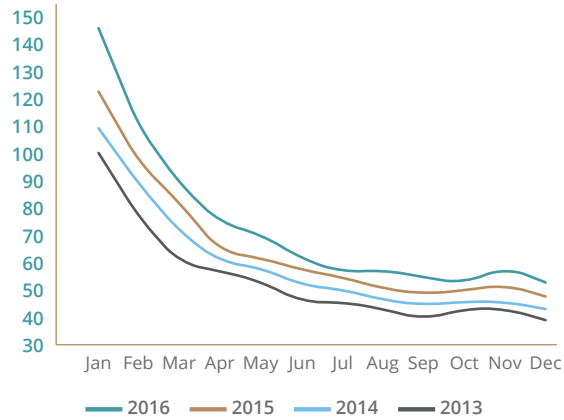
For the Above Threshold Benefit component, the frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options will also have an impact on the claims.

The frequency of these claims increases throughout the year as an increased number of members run out of their medical savings.

**Claimants Per 1000 From Above Threshold Benefits**
(Indexed to Jan 2013 = 100)




**Cost Per ATB Claimant**
(Indexed to Jan 2013 = 100)



## 31 Insurance risk management report *continued*

### Chronic benefits risk

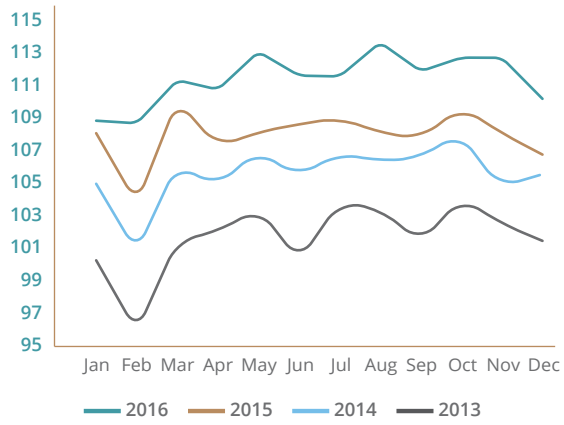
The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

The cost per claimant increases during the year because Single Exit Price increases usually occur during the first quarter (as opposed to other price increases which happen on 1 January). Each manufacturer also has discretion as to exactly when they will implement this increase following the publication of the increase by the Department of Health.

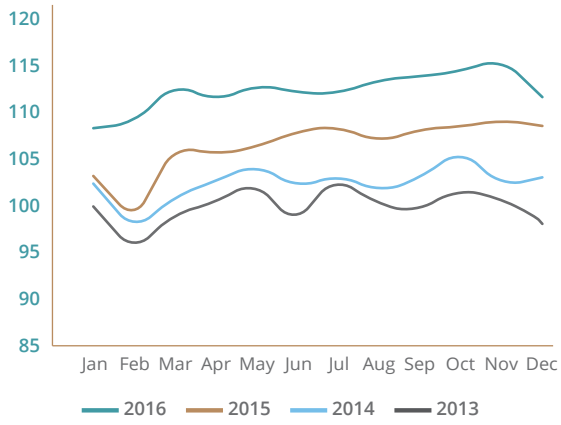
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. 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.

The following graphs indicate the change in the number of claimants over the past four years as well as the impact on the cost per claimant. These graphs are indexed to a value of 100 as at January 2013.

**Chronic Claimants Per 1000 Beneficiaries**
(Indexed to Jan 2013 = 100)




**Chronic Cost Per Claimant**
(Indexed to Jan 2013 = 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 Clinical Policy Unit, 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.
- The establishment of a 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.
- The establishment of the Coordinated Care Programme (CCP). This is a dedicated unit to ensure direct coordination of care from medical providers to high risk beneficiaries that are exposed to conditions that would generate multiple admissions if not managed.
- The establishment of an Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients that are terminally ill.
- The establishment of a disease management unit dedicated to managing high risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Clinical Policy Unit is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 31 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 contribution 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 six (2015: four) risk transfer agreements in which suppliers are paid to provide certain minimum benefits to Scheme members, as and when it is required by the members. These arrangements fix the cost to the Scheme of providing these benefits.

The first risk transfer arrangement covers in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans. There are also two arrangements providing optometry and dentistry services to members on the KeyCare Plus and KeyCare Access plans. The fourth arrangement covers the treatment for Executive and Comprehensive plan members diagnosed with diabetes (type I and II). The fifth and sixth arrangements covers Smart plan (newly introduced in 2016) members for acute medication prescribed by their network doctors.

#### Risk in terms of risk transfer arrangements

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. This is to mitigate against the reputational and operational risks that the Scheme faces should a supplier not meet its obligations. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims which are included in the arrangement.

#### Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments are typically resolved within one year and in the majority of cases within three months. At year end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chainladder method and another method using the estimated cost per event and pre-authorised admissions is also followed.

The estimation of the December 2016 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.

## 31 Insurance risk management report *continued*

### Concentration of insurance risk *continued*

Based on the processing patterns and claims development up to the end of December 2016 in respect of treatment dates during 2016, the provision for outstanding claims as at 31 December 2016 is R1 121 million (2015: R985 million).

| R'000 | 2016 | 2015 |
|---|---|---|
| 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 | **26 807 352** | 24 063 065 |
| Chronic claims incurred | **2 271 897** | 2 052 610 |
| Out-of-hospital risk claims incurred | **7 745 832** | 7 033 552 |

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 2016 R'000 | Impact on outstanding claims provision 2015 R'000 |
|---|---|---|---|
| In-hospital claims incurred | 1% reduction in claims processing | **318 755** | 233 675 |
| Chronic claims incurred | 1% reduction in claims processing | **7 682** | 8 687 |
| Out-of-hospital risk claims incurred | 1% reduction in claims processing | **78 728** | 67 418 |

#### 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 94% (2015: 98%) of this provision is settled within three months after the claim was incurred. 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 are always sufficiently liquid to meet current liabilities while excess reserves are invested to maximise investment return within the scope of Regulations to the Medical Schemes Act.

### Assumption risk

The Scheme's reserves and therefore solvency are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include assumptions regarding utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

## 32 Financial risk management report

### Overview

The Scheme is exposed to financial risk through its financial assets, insurance assets, financial liabilities and insurance liabilities. In particular, the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

The Board of Trustees has overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Overview *continued*

The Scheme manages the financial risks as follows:

- The Investment Committee, a committee of the Board of Trustees, determines, recommends, implements and maintains investment policies and procedures. The Investment Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- An independent valuation is performed by a third party.

### Personal Medical Savings Account trust assets

These portfolios have been established to manage members' Personal Medical Savings Account balances in portfolios which are distinct and separate from the Scheme.

The Scheme appointed two asset managers, Aluwani Capital Partners (Pty) Ltd (previously Momentum Asset Management) and Taquanta Asset Managers, to manage the assets underlying the members' Personal Medical Savings Account balances. These portfolios are managed in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes.

Changes in the interest rates have no bearing on the Scheme's surplus or deficit as the investment income earned, net of fees, is allocated to the members' Personal Medical Savings Account balance. Consequently, no further analysis is presented.

### Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

| R'000 | Total | Currency risk | Price risk | Interest rate risk |
|---|---|---|---|---|
| **31 December 2016** | | | | |
| **Investments** | **12 211 677** | | | |
| Offshore bonds | **1 245 709** | ✓ | | ✓ |
| Equities | **2 049 834** | | ✓ | |
| Yield enhanced bonds | **3 413 740** | | | ✓ |
| Inflation linked bonds | **610 476** | | | ✓ |
| Money market instruments | **4 891 918** | | | ✓ |
| **31 December 2015** | | | | |
| **Investments** | **11 399 332** | | | |
| Offshore bonds | 1 335 137 | ✓ | | ✓ |
| Equities | 1 415 647 | | ✓ | |
| Yield enhanced bonds | 3 058 012 | | | ✓ |
| Inflation linked bonds | 464 574 | | | ✓ |
| Money market instruments | 5 125 962 | | | ✓ |

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.

## 32 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 has invested 10 % (2015: 12%) of its investable assets in offshore bond portfolios (reference currency is the US dollar). Derivative financial instruments are utilised by bond managers within these portfolios to manage various currency exposures. At 31 December 2016 this equates to R1 246 million (2015: R1 335 million) (Note 2).

#### ▪ Currency derivatives financial instrument (zero-cost currency collars)

The Scheme enters into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in the Rand/US dollar rate with respect to its offshore bond portfolios. The current contract expires during 2017 and was entered into with the cap at R14.77 (9.5% above the floor level) to the US Dollar. The spot level (the floor) was entered into at R13.49 to the US Dollar.

The collar is not designated as a hedge instrument and hedge accounting is thus not applicable to the collar. The collar is categorised as fair value through profit or loss.

At the time of expiry the following transactions could occur depending on the rate at which the Rand is trading against the US Dollar:

If the spot rate is higher than the cap, the Scheme would be required to pay the difference between the cap and the spot rate to the counterparty.

- If the spot rate is trading lower than the cap but higher than the floor, no action would take place.
- If the spot rate is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the spot rate to the Scheme.

The fair value of these contracts have been included in financial assets. Gains and losses on these arrangements are included in the surplus (Note 7).

#### ▪ Currency risk sensitivity analysis

A 5% depreciation in the Rand would result in a gain on offshore bonds of R62 million (2015: R67 million) and a 15% depreciation in the Rand would result in a gain of R187 million (2015: R200 million). A 5% appreciation in the Rand would result in a loss of R62 million (2015: R67 million) and a 15% appreciation in the Rand would result in a loss of R187 million (2015: R200 million). This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that the Rand has strengthened or weakened against the US Dollar by 5% or 15%, with all other variables held constant. The analysis is performed without taking into account the effect of the currency hedges. If you consider the impact of hedging through the use of zero cost currency collars, all Rand appreciation below the current floor level of the zero cost currency collar is covered on a one-for-one basis i.e. for every Rand lost on the actual offshore bond portfolio you gain a Rand on the zero cost currency collar. Given current cap level pricing on zero cost currency collars, neither a 5% nor 15% depreciation of the Rand would impact overall currency gains of the actual offshore bond portfolio.

### Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as fair value through profit and loss. The Scheme is indirectly exposed to commodity risk through its investments in listed equities. The value of the Scheme's equity investments amounted to R2 billion (2015: R1.4 billion) (Note 2).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios are performed by asset managers in accordance with the mandate set by the Scheme.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market.

#### ▪ Equity derivative financial instrument (zero-cost equity collars)

The Scheme entered into zero-cost equity collar arrangements to hedge approximately 100% of the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 15% after a reduction in equity prices of 5% (Scheme at risk for the first 5% drop in equity prices). To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the pre-determined level (the cap). The cap for these contracts range between 16% and 18% above the pre-determined level. These contracts expire during 2017.

The fair value of these contracts have been included in financial assets and financial liabilities. Gains and losses on these arrangements are included in the Net surplus (Note 7).

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Price risk *continued*

**At the time of expiry the following transactions could occur depending on the level at which the equity index trades:**

- If the index level is higher than the cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the floor, no action would take place.
- If the index level is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the index level to the Scheme.

#### Equity price risk sensitivity analysis

A 5% increase in the price of equities within the equity portfolios would result in a gain of R102 million (2015: R73 million) and a 15% increase would result in a gain of R307 million (2015: R218 million). A 5% decrease would result in a loss of R102 million (2015: R73 million) and a decrease of 15% would result in a loss of R307 million (2014: R218 million). This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that equity prices had increased or decreased by 5% or 15%, with all other variables held constant. The analysis is performed without taking into account the affect of the equity hedges.

If we considered the effect of the current open hedges, gains on the equity portfolios for 5% and 15% increases in equity prices would not effect returns as the caps on these hedges are set at higher levels i.e. 16% to 18%. For a drop of 5% and 15% in equity prices, the above stated losses would reduce to approximately R18 million and R27 million respectively.

### Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in short dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

| **As at 31 December 2016** | **0 – 3 Months R'000** | **3 – 12 Months R'000** | **> 12 Months R'000** | **Total R'000** |
|---|---|---|---|---|
| Cash and cash equivalents | **2 397 788** | **–** | **–** | **2 397 788** |
| Money market instruments carried at fair value through profit or loss | **–** | **4 891 918** | **–** | **4 891 918** |
| Yield enhanced bonds carried at fair value through profit or loss | **–** | **3 413 740** | **–** | **3 413 740** |
| Inflation linked bonds carried at fair value through profit or loss | **–** | **610 476** | **–** | **610 476** |
| Offshore bonds carried at fair value through profit or loss | **–** | **1 245 709** | **–** | **1 245 709** |

| As at 31 December 2015 | 0 – 3 Months R'000 | 3 – 12 Months R'000 | > 12 Months R'000 | Total R'000 |
|---|---|---|---|---|
| Cash and cash equivalents | 2 198 127 | – | – | 2 198 127 |
| Money market instruments carried at fair value through profit or loss | – | 5 125 962 | – | 5 125 962 |
| Yield enhanced bonds carried at fair value through profit or loss | – | 3 058 012 | – | 3 058 012 |
| Inflation linked bonds carried at fair value through profit or loss | – | 464 574 | – | 464 574 |
| Offshore bonds carried at fair value through profit or loss | – | 1 335 137 | – | 1 335 137 |

The following table summarises the weighted average interest rate for monetary financial instruments:

| % | **2016** | 2015 |
|---|---|---|
| Money market instruments carried at fair value through profit or loss | **7.40** | 6.09 |
| Cash and cash equivalents | **7.23** | 5.85 |

The weighted average interest rate on short-term bank deposits (namely call account deposits) was 6.70% (2015 – 5.95%). These deposits have an average maturity of 25 days (2015 – 25 days).

## 32 Financial risk management report *continued*

### Interest rate risk *continued*

- **Interest rate risk sensitivity analysis**

A 1% increase in local interest rates would result in a gain of R332k (2015: loss of R9.5 million), and a 2% increase would result in a loss of R240k (2015: loss of R14.1 million). A 1% decrease in local interest rates would result in a gain of R1.1 million (2015: gain of R11.1 million) and a decrease of 2% would result in a loss of R2.7 million (2015: gain of R16.9 million). This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that local interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

A 1% increase in foreign interest rates would result in a loss of R64 million (2015: R66 million) and a 2% increase would result in a loss of R127 million (2015: R 133 million). A 1% decrease in foreign interest rates would result in a gain of R64 million (2015: R66 million) and a decrease of 2% would result in a gain of R127 million (2015: R133 million). This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

The majority of the Scheme's assets are invested in variable interest rate instruments with a significant portion of the fixed rate instruments maturing in the short term. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets due to the short duration thereof.

### Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2016 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

### Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities. Continuous monitoring takes place to ensure that appropriate liquid assets are held to meet the Scheme's liabilities, are dependent upon the performance of the investment portfolio and that a suitable match of assets exists for all liabilities.

The Scheme's Investment Committee oversees that the funds are invested in line with the Act.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at minimal risk, subject to any constraints imposed by legislation or the Board of Trustees. The Scheme diversifies its investment portfolio by investing in short-term deposits, bond, money market and equity portfolios managed by reputable asset managers.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure that the Scheme receives the benefit of top performing asset managers.

### Breakdown of investments

The investments are split between the following in the Annual Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Breakdown of investments *continued*

| R'000 | Segregated Funds | Collective Investment Schemes | Policy of Insurance | Total |
|---|---|---|---|---|
| **31 December 2016** | | | | |
| **Investments** | **10 965 968** | **672 885** | **572 824** | **12 211 677** |
| Offshore bonds | **–** | **672 885** | **572 824** | **1 245 709** |
| Equities | **2 049 834** | **–** | **–** | **2 049 834** |
| Yield enhanced bonds | **3 413 740** | **–** | **–** | **3 413 740** |
| Inflation linked bonds | **610 476** | **–** | **–** | **610 476** |
| Money market instruments | **4 891 918** | **–** | **–** | **4 891 918** |
| **Cash and cash equivalents:** | **940 981** | **1 456 807** | **–** | **2 397 788** |
| | **11 906 949** | **2 129 692** | **572 824** | **14 609 465** |
| **31 December 2015** | | | | |
| **Investments** | 10 064 195 | 716 812 | 618 325 | 11 399 332 |
| Offshore bonds | – | 716 812 | 618 325 | 1 335 137 |
| Equities | 1 415 647 | – | – | 1 415 647 |
| Yield enhanced bonds | 3 058 012 | – | – | 3 058 012 |
| Inflation linked bonds | 464 574 | – | – | 464 574 |
| Money market instruments | 5 125 962 | – | – | 5 125 962 |
| **Cash and cash equivalents:** | 842 123 | 1 356 004 | – | 2 198 127 |
| | 10 906 318 | 2 072 816 | 618 325 | 13 597 459 |

#### Money Market Portfolios

**Local portfolios**

The two local money market portfolios are each managed by an independent asset manager. The investment mandate is for an actively managed portfolio of financial products aimed at achieving out performance of the targeted (benchmark) return.

For the first portfolio, the weighted modified duration of the portfolio shall not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed 2 years. The term of each individual instrument is also limited.

The second portfolio has a number of liquidity restrictions ranging from a minimum of 20% of the assets under administration being available within 24 hours to an average portfolio duration of 180 days.

The performance of these portfolios is measured against the Short Term Fixed Income (STeFI) Composite Index.

The local money market portfolios comprise approximately 40% (2015: 45%) of the Scheme's Financial assets at fair value through profit or loss.

#### Bond portfolios

**Local portfolios**

The Scheme has two bond portfolios, each managed by an independent asset manager.

The one portfolio invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include but are not limited to asset types such as, listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is the 3-month Johannesburg Interbank Agreed Rate (JIBAR).

The second portfolio is a specialist yield-enhanced bond portfolio investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is 20% BEASSA All Bond Index (ALBI) and 80% STeFI. Mid-2016, the Scheme transitioned this portfolio to AA SteFI+ mandate which incorporates money market, fixed interest and yield enhanced debt and thereby reducing overall duration (interest rate risk) on this portfolio. The new portfolio's benchmark is the STeFI.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty and sets exposure limits to unrated investments. These portfolios comprise approximately 28% (2015: 27%) of the Scheme's financial assets at fair value through profit or loss.

## 32 Financial risk management report *continued*

### Breakdown of investments *continued*

**Offshore portfolios**

The Scheme has two offshore portfolios each managed by independent asset managers.

The primary objective of the first portfolio was the generation of a high level of income by means of investments in high-yielding fixed or floating rate securities of varying maturities denominated in a spread of currencies. The portfolio was structured as a collective investment undertaking with the Barclays Capital Global Aggregate as its benchmark index. During 2016, this product offering was terminated by the asset manager and the Scheme transferred the proceeds to a different fund offering that aims both to provide income and to protect and maximize the real asset value of its investments in terms of their international purchasing power by means of the management and diversification of currency exposure and investment in fixed interest bearing securities of varying maturities. The majority of the fund's assets are denominated in major currencies and exposure to minor currencies is managed on a cautious basis. The fund is benchmarked against ICE LIBOR Spot/Next Overnight USD.

The primary objective of the second portfolio is the long-term growth of capital and income and is a policy of insurance referencing participatory interests in a foreign collective investment scheme portfolio investing in fixed income instruments. The benchmark for this portfolio is the Barclays Capital Global Aggregate.

These portfolios comprise approximately 10% (2015: 12%) of the Scheme's financial assets at fair value through profit or loss.

**Inflation linked bonds**

The Scheme has two inflation-linked bond portfolios, each managed by an independent asset manager. The primary mandate of the first portfolio is aimed at generating inflation-linked bond returns on initial capital invested and achieving outperformance of the benchmarks on the JSE Composite Inflation-Linked Index (CILI).

The second portfolio is a fully discretionary, actively managed portfolio of inflation-linked and fixed income instruments. The portfolio only invests funds in domestic instruments. The returns of the portfolio are measured against the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV Index).

These portfolios comprise approximately 5% (2015: 4%) of the Scheme's Financial assets at fair value through profit or loss.

**Equity portfolios:**

The Scheme has three equity portfolios each managed by an independent asset manager.

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. The portfolios are managed on a moderate risk basis.

The portfolios may only be invested in South African equities and are subject to a maximum cash allocation of 5%. The portfolios are prohibited from investing in Discovery Limited or its subsidiaries and tobacco companies (as per the Scheme's responsible investment policy) and must comply with the Act.

The performance of the portfolios is measured against the benchmark, which is the FTSE/JSE Shareholder weighted index (SWIX) less tobacco (as per the Scheme's responsible investment policy).

These portfolios comprise approximately 17% (2015: 12%) of the Scheme's Financial assets at fair value through profit or loss.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Breakdown of investments *continued*

The following table compares the fair value and carrying amounts of assets and liabilities per class of assets and liabilities.

| | Financial assets and liabilities at fair value through profit and loss | | | | | | |
|---|---|---|---|---|---|---|---|
| | Designated upon initial recognition R'000 | Classified as held for trading R'000 | Loans and receivables R'000 | Insurance receivables and (payables) R'000 | Financial liabilities at amortised cost R'000 | Total carrying amount R'000 | Fair value amount R'000 |
| **31 December 2016** | | | | | | | |
| **Investments** | | | | | | | |
| – Offshore bond portfolio | **1 245 709** | **–** | **-** | **–** | **–** | **1 245 709** | **1 245 709** |
| – Listed equities | **2 049 834** | **–** | **–** | **–** | **–** | **2 049 834** | **2 049 834** |
| – Yield-enhanced bond portfolio | **3 413 740** | **–** | **–** | **–** | **–** | **3 413 740** | **3 413 740** |
| – Inflation-linked bond portfolio | **610 476** | **–** | **–** | **–** | **–** | **610 476** | **610 476** |
| – Money market portfolios | **4 891 918** | **–** | **–** | **–** | **–** | **4 891 918** | **4 891 918** |
| **Cash and cash equivalents:** | | | | | | | |
| Medical Scheme assets | **–** | **–** | **2 397 788** | **–** | **–** | **2 397 788** | **2 397 788** |
| Personal Medical Savings Account trust assets | | | **4 142 672** | | | **4 142 672** | **4 142 672** |
| **Trade and other receivables** | **–** | **–** | **179 900** | **1 878 108** | **–** | **2 058 008** | **2 058 008** |
| **Personal Medical Savings Accounts** | **–** | **–** | **(4 204 043)** | | **–** | **(4 204 043)** | **(4 204 043)** |
| **Trade and other payables** | **–** | **–** | **–** | **(784 555)** | **(521 690)** | **(1 306 245)** | **(1 306 245)** |
| **Derivatives held for trading** | | | | | | | |
| – Zero-cost collars | **–** | **50 384** | **–** | **–** | **–** | **50 384** | **50 384** |
| | **12 211 677** | **50 384** | **2 516 317** | **1 093 553** | **(521 690)** | **15 350 241** | **15 350 241** |

## 32 Financial risk management report *continued*

| | Financial assets and liabilities at fair value through profit and loss | | | | | | |
|---|---|---|---|---|---|---|---|
| | Designated upon initial recognition R'000 | Classified as held for trading R'000 | Loans and receivables R'000 | Insurance receivables and (payables) R'000 | Financial liabilities at amortised cost R'000 | Total carrying amount R'000 | Fair value amount R'000 |
| **31 December 2015** | | | | | | | |
| **Investments** | | | | | | | |
| – Offshore bond portfolio | 1 335 137 | – | – | – | – | 1 335 137 | 1 335 137 |
| – Listed equities | 1 415 647 | – | – | – | – | 1 415 647 | 1 415 647 |
| – Yield-enhanced bond portfolio | 3 058 012 | – | – | – | – | 3 058 012 | 3 058 012 |
| – Inflation-linked bond portfolio | 464 574 | – | – | – | – | 464 574 | 464 574 |
| – Money market portfolios | 5 125 962 | – | – | – | – | 5 125 962 | 5 125 962 |
| **Cash and cash equivalents:** | | | | | | | |
| Medical Scheme assets | – | – | 2 198 127 | – | – | 2 198 127 | 2 198 127 |
| Personal Medical Savings Account trust assets | – | | 3 667 456 | – | – | 3 667 456 | 3 667 456 |
| **Trade and other receivables** | – | – | 107 266 | 1 525 320 | – | 1 632 586 | 1 632 586 |
| **Personal Medical Savings Accounts** | – | – | (3 736 659) | | – | (3 736 659) | (3 736 659) |
| **Trade and other payables** | – | – | – | (714 900) | (467 705) | (1 182 605) | (1 182 605) |
| **Derivatives held for trading** | | | | | | | |
| – Zero-cost collars | – | (65 210) | – | – | – | (65 210) | (65 210) |
| – Other | – | – | – | – | – | – | – |
| | 11 399 332 | (65 210) | 2 236 190 | 810 420 | (467 705) | 13 913 027 | 13 913 027 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are through its trade and other receivables, investments and cash.

### Trade and other receivables

Trade and other receivables comprise of insurance receivables and loans and receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt.

### Exposure to credit risk

The carrying amount of trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis. The tables below highlights Trade and other receivables which are due and past due (by number of days).

| | Total member and service provider claims receivables | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| R'000 | Active member claims receivables | Withdrawn member claims receivables | Service provider claims receivables | Total | Contribution receivables | Other risk transfer arrangements | Broker fee receivables | Other insurance receivables | Loans and receivables | Total |
| **31 December 2016** | | | | | | | | | | |
| Not past due | **2 395** | **5 150** | **10 249** | **17 794** | **1 615 128** | **24 426** | **(90)** | **138 781** | **179 900** | **1 975 939** |
| Past due 0 – 30 days | **1 677** | **6 474** | **8 720** | **16 871** | **8 712** | **–** | **(78)** | **–** | **–** | **25 505** |
| Past due 31 – 60 days | **1 751** | **8 539** | **(2 511)** | **7 779** | **6 972** | **–** | **(13 524)** | **–** | **–** | **1 227** |
| Past due 61 – 90 days | **2 757** | **8 250** | **1 295** | **12 302** | **(7 135)** | **–** | **15 370** | **–** | **–** | **20 537** |
| Past due 91 – 120 days | **2 918** | **8 809** | **11 616** | **23 343** | **15 709** | **–** | **95** | **–** | **–** | **39 147** |
| Past due 121 – 150 days | **2 305** | **10 447** | **(4 980)** | **7 772** | **–** | **–** | **55** | **–** | **–** | **7 827** |
| 151 days to more than one year | **29 308** | **227 748** | **(1 444)** | **255 612** | **–** | **–** | **120** | **–** | **–** | **255 732** |
| **Gross receivables** | **43 111** | **275 417** | **22 945** | **341 473** | **1 639 386** | **24 426** | **1 948** | **138 781** | **179 900** | **2 325 914** |
| Provision for impairments | **(26 707)** | **(220 454)** | **(10 122)** | **(257 283)** | **(9 759)** | **-** | **(864)** | **-** | **-** | **(267 906)** |
| Trade and other receivables neither past due nor impaired | **16 404** | **54 963** | **12 823** | **84 190** | **1 629 627** | **24 426** | **1 084** | **138 781** | **179 900** | **2 058 008** |
| **31 December 2015** | | | | | | | | | | |
| Not past due | 1 239 | 4 217 | 8 796 | 14 252 | 1 379 759 | 7 520 | 11 394 | 60 869 | 107 266 | 1 581 060 |
| Past due 0 – 30 days | 2 330 | 6 583 | 2 119 | 11 032 | 9 595 | – | 317 | – | – | 20 944 |
| Past due 31 – 60 days | 4 023 | 7 653 | (5 731) | 5 945 | 4 514 | – | (242) | – | – | 10 217 |
| Past due 61 – 90 days | 1 904 | 6 598 | 6 834 | 15 336 | 6 261 | – | (22) | – | – | 21 575 |
| Past due 91 – 120 days | 2 321 | 9 872 | (1 112) | 11 081 | (3 992) | – | (441) | – | – | 6 648 |
| Past due 121 – 150 days | 3 015 | 9 977 | (5 904) | 7 088 | – | – | 11 | – | – | 7 099 |
| 151 days to more than one year | 24 476 | 183 021 | 6 614 | 214 111 | – | – | (10 122) | – | – | 203 989 |
| **Gross receivables** | **39 308** | **227 921** | **11 616** | **278 845** | **1 396 137** | **7 520** | **895** | **60 869** | **107 266** | **1 851 532** |
| Provision for impairments | (22 196) | (178 471) | (7 862) | (208 529) | (9 633) | – | (784) | – | – | (218 946) |
| Trade and other receivables neither past due nor impaired | 17 112 | 49 450 | 3 754 | 70 316 | 1 386 504 | 7 520 | 111 | 60 869 | 107 266 | 1 632 586 |

Based on past experience, the Scheme believes that no provision for impairment is required in respect of Contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Exposure to credit risk *continued*

#### Provision for impairment

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counter party.

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.

The movement in the provision for impairment, for each component of trade and other receivables, during the year ended 31 December:

| | Trade and other receivables | | | | |
|---|---|---|---|---|---|
| | *Insurance receivables* | | | | |
| R'000 | Contribution receivables | Member and service provider claims receivables | Other risk transfer arrangements | Broker fee receivables | Total |
| **Balance as at 1 January 2015** | 7 106 | 177 458 | – | 600 | 185 164 |
| Increase in provision for impairment | 2 527 | 61 005 | – | 184 | 63 716 |
| Amounts utilised during the year | – | (29 934) | – | – | (29 934) |
| **Balance as at 31 December 2015** | 9 633 | 208 529 | – | 784 | 218 946 |
| **Balance as at 1 January 2016** | **9 633** | **208 529** | **–** | **784** | **218 946** |
| Increase in provision for impairment | **126** | **76 422** | **–** | **81** | **76 629** |
| Amounts utilised during the year | **–** | **(27 668)** | **–** | **(1)** | **(27 669)** |
| **Balance as at 31 December 2016** | **9 759** | **257 283** | **–** | **864** | **267 906** |

## 32 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 pages 138 to 139 can be assessed by reference to historical information about counterparty default.

#### Contribution debtors

The Scheme collected over 97% (2015: 98%) of outstanding debt in January 2017. Therefore we can establish that the credit quality of contribution debtors is high. Consequently, no additional disclosure of the credit quality is provided.

#### Active member claims debtors

A provision for impairment covering 62% (2015: 56%) 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% (2015: 78%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

#### Other insurance receivables and loans and receivables

These debtors mainly comprises of amounts due by hospitals, which are inherently of high quality. As agreed with the providers the majority of these receivables are recovered by reducing future provider payments providing a high certainty of recoverability and thus no further analysis has been performed on these receivables.

#### Financial assets held at fair value through profit or loss, cash and cash equivalents and derivative financial instruments

The Scheme's credit risk exposures as at 31 December were as follows:

| R'000 | **2016** | 2015 |
|---|---|---|
| – Offshore bonds | **1 245 709** | 1 335 137 |
| – Yield enhanced bonds | **3 413 740** | 3 058 012 |
| – Inflation linked bonds | **610 476** | 464 574 |
| – Money market instruments | **4 891 918** | 5 125 962 |
| – Cash and cash equivalents | **2 397 788** | 2 198 127 |
| – Derivative financial instruments | **50 384** | – |
| | **12 610 015** | 12 181 812 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Exposure to credit risk

The Scheme manages credit risk 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 pages 144 to 145.

Derivative counterparties are limited to high credit quality financial institutions.

The Scheme's credit risk policy guides the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure;
- Industry exposure; and
- Expected loss.

Compliance with the limits are regularly monitored with a quarterly report back presented to the Scheme's Investment Committee.

The Scheme has assessed whether the above financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market value stated above.

### 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.

#### Short-term rating scales

**F1: Highest short-term credit quality**

F1 indicates the strongest intrinsic capacity for timely payment of financial commitments; they may have an added "+" to denote any exceptionally strong credit feature.

## 32 Financial risk management report *continued*

### 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.

At 31 December 2016 1.8% (2015: 2.8%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

**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.

At 31 December 2016 1% (2015: 0.6%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

**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.

At 31 December 2016 0.5% (2015: 0.5%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

**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.

At 31 December 2016 1.6% (2015: 2.6%) of the Scheme's financial assets at fair value through profit or loss invested in instruments with this credit rating.

**CC: Very high levels of credit risk**
Default of some kind appears probable.

At 31 December 2016 0% (2015: 0.1%) of the Scheme's financial assets at fair value through profit or loss invested in instruments with this credit rating.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

The following table discloses the Scheme's asset credit ratings using official credit ratings. 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 4% (2015: 4%) of the instruments are invested in non-investment grade instruments after consideration of internally assigned credit ratings.

| | | Short–term rating | | Long–term rating | | Long–term rating | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| R'000 | Total | F1+ | F1 | Govt | AAA | AA+ to AA– | A+ to A– | BBB– to BBB+ | BB– to BB+ | B– to B+ | CCC+ to CCC– | CC+ | Not rated |
| **2016** | | | | | | | | | | | | | |
| **At fair value through profit or loss:** | **10 161 843** | **833 313** | **5 779** | **565 317** | **1 380 392** | **2 360 938** | **3 718 408** | **223 471** | **128 709** | **57 319** | **189 501** | **–** | **698 696** |
| – Offshore bond portfolio | **1 245 709** | **843** | **5 282** | **–** | **242 723** | **445 651** | **221 380** | **113 316** | **128 709** | **57 319** | **4 460** | **–** | **26 026** |
| – Yield enhanced bond portfolio | **3 413 740** | **54 870** | **497** | **60 997** | **565 333** | **980 241** | **1 066 578** | **110 155** | **–** | **–** | **29 068** | **–** | **546 001** |
| – Inflation linked bond portfolio | **610 476** | **(21 377)** | **–** | **445 255** | **16 688** | **31 581** | **138 329** | **–** | **–** | **–** | **–** | **–** | **–** |
| – Money market portfolios | **4 891 918** | **798 977** | **–** | **59 065** | **555 648** | **903 465** | **2 292 121** | **–** | **–** | **–** | **155 973** | **–** | **126 669** |
| **Cash and cash equivalents** | **2 397 788** | **1 640 731** | **–** | **6 608** | **201** | **312 962** | **370 752** | **–** | **–** | **–** | **15 409** | **–** | **51 125** |
| **Total*** | **12 559 631** | **2 474 044** | **5 779** | **571 925** | **1 380 593** | **2 673 900** | **4 089 160** | **223 471** | **128 709** | **57 319** | **204 910** | **–** | **749 821** |
| **2015** | | | | | | | | | | | | | |
| **At fair value through profit or loss:** | 9 983 685 | 856 196 | 10 142 | 592 441 | 1 400 390 | 1 959 844 | 3 879 452 | 346 423 | 116 706 | 55 001 | 290 665 | 7 525 | 468 900 |
| – Offshore bond portfolio | 1 335 137 | 11 766 | 10 110 | 62 487 | 208 689 | 217 671 | 307 201 | 218 849 | 116 706 | 55 001 | 9 645 | 7 525 | 109 487 |
| – Yield enhanced bond portfolio | 3 058 012 | 16 323 | 32 | 205 127 | 549 463 | 1 058 456 | 740 692 | 127 165 | – | – | 35 339 | – | 325 415 |
| – Inflation linked bond portfolio | 464 574 | (31 702) | – | 318 724 | 1 015 | 15 271 | 161 266 | – | – | – | – | – | – |
| – Money market portfolios | 5 125 962 | 859 809 | – | 6 103 | 641 223 | 668 446 | 2 670 293 | 409 | – | – | 245 681 | – | 33 998 |
| **Cash and cash equivalents** | 2 198 127 | 1 370 052 | – | – | 40 756 | 528 382 | 203 198 | 3 | – | – | 20 468 | – | 35 268 |
| **Total*** | 12 181 812 | 2 226 248 | 10 142 | 592 441 | 1 441 146 | 2 488 226 | 4 082 650 | 346 426 | 116 706 | 55 001 | 311 133 | 7 525 | 504 168 |

* *Excludes derivative financial assets.*

At the reporting date the credit ratings shown are the most conservative of Moody's, Fitch and S&P and have been provided in a Fitch format.

The Scheme's investments in pooled funds 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. 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 risks relating to these investments have been identified other than those already disclosed in previous sections of this report.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Credit risk (continued)

#### Credit quality (continued)

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

| Name and description | 2016 R'000 | Authorised programme/ market size | % of authorised programme size/market size | Fair value hierarchy | Debt ranking | Credit ranking | Underlying assets |
|---|---|---|---|---|---|---|---|
| Asset backed commercial paper | – | R25.3 billion | 0.00% | Level 1 – 100% | Senior secured – 0.01%<br>Secured – 99.99% | F1+: 100% | Instalment sales agreements<br>Corporate Loans<br>Credit card receivables<br>Bonds<br>Equipment Leases |
| Residential mortgage-backed securitisations | 354 568 | R43.6 billion | 0.81% | Level 1 – 93.52%<br>Level 2 – 6.48% | Senior secured – 78.65%<br>Secured – 18.39%<br>Senior Unsecured – 2.96% | A to AAA: 91.50%<br>BBB: 2.16%<br>Not Rated: 6.34% | Prime Home Loans |
| Asset backed securitisations | 249 368 | R27.7 billion | 0.90% | Level 1 – 71.11%<br>Level 2 – 28.89% | Senior secured – 89.89%<br>Secured – 5.64%<br>Senior Unsecured – 4.47% | A to AAA: 71.11%<br>BBB: 0.34%<br>Not Rated: 28.55% | Vehicle Loans<br>Corporate Loans<br>Unsecured Loans<br>Equipment Leases |
| Commercial mortgage-backed securitisations | 24 401 | R2.5 billion | 0.98% | Level 1 – 100% | Senior secured | AA to AAA: 100% | Commercial Property |
| Collateralised loan obligations | 54 337 | R17 billion | 0.32% | Level 1 – 100% | Senior secured – 0.01%<br>Secured – 59.41%<br>Unsecured – 40.58% | AA to AAA: 100% | Vehicle Loans |
| Collective investment schemes | 3 692 | R52.8 billion | 0.01% | Level 2 | | AA+ | ABSA Money Market Fund |
| | 917 | R14.0 billion | 0.01% | Level 2 | | AA+ | Nedgroup Investments Money Market Class C2 |
| | – | R12.6 billion | 0.00% | Level 2 | | AA- | Nedgroup Investments Core Income Fund Class C2 |
| | _ | R9.2 billion | 0.00% | Level 2 | | AA+ | Momentum Money Market Fund B6 |
| | 1 468 | R26.4 billion | 0.01% | Level 2 | | AA+ | Standard Bank Corporate Money Market Fund |
| | 848 | R13.7 billion | 0.01% | Level 2 | | AA+ | Investec Corporate Money Market Fund |
| | 672 885 | R4.5 billion | 0.02% | Level 2 | | A | Investec Target Return Fund |

## 32 Financial risk management report *continued*

### Credit risk (continued)

#### Credit quality (continued)

| Name and description | 2015 R'000 | Authorised programme/ market size | % of Authorised programme size/market size | Fair Value hierarchy | Debt ranking | Credit ranking | Underlying assets |
|---|---|---|---|---|---|---|---|
| Asset backed commercial paper | 5 086 | R25.3 billion | 0.02% | Level 1 – 100% | Senior secured – 0.01%<br>Secured – 99.99% | F1+: 100% | Instalment sales agreements<br>Corporate Loans<br>Credit card receivables<br>Bonds<br>Equipment Leases |
| Residential mortgage-backed securitisations | 429 092 | R69.4 billion | 0.62% | Level 1 – 97.06%<br>Level 2 – 2.94% | Senior secured – 26.24%<br>Secured – 72.44%<br>Senior Unsecured – 1.32% | A to AAA: 93.17%<br>Bbb: 1.67%<br>F1+: 2.22%<br>Not Rated: 2.94% | Prime Home Loans |
| Asset backed securitisations | 233 452 | R28.2 billion | 0.83% | Level 1 – 79.69%<br>Level 2 – 20.31% | Senior secured – 16.89%<br>Secured – 79.69%<br>Senior Unsecured – 3.42% | A to AAA: 79.01%<br>BBB: 0.39%<br>CCC: 2.17%<br>Not Rated: 18.43% | Vehicle Loans<br>Corporate Loans<br>Unsecured Loans<br>Equipment Leases |
| Commercial mortgage-backed securitisations | 10 242 | R2.5 billion | 0.41% | Level 1 – 100% | Senior secured | AA to AAA: 100% | Commercial Property |
| Collateralised loan obligations | 64 033 | R33.5 billion | 0.19% | Level 1 – 100% | Senior secured – 0.01%<br>Secured – 59.41%<br>Unsecured – 40.58% | AA to AAA: 100% | Vehicle Loans |
| Collective investment schemes | 8 135 | R52.8 billion | 0.02% | Level 2 | | AA+ | ABSA Money Market Fund |
| | 1 317 999 | R14.0 billion | 9.42% | Level 2 | | AA+ | Nedgroup Investments Money Market Class C2 |
| | 1 325 | R12.6 billion | 0.01% | Level 2 | | AA- | Nedgroup Investments Core Income Fund Class C2 |
| | 751 | R9.2 billion | 0.01% | Level 2 | | AA+ | Momentum Money Market Fund B6 |
| | 4 818 | R26.4 billion | 0.02% | Level 2 | | AA+ | Standard Bank Corporate Money Market Fund |
| | 1 421 | R13.7 billion | 0.01% | Level 2 | | AA+ | Investec Corporate Money Market Fund |
| | 716 812 | R4.5 billion | 0.02% | Level 2 | | A | Investec Global Strategic Income Fund |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 Financial risk management report *continued*

### Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 94% (R1.6 billion) (2015: 98% – R1.5 billion) of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

A maturity analysis for financial liabilities carried at amortised cost, excluding liabilities arising from insurance contracts is provided below:

| | Less than 1 year | Between 1 and 2 years | Between 2 and 5 years |
|---|---|---|---|
| **As at 31 December 2016** | | | |
| Personal Medical Savings Accounts (Note 8) | **4 204 043** | **–** | **–** |
| Trade and other payables (Note 9) | **521 690** | **–** | **–** |
| | **4 725 733** | **–** | **–** |
| **As at 31 December 2015** | | | |
| Personal Medical Savings Accounts (Note 8) | **3 736 659** | **–** | **–** |
| Trade and other payables (Note 9) | **467 705** | **–** | **–** |
| | **4 204 364** | **–** | **–** |

### 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 (for example, investments in pooled funds and collective investment schemes) 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.

## 32 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 | **R'000** | **Level 1** | **Level 2** | **Level 3** |
| **2016** | | | | |
| Financial assets at fair value through profit or loss: | | | | |
| Offshore bonds | **1 245 709** | **–** | **1 245 709** | **–** |
| Equities | **2 049 834** | **2 049 608** | **226** | **–** |
| Yield-enhanced bonds | **3 413 740** | **1 872 474** | **1 541 266** | **–** |
| Inflation-linked bonds | **610 476** | **587 154** | **23 322** | **–** |
| Money market instruments | **4 891 918** | **2 408 873** | **2 483 045** | **–** |
| | **12 211 677** | **6 918 109** | **5 293 568** | **–** |
| **2015** | | | | |
| Financial assets at fair value through profit or loss: | | | | |
| Offshore bonds | 1 335 137 | – | 1 335 137 | – |
| Equities | 1 415 647 | 1 413 048 | 2 599 | – |
| Yield-enhanced bonds | 3 058 012 | 1 477 038 | 1 545 635 | 35 339 |
| Inflation-linked bonds | 464 574 | 454 127 | 10 447 | – |
| Money market instruments | 5 125 962 | 2 334 946 | 2 545 335 | 245 681 |
| | 11 399 332 | 5 679 159 | 5 439 153 | 281 020 |

During the 2015 financial year, investments in African Bank to the value of R281 million were classified under level 3 as a result of no trading activity in these instruments due to the curatorship. The valuation was determined using a discounted cash flow methodology based on information available in the market and incorporates certain assumptions applicable to these instruments. The discount rate was determined by adding a premium to comparative rates of similar institutions operating in the unsecured lending market. During the year under review, trading activity resumed on African Bank instruments and these have now been reclassified to Level 2.

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 ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 32 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 | Fair value as at 31 December 2016 R'000 | Fair value as at 31 December 2015 R'000 | Valuation techniques | Observable Input |
|---|---|---|---|---|
| Financial assets at fair value through profit or loss: | | | | |
| **Unlisted:** | | | | |
| Debt securities | **2 810 297** | 2 891 219 | Reference to listed benchmark bond | Risk free yield to maturity curve risk free zero curve |
| Money market securities | **2 483 271** | 2 547 934 | 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 |
| | **5 293 568** | 5 439 153 | | |

### 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 to be 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 | 2016 | 2015 |
|---|---|---|
| Total members' funds per Statement of Financial Position | **14 234 461** | 12 929 011 |
| Less: cumulative unrealised net gain on remeasurement of investments to fair value | **–** | – |
| Accumulated funds per Regulation 29 | **14 234 461** | 12 929 011 |
| Gross annual contribution income | **54 056 212** | 49 759 756 |
| Solvency margin | | |
| = Accumulated funds / gross annual contribution income x 100 | **26.33%** | 25.98% |

At 31 December 2016, the Scheme's regulatory capital level of 26.33% (2015: 25.98%) was R719 million (2015: R488 million) more than the statutory capital requirement of 25%.

## 33 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 31.

### Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 11.

### Impairment of assets

The critical estimates made by the Scheme are set out under Note 32 and judgements relating to the impairment of assets are set out under Note 7 of the Accounting policies.

## 34 Non-compliance matters

The Council for Medical Schemes issued Circular 11 of 2006 (the "Circular") dealing with issues to be addressed in the audited financial statements of medical schemes. The Circular requires that all non-compliance matters noted should be disclosed in the audited financial statements, irrespective of whether the auditor considers it as material or immaterial.

During the year the Scheme did not comply with the following Sections and Regulations of the Act.

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

  During 2016, the Scheme's solvency level dropped below 25% during January and November. The reason for the drop below 25% in January was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year). Negative claims experience during November, in line with historic trends, caused the solvency ratio to drop below 25%.

  At 31 December 2016, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 26.33% (2015: 25.98%), which exceeds the statutory solvency requirement of 25%.

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

  For the year ended 31 December 2016 the following plans did not comply with Section 33 (2):

| | Net healthcare result (R'000) | Net surplus/ (deficit) (R'000) |
|---|---|---|
| **Benefit plan** | | |
| Executive | **(350 528)** | **(341 248)** |
| Classic Comprehensive | **(872 500)** | **(741 888)** |
| Classic Comprehensive Zero MSA | **(2 040)** | **(1 072)** |
| Coastal Saver | **(184 640)** | **(31 011)** |
| Coastal Core | **(32 915)** | **67 366** |
| KeyCare Plus | **(579 629)** | **(314 518)** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS *continued*

for the year ended 31 December 2016

## 34 Non-compliance matters *continued*

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes, and we continually evaluate different strategies to address the deficit in these plans.

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

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

- **Investment in Employer Groups and Medical Scheme Administrators**
  Section 35 (8) (a) and (c) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. 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 granted DHMS exemption from these sections of the Act up to 21 April 2018.

- **Investments in other assets in territories outside the Republic of South Africa**
  The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by International Swaps and Derivatives Association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied. Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Medical Schemes Act 131 of 1998.

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

  During August and September, a breach of the Scheme's foreign derivative exemption (Category 7 (b) of Annexure B) occurred where the Investec Target Return Bond Fund portfolio (collective investment scheme) derivative exposure was greater than 2.5% due to large foreign exchange fluctuations as a result of Brexit. The breach was rectified on 21 September 2016. This was duly reported to the CMS on 26 October 2016. It should be noted despite the recorded breach at an Investec Target Return Bond Fund portfolio level, the fair value of the Scheme's total offshore derivative exposures was only 0.19% of the aggregate fair value of Scheme liabilities and minimum accumulated funds at 31 August 2016.

## 34 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 days; however, there are no contracts in place agreeing to this practice. It is important to note that the Scheme has no control over the timely payment of contributions. The legal obligation resides with the members/employers to pay contributions within the prescribed period.

  DHMS however employ 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).

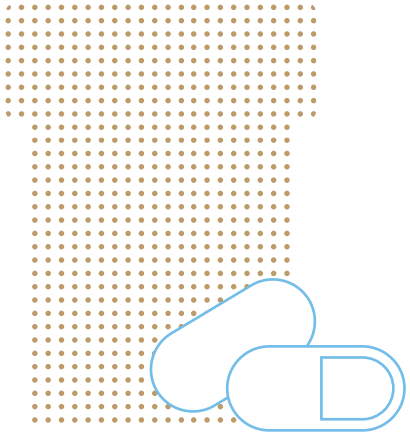
  In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.02% 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.

- **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 process of transitioning to a new claims administration platform, quality assurance processes were significantly extended to ensure valid, accurate and complete processing of claims on the new claims administration platform. This process resulted in a delay in the processing of claims payments. A total number of 34 claims were identified that were paid later than 30 days after claims notification date. The value of exceptions should be considered in the context of net claims incurred of R36.6 billion during 2016. Exceptions identified pertained to a specific event i.e. transitioning to a new claims administration platform and thus no further action is required. The claims administration platform is set up to ensure payments occur within regulatory requirements.

# 07 Information Toolkit



## PRINCIPAL OFFICER CONTACT DETAILS

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS).

## COUNCIL FOR MEDICAL SCHEMES CONTACT DETAILS

DHMS is regulated by the Council for Medical Schemes (CMS).

The CMS can be contacted telephonically on **0861 123 267** or via email on **information@medicalschemes.com**.

The CMS is located at Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157.

## Important sources of information

More information about DHMS is available at **www.discovery.co.za/portal/individual/about-discovery-health-medical-scheme**.

A full version of the Scheme Rules is available to registered members at **www.discovery.co.za/medical-aid/scheme-rules**.

More information about the various health plans offered by the Scheme are available at **www.discovery.co.za/portal/individual/medical-aid-plan-range**.

The Medical Schemes Act 131 of 1998, as amended, which regulates medical schemes, is available on the Council for Medical Schemes' website at **www.medicalschemes.com/Content.aspx?130**.

The International Integrated Reporting Framework and related resources can be found at **http://integratedreporting.org/**.

The King Code of Governance for South Africa 2009 (King III) and the King IV Report on Corporate Governance for South Africa 2016 (King IV) can be found at **www.iodsa.co.za/?page=kingIII**.

## Who to contact when you

**→ HAVE ANY QUERIES ABOUT YOUR HEALTH PLAN**

Email **healthinfo@discovery.co.za** or call **0860 99 88 77 (+27 11 541 1222 when overseas)**. Remember to put your membership number in the subject line of the email.

**→ HAVE A MEDICAL EMERGENCY**

Call **0860 999 911 (+27 11 541 1222 when overseas)**. Remember to have your membership number ready.

**→ WANT TO SUBMIT A CLAIM**

Email **claims@discovery.co.za**. Remember to put your membership number in the subject line of the email.

**→ HAVE A QUERY ABOUT HOW A CLAIM WAS PAID**

**www.discovery.co.za/portal/individual/claims-search**. You will need to be logged into the website to find the information you need.

**→ WANT TO FIND INFORMATION ABOUT HOW WE COVER CERTAIN PROCEDURES**

**www.discovery.co.za/portal/individual/what-we-cover**. You will need to be logged into the website to find the information you need.

**→ WANT TO FIND A DOCTOR WHERE YOU WON'T HAVE TO PAY A CO-PAYMENT**

**www.discovery.co.za/portal/individual/maps-new**. You will need to be logged into the website to find the information you need.

**→ WANT TO GET PRE-AUTHORISATION FOR HOSPITAL STAYS, OR FIND OUT ABOUT GOING TO HOSPITAL**

**www.discovery.co.za/portal/individual/going-to-hospital**. You will need to be logged into the website to apply for authorisation.

**→ NEED A DOCUMENT, FOR EXAMPLE, A TAX CERTIFICATE OR MEMBERSHIP CERTIFICATE**

**www.discovery.co.za/portal/individual/find-a-document**. You will need to be logged into the website to find the information you need.

## If you want to submit a complaint or compliment, or lodge a dispute

Email **healthinfo@discovery.co.za**.
Remember to include your Discovery Health Medical Scheme membership number. Alternately, use the contact form on **www.discovery.co.za.**

### When you want to escalate a complaint to which you haven't received a satisfactory answer

Email **healthinfo@discovery.co.za**. Remember to include your Discovery Health Medical Scheme membership number, and specify in your email that you would like a Client Relationship Manager to contact you. If you have reference numbers from previous emails, please include these as well.

### When you want to contact the Principal Officer regarding a complaint escalation

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme.

### When you want to lodge a formal dispute

Email **mydispute@discovery.co.za** or call **+27 11 529 2888** and ask to speak to a member of the Disputes team.

### When you want to submit a complaint to the Council for Medical Schemes (CMS)

You can contact the CMS at any stage of the complaints process but are encouraged to follow the steps above to resolve your complaint before contacting the CMS directly.

Email **complaints@medicalschemes.com** or call CMS Customer Care on **0861 123 267**.

## If you want to provide feedback on the Scheme's Integrated Annual Report

**We would welcome specific feedback on the following:**

- Was the Report understandable to you?
- Were you able to find the information you were looking for?
- Did the Report cover all the information relevant to your relationship with the Scheme?
- Was the 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**.

### Want to choose the best plan for you and your family?

Choosing a plan for your family can be confusing, given the amount of information you have to consider. It is best to speak to your financial adviser, who will help you make the right decision based on your unique needs. It is also important to re-assess your plan every year before the annual cut-off date for plan changes, as your needs change and so do the contributions and benefits.

Financial advisers must be registered with the Financial Services Board and accredited by the Council for Medical Schemes. The Scheme pays the financial advisers' commission.

## If you want to report fraud or unethical behaviour

Discovery Health provides a fraud hotline on behalf of the Scheme, and investigates possible instances of fraud. If you even slightly suspect someone of committing fraud, report all information to the fraud hotline.

You can also email our fraud department at **forensics@discovery.co.za** directly to investigate the matter. Discovery Health may reward you up to 10% of the monies recovered, as a result of reporting suspected fraud.

You may remain anonymous if you prefer.

- Toll-free phone: **0800 0045 00**
- Toll-free fax: **0800 00 77 88**
- Email: **discovery@tip-offs.com**
- Post: **Freepost DN298, Umhlanga Rocks 4320**

## Information Toolkit *continued*

## REGISTERED ADDRESSES

**PRINCIPAL OFFICER**
Dr Nozipho Sangweni
Discovery Health Medical Scheme
16 Fredman Drive
Sandton, 2196

**REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS**
Discovery Health Medical Scheme
16 Fredman Drive
Sandton, 2196
*PO Box 78622*
*Sandton, 2146*

**ADMINISTRATOR AND MANAGED CARE PROVIDER**
Discovery Health (Pty) Ltd
16 Fredman Drive
Sandton, 2196
*PO Box 786722*
*Sandton, 2146*

**AUDITORS**
PricewaterhouseCoopers Incorporated
2 Eglin Road
Sunninghill, 2157
*Private Bag X36*
*Sunninghill, 2157*

**PRINCIPAL BANKERS**
FNB Corporate
4 First Place, FNB Bank City
Cnr Pritchard & Simmonds Streets
Johannesburg, 2011
*PO Box 7791*
*Johannesburg, 2000*

## INVESTMENT MANAGERS

**ABAX INVESTMENTS (PTY) LTD**
Coronation House, The Oval
1 Oakdale Road
Newlands, 7700
*PO Box 23851*
*Claremont, 7735*

**ALLAN GRAY INVESTMENTS (PTY) LTD**
1 Silo Square
V&A Waterfront
Cape Town, 8001
*PO Box 51318*
*V&A Waterfront*
*Cape Town, 8002*

**ALUWANI CAPITAL PARTNERS**
EPPF Office Park
24 Georgian Crescent East
Bryanston East
*2152*

**ELECTUS FUND MANAGERS (PTY) LTD**
Ground Floor
Great Westerford Building
240 Main Road
Rondebosch, 7700
*PO Box 23540*
*Cape Town, 8000*

**FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD**
3rd Floor, Great Westerford Building
240 Main Road
Rondebosch, 7700
*Private Bag X6*
*Newlands, 7725*

**INVESTEC ASSET MANAGEMENT (PTY) LTD**
36 Hans Strijdom Avenue
Foreshore
Cape Town, 8001
*PO Box 1826*
*Cape Town, 8000*

100 Grayston Drive
Sandown
Sandton, 2196
*PO Box 785700*
*Sandton, 2146*

**LIBERTY CORPORATE**
Libridge Building
25 Ameshoff Street
Braamfontein

**MAZI ASSET MANAGEMENT**
4th Floor North Tower
90 Rivonia Road
Sandton
*2196*

**TAQUANTA ASSET MANAGERS (PTY) LTD**
7th Floor, Newlands Terraces
Boundary Road
Newlands
Cape Town, 7700
*PO Box 23540*
*Claremont, 7735*

# GLOSSARY

This glossary contains definitions of some of the terms used in this Report, as well as some additional terms which may be of interest to readers. The list of terms is not exhaustive – see more at **www.discovery.co.za/portal/medical-aid/terminology**.

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| **Administration** | Basic medical scheme administration services include the collection of contributions, member and provider support services and the processing and paying of claims. Discovery Health (Pty) Ltd provides (DHMS) with a broad range of additional administration services, such as research and development activities, actuarial and business analytics, benefit design, fraud and forensics investigation, and marketing and communication services. |
| **Benefits** | Benefits (including medical services, procedures and/or medication) are offered by DHMS and relate to the healthcare cover a member receives in return for monthly contributions. DHMS has a wide range of plans designed to offer a variety of benefits to cater for individual requirements. Examples of DHMS benefits include *Hospital Benefits, Chronic Illness Benefits* and *Day-to-day Benefits*. |
| **Board of Trustees** | The Board oversees the affairs of the Scheme in the best interest of its members and stakeholders. Trustees are highly skilled individuals who offer their knowledge and experience to the Scheme. They may be elected or appointed, but at any time at least 50% of the Board must be elected by Scheme members. |
| **Brokers** | See financial advisers. |
| **Claims paying ability** | Claims paying ability refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments. |
| **Claims provision** | See incurred but not reported (IBNR). |
| **Consumer Price Index (CPI)** | The Consumer Price Index (CPI) is the official measure of inflation in South Africa. CPI measures monthly changes in prices for a range of consumer products. Changes in CPI record the rate of inflation. CPI can also be used as a cost-of-living index. |
| **Council for Medical Schemes** | The Council for Medical Schemes (CMS) is a statutory body responsible for regulating the medical schemes industry in South Africa; it administers and enforces the Medical Schemes Act 131 of 1998, as amended. |
| **Dependant** | A person admitted as a dependant of a member. Beneficiaries of the Scheme include all members and their dependants. |
| **Designated Service Provider (DSP)** | The hospitals and healthcare providers and professionals with whom DHMS has contracted to provide healthcare services to members. DSPs have a payment arrangement with the Scheme to provide treatment or services at an agreed rate and without any co-payments required by members. |
| **Discovery Limited** | An international organisation made up of companies like Discovery Health, Discovery Life, Discovery Vitality, Discovery Card and Discovery Insure. Discovery was named by Fortune Magazine as one of the 51 companies globally that have made a sizeable impact on major global, social or environmental problems as part of their competitive strategy and in 2015 received the Geneva Forum for Health Award, which recognises advances and contributions to healthcare systems.<br><br>DHMS members have the option to join Discovery Vitality to take advantage of Vitality's wellness programmes as a complement to their medical insurance. |
| **Discovery Health (Pty) Ltd** | Discovery Health (Pty) Ltd has been appointed by the Board of Trustees to provide administration and managed care services to the Scheme. |
| **Discovery Health Medical Scheme (DHMS or the Scheme)** | Discovery Health Medical Scheme is a registered medical scheme, and like all other medical schemes in South Africa is a non-profit entity. The Scheme pools all members' contributions in order to fund members' claims. Any surplus funds are transferred to Scheme reserves for the benefit of members. The Scheme exists to serve its members' interests by enabling the sustainable provision of high-quality and affordable healthcare to all of its members. |

## Glossary *continued*

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| **Discovery Health Medical Scheme Rules (Scheme Rules or the Rules)** | The Rules of the Scheme are registered by the Registrar for Medical Schemes in terms of the Medical Schemes Act 131 of 1998, as amended (the Act), including the benefit plan and schedules. Together with the Act, the Rules dictate how Discovery Health Medical Scheme operates. |
| **Discovery Vitality** | Discovery Vitality is a voluntary science-based wellness programme that encourages its members to get healthier by rewarding them for making healthy choices in support of wellness. Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider. |
| **Financial advisers (brokers)** | Financial advisers (commonly also referred to as "brokers") provide members with independent advice about their health plan options based on individual medical and affordability needs. Financial advisers must be registered with the Financial Services Board and accredited by the Council for Medical Schemes. The Scheme pays contracted financial advisers a legislated commission. |
| **Formulary** | See *Medicine list*. |
| **Global Credit Rating Co. (GCR)** | GCR rates the full spectrum of security classes and accords both International Scale and National Scale credit ratings, and together with its international affiliates, rates almost 3 000 organisations and debt issues – spanning four continents. (Source: https://globalratings.net/). GCR has issued DHMS with the highest possible credit rating in the medical scheme industry of AA+, confirming its financial strength and claims-paying ability. |
| **Incurred but not reported (IBNR)** | The incurred but not reported (IBNR) (or "outstanding claims provision") is the total amount of payments due by the Scheme (in terms of its Rules) to healthcare providers for claims incurred (healthcare services provided/medicine supplied) by its members and/or their dependants, but which have not been lodged/reported to the Scheme by the period end. The IBNR is an estimate and the Scheme makes use of various actuarial methods to reasonably predict such amounts at the period end. Further detail has been provided in Note 31 (Insurance Risk Management Report) to the Annual Financial Statements on pages 125 – 129. |
| **King Code of Governance Principles and the King Report on Governance (King III), and the King IV Report (King IV)** | The King Code is a set of guidelines for the governance structures and operations of organisations in South Africa and is non-legislative, being based on principles and practices. The Institute of Directors in Southern Africa (IoDSA) introduced the King Code of Governance Principles and the King Report on Governance (King III) in 2009 and introduced King IV in 2016. |
| **Managed care** | Managed care is the provision of appropriate, affordable, quality healthcare services through rules-based, clinical and disease management programmes. |
| **Material matters** | These are issues that impact on the Scheme's ability to create value. They are determined by considering their effect on the organisation's strategy, governance, performance or prospects. An understanding of the perspectives of key stakeholders is critical to identifying relevant matters. |
| **Medical Savings Account** | The Medical Savings Account (MSA) is an amount that gets set aside for members at the beginning of each year or when they join the Scheme. Members who choose a health plan with an MSA can use it for day-to-day healthcare expenses like doctor's visits, optometry, medicine, pathology and radiology as long as they have money available. MSA funds not used at the end of the year will be carried over to the next year. |
| **Medical Schemes Act 131 of 1998, as amended (the Act)** | All registered schemes are regulated according to the Medical Schemes Act. Discovery Health Medical Scheme operates according to the Act.<br>See **www.medicalschemes.com/Content.aspx?130**. |

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| **Medicine list** | A list of approved medicines the Scheme covers in full. The list is also known as a formulary or preferred medicine list and includes an extensive range of high-quality medicines. The medicine list used by the Scheme for the Chronic Disease List complies with the guidelines issued by the Council for Medical Schemes and are safe, clinically appropriate, and cost-effective for the treatment of a specific condition. |
| **Member** | A person who is admitted as a member in terms of the Rules of the Scheme. A member may not be a dependent of another member, but may have dependants. |
| **Networks and network providers** | Some health plans, benefits and healthcare services require members to use the Scheme's network providers. By using these providers, the Scheme is able to keep member contributions as affordable as possible while at the same time ensuring full cover. |
| **Non-healthcare expenses** | The sum of non-healthcare fees paid to the Administrator, financial adviser commissions (acquisition costs) and other management expenses (which include advertising expenditure, staff costs, bad debts, impairments, etc). Schemes are obligated to exercise a high degree of control over non-healthcare expenditure, as these can place additional pressure on their net healthcare performances, particularly in high-claiming years. |
| **Open (unrestricted) scheme** | A medical scheme which anyone can join, subject to the rules of the scheme (see restricted (closed) scheme). |
| **Prescribed Minimum Benefit conditions** | In terms of the Medical Schemes Act 131 of 1998 and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:<br>▪ Any life-threatening emergency medical condition;<br>▪ A defined set of 270 diagnosis and treatment pairs; and<br>▪ 27 chronic conditions.<br>These conditions and their treatments are known as the Prescribed Minimum Benefits (PMB).<br>All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members. There are, however, certain requirements that a member must meet before they can benefit from the Prescribed Minimum Benefits.<br>The three requirements are:<br>1. The condition must be part of the list of defined PMB conditions;<br>2. The treatment needed must match the treatments in the defined benefits on the PMB list; and<br>3. Members must use the scheme's designated healthcare service providers, unless in an emergency, or may be required to make a co-payment. |
| **Restricted (closed) scheme** | A medical scheme to which membership is restricted, based on employment by a particular employer or in a particular profession, trade or industry (see open (unrestricted) scheme). |
| **Scheme Rules** | See *Discovery Health Medical Scheme Rules*. |
| **Solvency** | The Medical Schemes Act of 1998 requires that each scheme retain a buffer of cash reserves to utilise against higher than expected claims resulting from random industry variations, including unexpected changes in membership profile, very large individual claims, and multiple claims arising from a catastrophic event or an epidemic. The minimum required solvency level to be maintained by a medical scheme is 25% of gross annual contributions. |
| **Vested®** | Vested® is an outsourcing business model, methodology, mindset and movement for creating highly collaborative business relationships that enable true win-win relationships in which both parties are equally committed to each other's success. When applied, a Vested® approach fosters an environment that sparks innovation, resulting in improved service, reduced costs and value that didn't exist before – for both parties. Vested® is based on award-winning research conducted by the University of Tennessee's College of Business Administration. (Source: www.vestedway.com/). |
| **Vitality** | See *Discovery Vitality*. |

Find more terms at **www.discovery.co.za/portal/medical-aid/terminology.**

Discovery Health Medical Scheme

Contact Centre 0860 99 88 77 | healthinfo@discovery.co.za | www.discovery.co.za

Discovery
Health Medical Scheme